BARRY LIBERONI, M.D., P.A.
INTERNAL MEDICINE

COMPLETE ALL SECTIONS
PERSONAL INFORMATION
2024

Patient (LEGAL) Name:		Date of Birth:	Social Security #:
Mailing Address	City, State, Zip:	Home # ( )	Cell Phone # ( )
Email Address:	Employer Name:	Employer phone:	
Sex: M F	Marital Status: M S D W	Valid Texas Drivers Licenses Number:	
Name of Spouse or Guarantor:	Spouse or Guarantor S.S #:	Spouse or Guarantor Cell Phone #	
In Case of Emergency Nearest Relative Not Living with You:		Phone # ( )	

FULLY COMPLETE THIS SECTION	
O.K. to leave message with detailed information at home Yes □ or No □	O.K. to leave message with call-back number Home only □ Work only □ Both □
O.K. to contact via e-mail Yes □ or No □	E-Mail Address (Strictly Confidential)

PAYMENT FOR SERVICES RENDERED IS DUE AT THE TIME SERVICES ARE RENDERED:

INSURANCE AUTHORIZATION:

I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have completed the New Patient Information form and I certify that this information is true and correct to the best of my knowledge. I will notify you of any change in the above information.

I authorize disclosure of my health information to the insurers on record, or to any agency concerned with the payment of my health care charges, any and all information related to acquired immunodeficiency syndrome (AIDS), infection with human immunodeficiency virus (HIV), psychiatric care, or treatment for alcohol or drug abuse relating to this episode of care.

Signature of Patient or Responsible Party:	Date:

OFFICE USE ONLY	
Date Insurance Verified:	Referrals Needed Yes □ or No □

Full Name: _____

Date of Birth: _____

Family History	YES	NO	Current Age (S)	Age at Death
Is Your Mother Living?	☐	☐		
Is Your Maternal Grandmother Living?	☐	☐		
Is Your Maternal Grandfather Living?	☐	☐		
Is Your Father Living?	☐	☐		
Is Your Paternal Grandmother Living?	☐	☐		
Is Your Paternal Grandfather Living?	☐	☐		
Do You Have Any Brothers Living?	☐	☐		
Do You Have Any Sisters Living?	☐	☐		

Social History					
Place of Birth? _____			Marital Status: M ☐ S ☐ D ☐ W ☐		
How Many Natural Children do you have?			Age of Children?		
Have You Ever Attended College?	YES ☐	NO ☐	Previous Military Service?	YES ☐	NO ☐
List Your Hobbies: _____ _____					

Female History

Name: _____
D.O.B.: _____

Personal Medical History

Please List Previous Doctors You Have Seen in the Last 10 Years:
(Include Surgeons, Specialists, and Your Primary Care Physicians)

Name	City/State

Please List Allergies to Medications, Latex, Food (Shellfish)	

Please List Current Medications: Name/Dosage	

Please List Current Dietary Supplements	

Please Answer The Following Questions About Your Tobacco and / or Alcohol Use:

	YES	NO		YES	NO
Do You Currently Use Tobacco?	☐	☐	Do You Currently Use Alcohol?	☐	☐
If So, How Many Years? _____			How Much Per Day Average? _____		
How Much Per Day? _____			Have You Used Alcohol In The Past?	☐	☐
Have You Used Tobacco in the past?	☐	☐			
If Yes, How Many Years Since You Quit? _____					

	YES	NO			YES	NO
Are You Menopausal?	☐	☐		Have You Had A Bone Density Scan?	☐	☐
When Was Your Last Menstrual Period? Day ☐☐ Month ☐☐ Yr. ☐☐				Do You Have Yearly Mammograms?	☐	☐
				Year Of Last Mammogram? _____		
Are You Pregnant? Yes ☐ No ☐					YE	NO
				Do You Have A Yearly Pap Smear/ Pelvic Exam?	☐	☐
Don't Know ☐				Year Of Last Pap Smear/ Pelvic Exam?_____		

Past Medical History and Family Medical History

Fill in the circle in the column labeled "Self" to indicate if you have any of these diseases. If any of these diseases run in your family, please indicate which relative(s) have the problem by filling in the circle(s). Use the numbers to the left of the circles and the letters in the circles to help keep your place. This information is very important to us and will help us take better care of you.

