1146 South Cedar Crest Blvd, Allentown PA 18103
610-366-9411 Fax: 610-366-9229

PATIENT DEMOGRAPHIC INFORMATION

TODAY'S DATE ______________________

NAME ______________________________________

ADDRESS ______________________________________

____

SEX ______________________________________

HOME PHONE ( ) ______________________________

WORK PHONE ( ) ______________________________

SPOUSE'S NAME ______________________________

SPOUSE'S EMPLOYER ______________________________

____

ADDRESS ______________________________________

____

SOC. SEC. # ______________________________________

OCCUPATION ______________________________________

DATE OF BIRTH ______________________________________

FULL TIME STUDENT? ❑ YES ❑ NO

ARE YOU DISABLED? ❑ YES ❑ NO

PERSON TO NOTIFY IN EMERGENCY:

NAME ______________________________________

ADDRESS ______________________________________

PHONE ( ) ______________________________________

RELATION ______________________________________

HOW DID YOU HEAR ABOUT US? – (Circle One)

ADVERTISEMENT? **TV** **Radio** **Direct Mail**

Word of Mouth **Newspaper Ad**

OTHER ______________________________________

FAMILY PHYSICIAN:

NAME ______________________________________

ADDRESS ______________________________________

____

REFERRING PHYSICIAN:

NAME ______________________________________

ADDRESS ______________________________________

____

PHONE ( ) ______________________________________

I AM HERE TODAY FOR TREATMENT RELATED TO:

( ) WORK INJURY – DATE ______________________

( ) AUTO ACCIDENT – DATE ______________________

( ) OTHER ______________________________________

____

____

ADDRESS ______________________________________

____

PHONE ( ) ______________________________________

CONTACT ______________________________________

COMMERCIAL

Name: ______________________________________

I.D.# ______________________________________

GROUP # ______________________________________

SUBSCRIBER'S NAME ______________________________

RELATIONSHIP TO PATIENT ______________________________

SUB. DATE OF BIRTH ______________________________

SOC. SEC. # ______________________________________

WORKER'S COMPENSATION

INS. CO. ______________________________________

ADDRESS ______________________________________

____

PHONE ( ) ______________________________________

CLAIM # ______________________________________

ADJUSTER ______________________________________

HAS INJURY BEEN REPORTED TO YOUR EMPLOYER? ❑ YES ❑ NO

MEDICARE

I.D. # ______________________________________

NAME OF INSURED ______________________________

DO YOU HAVE 65 SPECIAL? ❑ YES ❑ NO

IF YES I.D. # ______________________________________

GROUP # ______________________________________

OTHER/AUTO/MEDICAL ASSISTANCE

COMPANY NAME ______________________________________

ADDRESS ______________________________________

____

PHONE ( ) ______________________________________

NAME OF INSURED ______________________________

POLICY # ______________________________________

GROUP # ______________________________________

CLAIM/FILE # ______________________________________

CONTACT ______________________________________ I

REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO PERSONALIZED LONGEVITY MEDICAL CENTER (PLMC) FOR ANY SERVICES FURNISHED ME BY *PLMC*. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO *PLMC* FOR ANY AMOUNT NOT COVERED BY THIS AUTHORIZATION. I WILL BE NOTIFIED WHEN FINAL ACTION (REJECTION, ETC.) BY MY INSURANCE CARRIER HAS BEEN RECEIVED BY *CPC*. PAYMENT WILL BE EXPECTED WITHIN 10 DAYS OF THAT NOTICE. IN THE EVENT THAT THIS ACCOUNT IS PLACED WITH AN ATTORNEY OR COLLECTION AGENCY, THE UNDERSIGNED IS REPONSIBLE FOR COLLECTION FEES, REASONABLE ATTORNEY'S FEES AND COURT COSTS.

PATIENT'S SIGNATURE ______________________________________ **DATE** ______________________

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610-366-9411 Fax: 610-366-9229

PATIENT NAME_________________________________DATE____________DATE OF BIRTH_____________________

CONSENT TO USE AND DISCLOSURE OF INFORMATION FOR TREATMENT PAYMENT OR OPERATIONS

- I hereby consent to the use and disclosure of information in my medical records for treatment, payment and health care operations purpose: I understand that this consent is voluntary. I understand that information in my medical records may be used and disclosed to persons other than Personalized Longevity Medical Center to carry out their responsibilities in connection to my medical health care treatment, in payment for health care services rendered to me and in activities related to health care operations.

Initials: __________

- I understand that additional information on Personalized Longevity Medical Center privacy practices related to my medical record is available from the Personalized Longevity Medical Center Notice of Privacy Practices, a copy of which has been-made available to me, and which I have read or do not wish to read, prior to signing this consent.

