THE LUCAS CENTER

(865) 218-6210

Patient Information as of ________________ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ______________________________
Last First Middle

Address ______________________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Any restrictions for contacting you? ❒ No ❒ Yes E-mail ____________

Contact Restrictions: ____________ Drivers License # (include State) ____________

Age ______ Birthdate ___/___/___ SS# ___-___-___ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married Spouse's Name: ____________ Phone# ____________

Primary Care Physician ____________ **Referring Physician** ____________

Phone # ____________ Phone # ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ______ Is it okay to call you at work? ❒ Yes ❒ No

Address ______________________________
Street & Suite # City State Zip

Emergency Contact ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Address ______________________________
Street & Apt # City State Zip

Primary Health Insurance Company ____________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ________

Insured: Name ____________ DOB ____________ Employer ____________

Secondary Health Insurance Company ____________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ________

Insured: Name ____________ DOB ____________ Employer ____________

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Lucas to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Lucas and myself.

Signature ______________________________ **Date** ____________

Medical History Form

Name:____ Date: __________

SOCIAL

Age: _______ Sex M F Married Y N Occupation: _____________

Responsible Adult Available to Assist During Recovery Period Y N

Relationship: _________________

HABITS

Smoke Y N Amount: ____ Caffeine Y N Amount: ______

Alcohol Y N Amount:__________ How often? _______

MEDICATIONS List All Prescription and Non-Prescription Drugs

Medication	Dose	Frequency

Drug Allergies Y N List Drug and Type of Reaction: _______________

____

Latex Allergy Y N Tape Allergy Y N

PERSONAL MEDICAL HISTORY Have you ever had:

Abnormal Bleeding	Y	N	Asthma	Y	N	Cancer	Y	N
Anemia	Y	N	Diabetes	Y	N	Hypertension	Y	N
Heart Attack	Y	N	Hepatitis	Y	N	Blood Clots	Y	N
Mitral Valve Prolapse	Y	N	Stroke	Y	N	Kidney Disease	Y	N
Weight Changes	Y	N						

Have you ever been under psychiatric care? Y N When?___________

Have you ever received a blood transfusion? Y N If yes, what year? _________

Have you ever been tested for HIV? Y N If yes, what year? _________

PREVIOUS HOSPITALIZATIONS

Date	Type of Surgery	Reason

Primary Care Physician ______________________ Date last seen ___________

Date last Chest X-Ray __________ Last EKG ________

THE LUCAS CENTER
280 FORT SANDERS WEST BLVD.
BLDG. 4, SUITE 112
KNOXVILLE, TN 37922

CONSENT FOR PHOTOGRAPHY

PATIENT NAME: ______________________________ **RECORD #**______

I understand that photographing and/or videotaping may be deemed appropriate as part of my/my child's evaluation and treatment by the physicians and staff of The Lucas Center. I understand and accept that I/my child may be recognized from my/my child's likeness or case history.

I authorize the physician of The Lucas Center, to use my/my child's photographs, videotapes and case information in educational and scientific settings, including lectures and multi-media presentations for an audience of healthcare professionals, at which members of the press may be present, and medical, surgical and scientific journal articles.

I authorize the use of my/my child's photographs and case information in the following educational/marketing settings: the practice's patient education materials; the file of pre- and post-operative patient photographs available to prospective patients for viewing; newspaper and magazine articles in which the practice's physician participates; the practice's web site; other web sites approved by the practice for education and marketing; and lectures and multi-media presentations given by the practice's physician to the general public.

In any case, it is specifically understood that I / my child shall not be identified by name.

I understand that this consent remains in effect until revoked by me in writing.

Therefore, I (initial one):

_____ give my permission for photographs, videotapes or case history to be used as described above.

_____do not give my permission for photographs, videotapes or case history to be used as described above.

____ ____________________

Signature (patient or legal guardian if minor) **Date**

____ ____________________

Witness signature **Date**

THE LUCAS CENTER
280 Ft. Sanders West Blvd.
Bldg. 4, Suite 112
KNOXVILLE, TN 37922

PATIENT NAME:______________________________ DATE OF BIRTH:_______

Please check the appropriate answer and sign below:

Do you smoke? Yes____ No____

____ ________________________
Patient Signature **Date**

If you answered "yes" to this question, please read the following. This information will be discussed with you during your office visit.

INFORMED CONSENT FOR PATIENTS WHO SMOKE

As a smoker, I, ______________________________, have been informed and understand that smoking and its subsequent physiological effects pose serious consequences for smokers undergoing medical treatment and undergoing or recovering from surgery.

Smoking decreases the supply of oxygen to tissues and a decreased oxygen supply delays wound healing. Nicotine is a vasoconstrictor that will reduce oxygen to tissues. Smoking interferes with healing of surgical wounds and may also lead to skin actually dying and requiring further treatment or surgery.

I understand that I should refrain from smoking three to four weeks prior to surgery and refrain from smoking after surgery and that risks are still increased to some extent.

I have read this informed consent document and understand the dangers of smoking prior to, during, and after my surgery and treatment.

____________________________________ ____________________________
Patient Signature Date

____________________________________ ____________________________
Witness Signature Date

THE LUCAS CENTER
JAY H. LUCAS, MD

PATIENT PRIVACY CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The Terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

This Consent was signed by:____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): ________________________________

Signature____________________________________ Date___/___/_____

In front of_______________________________ Signature_____________________
Printed Name- Practice Representative

THE LUCAS CENTER

One Time Authorization Form

Patient's Name ____ **Date** ______________________
(Please Print)

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named PROVIDER all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I and not the insurance company, am responsible for the payment of all services.

Initial:

Responsibility for Co-pay Amounts: I agree to be full responsible for paying co-pays of set amounts at the time of physicians visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received once insurance is paid, will be due upon receipt.

Initial:

Assumption of Referrals: I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician, it must be received in order to receive the maximum benefits from the insurance company, I further understand that it is my responsibility to obtain a hardcopy referral from my Primary Care Physician. I have been given the opportunity by the above said provider to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

Initial:

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of a third party or organization, and so forth, payable to or for the above said patient until account is paid in full.

Signature:____ Date: ______________________________

Acknowledgement of Receipt of Privacy Notice: I acknowledge receiving today a copy of the PROVIDER'S notice of privacy policies. I consent to the PROVIDER'S use of protected health information as described in the notice of treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

Signature:____ Date: ______________________________

Authorization for release: By signing below, I am authorizing the practice to disclose my protected health information about my current health condition to the following:
___ spouse ___ parents ___ children ___ clergy ___ other (list names) _____________________________
I understand my rights and how to revoke this permission as described in the Notice of Privacy Practices given to me by the practice.

Signature:____ Date:_______________________________

Request for restrictions: I request that my protected health information not be disclosed to the following:

____

Signature:____ Date:_______________________________