Allergy/Immunology

		Self		Mother	Father	Brother	Sister	Grandmother	Grandfather
1.	Seasonal Allergies	( )	1.	(A)	(B)	(C)	(D)	(E)	(F)
2.	Asthma	( )	2.	(A)	(B)	(C)	(D)	(E)	(F)

Cardiovascular

		Self		Mother	Father	Brother	Sister	Grandmother	Grandfather
1.	Hypertension (high blood pressure)	( )	1.	(A)	(B)	(C)	(D)	(E)	(F)
2.	Cardiac arrest (heart attack)	( )	2.	(A)	(B)	(C)	(D)	(E)	(F)
3.	Congestive heart failure	( )	3.	(A)	(B)	(C)	(D)	(E)	(F)
4.	Pacemaker	( )	4.	(A)	(B)	(C)	(D)	(E)	(F)
5.	Rapid or Irregular Heart Beats	( )	5.	(A)	(B)	(C)	(D)	(E)	(F)
6.	Peripheral Vascular Disease	( )	6.	(A)	(B)	(C)	(D)	(E)	(F)
7.	Rheumatic Heart Disease	( )	7.	(A)	(B)	(C)	(D)	(E)	(F)
8.	Cerebrovascular accident (stroke)	( )	8.	(A)	(B)	(C)	(D)	(E)	(F)
9.	Transient ischemia attacks ("little strokes")	( )	9.	(A)	(B)	(C)	(D)	(E)	(F)

Gastrointestinal

		Self		Mother	Father	Brother	Sister	Grandmother	Grandfather
1.	Stomach Ulcers	( )	1.	(A)	(B)	(C)	(D)	(E)	(F)
2.	Gastro esophageal Reflux (*Heart Burn)	( )	2.	(A)	(B)	(C)	(D)	(E)	(F)
3.	Hiatal Hernia	( )	3.	(A)	(B)	(C)	(D)	(E)	(F)
4.	Irritable Bowel Syndrome	( )	4.	(A)	(B)	(C)	(D)	(E)	(F)
5.	Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)	( )	5.	(A)	(B)	(C)	(D)	(E)	(F)
6.	Polyps in colon	( )	6.	(A)	(B)	(C)	(D)	(E)	(F)
7.	Diverticulitis	( )	7.	(A)	(B)	(C)	(D)	(E)	(F)
8.	Gallstones	( )	8.	(A)	(B)	(C)	(D)	(E)	(F)
9.	Pancreatitis	( )	9.	(A)	(B)	(C)	(D)	(E)	(F)

10.	Hepatitis	( )	10.	(A)	(B)	(C)	(D)	(E)	(F)
11.	Appendicitis	( )	11.	(A)	(B)	(C)	(D)	(E)	(F)
12.	Colon cancer	( )	12.	(A)	(B)	(C)	(D)	(E)	(F)
13.	Cirrhosis of the liver	( )	13.	(A)	(B)	(C)	(D)	(E)	(F)

Endocrine	Self	Mother	Father	Brother	Sister	Grandmother	Grandfather
1. Diabetes (“High Blood Sugar”)	( )	1. (A)	(B)	(C)	(D)	(E)	(F)
2. Hypoglycemia (“Low Blood Sugar”)	( )	2. (A)	(B)	(C)	(D)	(E)	(F)
3. Hyperthyroidism (“high” or “overactive” thyroid)	( )	3. (A)	(B)	(C)	(D)	(E)	(F)
4. Obesity	( )	4. (A)	(B)	(C)	(D)	(E)	(F)
5. Hypothyroidism (“low thyroid”)	( )	5. (A)	(B)	(C)	(D)	(E)	(F)

Pulmonary / Respiratory / Lungs	Self	Mother	Father	Brother	Sister	Grandmother	Grandfather
1. Asthma	( )	1. (A)	(B)	(C)	(D)	(E)	(F)
2. COPD (“emphysema”)	( )	2. (A)	(B)	(C)	(D)	(E)	(F)
3. Chronic bronchitis (“smoker’s cough”)	( )	3. (A)	(B)	(C)	(D)	(E)	(F)
4. Tuberculosis	( )	4. (A)	(B)	(C)	(D)	(E)	(F)
5. Lung cancer	( )	5. (A)	(B)	(C)	(D)	(E)	(F)
6. Sleep apnea	( )	6. (A)	(B)	(C)	(D)	(E)	(F)