Initials: __________

- I understand that changes in Personalized Longevity Medical Center n privacy practices will result in modifications to the Notice of Privacy Practices and that up-to-date notices will be available at the reception desk of Personalized Longevity Medical Center 1146 S. Cedar Crest Blvd, Allentown, PA 18103

Initials: __________

- I understand that I may request Personalized Longevity Medical Center to restrict how or to whom my medical records are used or disclosed, but that Personalized Longevity Medical Center may refuse the restrictions I request. However if Personalized Longevity Medical Center agrees to the restrictions, it is bound to them when disclosing information in my medical records.

Initials: __________

- I understand that I can revoke this consent at any time, by notifying Personalized Longevity Medical Center in writing, but if I do, it won't have any effect on actions Personalized Longevity Medical Center took before they received the notification.

Initials: __________

- I understand that this consent applies to the use and disclosure of information for treatment, payment or operations purposes only and that Personalized Longevity Medical Center may decline to provide medical health care services to me if I do not sign it.

Initials: __________

- I understand and hereby agree to be financially liable for and to pay to Personalized Longevity Medical Center the amount of certain health care services which may not be covered under my insurance plan because plan determined to be not medical necessary. If my insurance denies payment, I agree to be personally and fully responsible for payment.

Initials: __________

____ ____________________
Signature of Patient or Patient's Representative **Date**

Printed Name of Patient Representative____

Relationship to Patient____

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MEMBER FINANCIAL LIABILITY ACKNOWLEDGEMENT FORM

THE UNDERSIGNED MEMBER HEREBY AGREES TO BE FINANCIALLY LIABLE FOR ANY SERVICES THAT MAY NOT BE COVERED UNDER THEIR INSURANCE PLAN.
I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS

PRINT NAME OF PATIENT SIGNATURE OF PATIENT DATE

IN THE EVENT THE ABOVE METIONED PATIENT IS A MINOR, THE UNDERSIGNED PARENT /GAURDIAN OF THAT MINOR AGREES TO BE FINANCIALLY LIABLE FOR THE SERVICES DESCRIBED ABOVE.

PRINT NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN DATE

UNDERSTANDING OUR BILLING POLICY

CO-PAYS ARE YOUR RESPONSIBILITY TO PAY AT THE TIME OF YOUR APPOINTMENT. WHEN YOU SIGN IN AT THE FRONT DESK YOU WILL BE ASKED TO PAY YOUR CO-PAY AND ANY BALANCETHAT IS DUE. WE WILL CHARGE A SURCHARGE OF $10.00 IF THE CO-PAY IS NOT PAID AT THE TIME OF APPOINTMENT. MOST SERVICES ARE BILLABLE TO YOUR INSURANCE. IF, HOWEVER YOU HAVE A MAJOR MEDICAL POLICY OR A PLAN THAT DOES NOT COVER OFFICE VISITS, WE DO ASK FOR PAYMENT AT THE TIME OF SERVICE. FOR ANY BALANCE OWED, PAYMENT ARRANGEMENTS CAN BE MADE BY CALLING **610-366-9411**. IF THE ACCOUNT IS NOT PAID AFTER THE FIRST STATEMENT IS SENT IT IS CONSIDERED **PAST DUE.** IT IS IMPORTANT THAT WE HEAR FROM YOU AT THIS POINT OF TIME. THIRTY DAYS FROM YOUR PAST DUE BILLING YOU WILL RECEIVE YOUR LAST STATEMENT WHICH IS CONSIDERED A **FINAL NOTICE**. IF PAYMENT IS NOT RECEIVED WITHIN 10 DAYS OF THIS STATEMENT AND WE HAVE NOT HAD ANY CONTACT\PAYMENT FROM YOU, WE WILL UTILIZE THE SERVICES OF OUR PROFESSIONAL COLLECTION AGENCY. IT IS IMPORTANT FOR YOU TO CONTACT US IMMEDIATELY WITH ANY INQUIRIES OR CONCERNS. WITHOUT CONTACT FROM YOU, THE ABOVE POLICY WILL BE FOLLOWED.

TELEPHONE CONSUMER PROTECTION ACT (TCPA):
YOU AGREE, IN ORDER FOR US TO SERVICE YOUR ACCOUNT OR OT COLLECT MONIES YOU MAY OWE, PERSONALIZED LONGEVITY MEDICAL CENTER, AND/OR OUR AGENTS MAY CONTACT YOU BY TELEPHONE NUMBER ASSOCIATED WITH YOUR ACCOUNT, INCLUDING WIRELESS TELEPHONE NUMBERS, WHICH COULD RESULT IN CHARGES TO YOU. WE MAY ALSO CONTACT YOU BY SENDING TEXT MESSAGES OR E-MAIL, USING ANY E-MAIL YOU PROVIDE TO USE. METHODS OF CONTACT MAY INCLUDE USING PRE-RECORDED/ARTIFICAL VOICE MESSAGES AND/OR USE OF AUTOMATIC DAILING DEVICE, AS APPLICABLE.
AGREEMENT TO PAY: I, THE UNDERSIGNED, ACCEPT THE FEE CHARGED AS LEGAL AND LAWFUL DEBT AND AGREE TO PAY SAID FEE, INCLUDING ANY/ ALL COLLECTION AGENCY FEES, (33.33%), ATTORNEY FEES AND /OR COURT COSTS, IF SUCH BE NECESSARY. I/WE HAVE READ THIS DISCLOSURE AND AGREE THAT PERSONALIZED LONGEVITY MEDICAL CENTER, ITS EMPLOYEES AND/ OR AGENTS MAY CONTACT ME/US AS DESCRIBED ABOVE.

