



## Patient Registration Form

Date: \_\_\_\_\_

Full Name:	Last	First	Middle	(Maiden)
Address: (Street or Box)	City		State	Zip
Home Phone #	Work Phone #	Cell Phone #		Email Address
Date of Birth	Age	Gender	Driver's License # / State	
		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Marital Status (check one)			Spouse's Name (if applicable)	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated				
Occupation	Employer		Employer's Address	
If patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation may be required)				
Emergency Contact (not living at the same address)			Relationship to Patient	
City	State	Zip	Phone	
How did you hear about the Viverae Care Center?				
<input type="checkbox"/> Existing Patient (Dr. Boyd Lyles) <input type="checkbox"/> Website/Internet <input type="checkbox"/> Family/Friend (Who?) <input type="checkbox"/> Physician (Who?)				

### Pharmacy Information

Preferred Pharmacy	Address or Major intersection	Telephone Number



## Financial Responsibility Authorization

*I hereby authorize payment of medical benefits directly to Viverae Care Center, Inc. (hereinafter "VCC") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim and/or payment. I understand that this authorization may include release of information regarding mental health conditions or communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered, which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to VCC. I understand there will be a fee for any electronic correspondence anytime with Dr. Lyles as well as afterhours phone calls. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of VCC, if any.*

*The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this authorization, I am responsible for payment of services in full before the services are rendered.*

\_\_\_\_\_  
**Signature of Patient, Parent, or Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Please print name (if different from patient name below)**

\_\_\_\_\_  
**Patient name**



## Consent & Waiver

### To the Patient

By participating in the Viverae Care Center (“VCC”) programs, you have the right to be given information about VCC Services (defined below) and the risks and hazards of these Services. The purpose of this Consent and Waiver form is to provide you with this information and to obtain your consent to the Services provided by VCC.

### To the Patient’s Parent, Legal Guardian, or Managing Conservator

As the parent, legal guardian, or managing conservator of a child, you have the right to be given information about the Services provided by VCC to your child or ward and the risks and hazards associated with those Services. You are also required to provide written consent, or permission, for these Services as provided in this Consent and Waiver form. A child includes each person who is under 18 years old, unmarried, and has not had the disabilities of minority removed by court order.

I do hereby voluntarily consent to and request to have health screening and diagnostic testing performed on me by VCC. This may include, but is not limited to, (i) having my blood drawn, (ii) giving a urine specimen, and (iii) participating in: various stress tests (including a treadmill stress test); vision, hearing and heel bone density testing; psychological screening; nutritional consultations; phone and internet coaching; lung capacity testing; heart echocardiograms; and medical evaluations (collectively referred to as the “Services”). I give my permission to the VCC doctors, physician assistants, nurses, technical assistants, and other healthcare professionals, employees, volunteers and contractors to provide the Services.

### Risks and Hazards of the Services

Although it is rare that an individual is harmed by the Services performed by VCC. I have been informed by VCC and understand that the risks and hazards that may occur to me as the result of the Services include, but are not limited to: infection from the drawing of blood, heart complications or cardiac arrest from a stress test, sprained ankle or bodily injury from a treadmill stress test, and lung irritation from the lung capacity test.

In accepting these screening tests and assessments, I hereby waive all claims against VCC, its respective owners, employees, affiliates, consultants, advisors, agents, volunteers, and/or health professionals with regard to acts performed and Services rendered, statements made, or results reported to me in connection with the health screening tests and assessments. I further release VCC, its respective owners, employees, affiliates, consultants, advisors, agents, volunteers, and/or health professionals, from any and all liability, including any matter concerning any follow-up examination. My signature below indicates that I have read and fully understand this Waiver and Consent. I hereby give my permission and consent for VCC to provide myself or, as applicable, my child or ward with the Services.

I certify that I have read and fully understand this Consent and Waiver form and certify that no guarantee or assurance has been made to me concerning the results or follow-up of the Services. My signature below indicates that I have read and fully understand this Waiver and Consent. I hereby give my permission and consent for VCC to provide myself or, as applicable, my child or ward with the Services.