RESPONSIBLE PARTY SIGNATURE DATE

PERSONALIZED LONGEVITY MEDICAL CENTER

PATIENT NAME___________________________________ DATE_____________ DATE OF BIRTH______________________

Purpose of Visit:

____New Patient Visit ____Follow up for existing problem ____Follow up after injection _____Script Refill Visit

_____New Complaint/concern ---- if checked, please provide details below:

The problem:____

When did it start:____

Is it improving, worsening, staying constant, or intermittent:____

Severity of any discomfort (mild, moderate, severe):____

Anything that makes symptoms worse:____

Any Home treatments, i.e. physical therapy:____

_____**Allergies:**____

Current Symptoms: (Circle all that apply)

Constitutional : weight loss/gain fever/chills fatigue insomnia night sweats

Eyes: blurry vision double vision eye pain visual disturbance

ENT: sore throat hoarseness ear pain hearing loss sinus pain/pressure nasal congestion

Cardiovascular: chest pain dizziness palpitations leg swelling varicose veins

Respiratory: shortness of breath chest tightness cough sputum production

Gastrointestinal: abdominal pain nausea/ vomiting diarrhea constipation heartburn

Genitourinary: urinary frequency painful urination urinary incontinence/retention nocturia

Skin: rashes lesions itching nail changes hair changes

Musculoskeletal: joint pain muscle pain leg cramps muscle weakness joint swelling back/neck pain

Psychiatric: anxiety/panic depressed mood suicidal thoughts alcohol/drug dependence fatigue

Neurological: headache dizziness/fainting tremor tingling/numbness difficulty walking seizures numbness

Heme/Lymph: easily bruised swollen lymph nodes prolonged bleeding blood clot

Endocrine: excessive sweating excessive thirst heat/cold intolerance irregular menses

Allergy/Immuno: seasonal allergies frequent infections

Peripheral Vascular: cold extremities painful extremities sores that won't heal

MEDICATION LIST: (Please list all medications you are taking or bring a list with you)

MEDICATION	DOSE/ROUTE	FREQUENCY	SIDE EFFECTS

PATIENT NAME___________________________________DATE_____________DATE OF BIRTH______________________

MEDICAL HISTORY

PAST MEDICAL HISTORY: **Please Circle all that apply.**

Diabetes
Chest Pain/Angina
High Blood Pressure
Heart Disease
Heart Attack
High Cholesterol
Pacemaker
Headaches
Kidney Stones
Kidney Disease
Cancer
Osteoporosis
Asthma/COPD
Stroke/CVA/TIA
Seizures
Pregnant
HIV/AIDS
Hepatitis
Stomach Ulcer
Liver Disease
Heart Palpitations
Arthritis
Heart Surgery
Blood Clots
Peripheral Vascular Disease
Tuberculosis
Depression
Congestive Heart Failure
Thyroid Disease

Other:____

____

RELATED PROBLEMS: **Change in sleep pattern:**____

IF FEMALE: **Pregnant** ☐ **Planning to Become** ☐ **Not Pregnant** ☐

WEIGHT: **Gain** ☐ **Loss** ☐ **Since**_____________ **Weight Change** ________ **lbs.**

SEXUAL ACTIVITY: **No Change** ☐ **Decreased Libido** ☐

MENTAL STATUS: **Anxious** ☐ **Confused** ☐ **Depressed** ☐ **Since**_________________________________

PREVIOUS TREATMENTS: **Medications** ☐ **Surgeries** ☐ **Nerve Block** ☐ **TENS** ☐ **Physical Therapy** ☐

Others: ____

SURGICAL HISTORY: **List Procedure & Dates** ____

____

SOCIAL HISTORY: **Marital Status** _____________ **Occupation (job most recently held)**_______________

Smoke ☐ **How much(packs/day)**__________ **Quit/How long ago**__________ **Never smoked** ☐

Alcohol Intake:__________________**never** ☐ **occasional** ☐ **frequent** ☐

Drug Abuse:_____________________________________

Radiology Studies: **(MRI, BONE SCAN, X-RAYS, CT SCANS)** **Results:** __________________________________

PERSONALIZED LONGEVITY
MEDICAL CENTER

REVIEW OF SYSTEMS

PATIENT NAME___________________________________DATE_____________DATE OF BIRTH______________________

FAMILY HISTORY: Please list any known Medical Problems.

Mother____

Father____

Brothers/Sisters____

Children____