\_\_\_\_\_  
Signature of Patient (if over 12, must sign)

\_\_\_\_\_  
Printed Name of Patient (if over 12, must sign)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian (if applicable)

\_\_\_\_\_  
Printed Name of Parent/Guardian (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date





## Medicare Opt-Out Contract

This agreement is between Boyd D. Lyles, M.D. ("Physician"), whose principal place of business is 12810 Hillcrest Rd., Ste B129, Dallas, TX 75230, and \_\_\_\_\_ ("Patient"), who resides at \_\_\_\_\_ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B, pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on \_\_\_\_\_ for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"):

- Physical Exams
- Non-urgent healthcare

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him/her.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on: \_\_\_\_\_

by: \_\_\_\_\_

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Physician name

\_\_\_\_\_  
Physician signature



## Returning Patient Update

Appointment Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Contact's Phone \_\_\_\_\_

Physicians seen:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason seen:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your health concerns at this time:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When symptoms/concern began:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Prescription Medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dose:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication Allergies:  
\_\_\_\_\_  
\_\_\_\_\_

Reaction (rash, breathing, etc.):  
\_\_\_\_\_  
\_\_\_\_\_

Vitamins and Supplements you are now taking:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Family Health

	Age If Living	Age Deceased	Chronic Health Problems
Mother			
Father			
Brother or Sister			
Brother or Sister			
Brother or Sister			
Ages of Children			

Since your last visit, have you experienced problems with any of the following?

	Yes	No	If yes, please explain
Loss of energy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest or heart symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung or breathing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach or bowel?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone, joint or muscle?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headache or numbness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bruising or bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pelvic/sexual problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Diet and Nutrition (please just estimate a "typical" day)

Usual Breakfast \_\_\_\_\_  
 Usual Lunch \_\_\_\_\_  
 Usual Dinner \_\_\_\_\_  
 Snacks \_\_\_\_\_ Alcohol Servings per Week \_\_\_\_\_

### Current Exercise:

### Frequency:




Have you smoked/used tobacco in the past 10 years? No \_\_\_\_\_ Yes \_\_\_\_\_

Type? \_\_\_\_\_

How many nights per month do you travel and are away from home? \_\_\_\_\_

Any international trips planned in the coming year? \_\_\_\_\_

If yes, the destination? \_\_\_\_\_

Most recent Tetanus vaccination? \_\_\_\_\_ (Recommended every 10 years)

Most recent colonoscopy? \_\_\_\_\_

How is your current exposure to stress? High \_\_\_\_\_ Moderate \_\_\_\_\_ Low \_\_\_\_\_

How is your anxiety level? High \_\_\_\_\_ Moderate \_\_\_\_\_ Low \_\_\_\_\_

Do you have any concerns about being depressed? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have a hobby? \_\_\_\_\_

Do you have a Living Will? \_\_\_\_\_

Do you feel safe in your environment? (if no, please explain) \_\_\_\_\_

Health questions/concerns that you would like to have addressed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





## Your “Bucket List”

Name \_\_\_\_\_

Although known about for years, the “bucket list” concept was popularized by the 2007 movie of the same name, starring Jack Nicholson and Morgan Freeman. What is known is that formulating such a list of personal goals can be helpful in refocusing and prioritizing your time and efforts. It can be both fun and rewarding if you haven’t updated your list recently, and on a more sober note, can help you achieve some of your suppressed desires during the short time we have on this planet. Take a few minutes and complete the following. We think it will be both enlightening and helpful in your overall quest for well-being and life satisfaction.

*A couple of tips on completing your list: make sure to include childhood dreams—focus on activities or relationships rather than things and items that you realistically feel you would do. Rank them either in order of importance or in order of likelihood.*

Date completed \_\_\_\_\_

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_
- 9) \_\_\_\_\_
- 10) \_\_\_\_\_

*If you have not watched it yet, you might want to take in the video, “The Last Lecture” (2007) by Randy Pausch of Carnegie Mellon University, on YouTube. It is time (76 minutes) well spent and a heartfelt lesson from someone who really understood the value of the bucket list.*