Hematology / Blood Diseases:	Self	Mother	Father	Brother	Sister	Grandmother	Grandfather
1. Anemia	( )	1. (A)	(B)	(C)	(D)	(E)	(F)
2. Sickle cell anemia	( )	2. (A)	(B)	(C)	(D)	(E)	(F)
3. Leukemia	( )	3. (A)	(B)	(C)	(D)	(E)	(F)
4. Easy bleeding	( )	4. (A)	(B)	(C)	(D)	(E)	(F)
5. History of blood clots	( )	5. (A)	(B)	(C)	(D)	(E)	(F)

Oncology / Cancers (unless otherwise covered)	Self	Mother	Father	Brother	Sister	Grandmother	Grandfather
1. Breast cancer	( )	1. (A)	(B)	(C)	(D)	(E)	(F)
2. Fibroids	( )	2. (A)	(B)	(C)	(D)	(E)	(F)
3. Prostate cancer	( )	3. (A)	(B)	(C)	(D)	(E)	(F)
4. Brain cancer	( )	4. (A)	(B)	(C)	(D)	(E)	(F)
5. Bone cancer	( )	5. (A)	(B)	(C)	(D)	(E)	(F)

Neurological (Disorders of the Nervous System)

		Self		Mother	Father	Brother	Sister	Grandmother	Grandfather
1.	Migraines	( )	1.	(A)	(B)	(C)	(D)	(E)	(F)
2.	Headaches	( )	2.	(A)	(B)	(C)	(D)	(E)	(F)
3.	Seizures / Convulsions	( )	3.	(A)	(B)	(C)	(D)	(E)	(F)
4.	Tremors	( )	4.	(A)	(B)	(C)	(D)	(E)	(F)
5.	Alzheimer's Disease	( )	5.	(A)	(B)	(C)	(D)	(E)	(F)
6.	Menière's Disease	( )	6.	(A)	(B)	(C)	(D)	(E)	(F)
7.	Huntington's Chorea	( )	7.	(A)	(B)	(C)	(D)	(E)	(F)
8.	Cerebrovascular accidents (stroke)	( )	8.	(A)	(B)	(C)	(D)	(E)	(F)
9.	Transient Ischemic Attacks ("little strokes")	( )	9.	(A)	(B)	(C)	(D)	(E)	(F)
10.	Parkinson's Disease	( )	10.	(A)	(B)	(C)	(D)	(E)	(F)
11.	Meningitis	( )	11.	(A)	(B)	(C)	(D)	(E)	(F)
12.	Concussion	( )	12.	(A)	(B)	(C)	(D)	(E)	(F)
13.	Bell's palsy	( )	13.	(A)	(B)	(C)	(D)	(E)	(F)

Psychiatric Disorders

		Self		Mother	Father	Brother	Sister	Grandmother	Grandfather
1.	Depression	( )	1.	(A)	(B)	(C)	(D)	(E)	(F)
2.	Schizophrenia	( )	2.	(A)	(B)	(C)	(D)	(E)	(F)
3.	Anxiety disorder	( )	3.	(A)	(B)	(C)	(D)	(E)	(F)
4.	Alcoholism	( )	4.	(A)	(B)	(C)	(D)	(E)	(F)
5.	Drug dependence	( )	5.	(A)	(B)	(C)	(D)	(E)	(F)
6.	Bipolar disorder	( )	6.	(A)	(B)	(C)	(D)	(E)	(F)

Kidney Disease

		Self		Mother	Father	Brother	Sister	Grandmother	Grandfather
1.	Renal Failure (Dialysis)	( )	1.	(A)	(B)	(C)	(D)	(E)	(F)
2.	Polycystic Kidney Disease	( )	2.	(A)	(B)	(C)	(D)	(E)	(F)
3.	Kidney stones	( )	3.	(A)	(B)	(C)	(D)	(E)	(F)
4.	Chronic bladder infections	( )	4.	(A)	(B)	(C)	(D)	(E)	(F)
5.	Kidney cancer	( )	5.	(A)	(B)	(C)	(D)	(E)	(F)
6.	Bladder cancer	( )	6.	(A)	(B)	(C)	(D)	(E)	(F)

Rheumatology
(Musculoskeletal/Connective Tissue)

		Self		Mother	Father	Brother	Sister	Grandmother	Grandfather
1.	Osteoarthritis (Degenerative Joint Disease)	( )	1.	(A)	(B)	(C)	(D)	(E)	(F)
2.	Gout	( )	2.	(A)	(B)	(C)	(D)	(E)	(F)
3.	Scleroderma	( )	3.	(A)	(B)	(C)	(D)	(E)	(F)
4.	Vasculitis	( )	4.	(A)	(B)	(C)	(D)	(E)	(F)
5.	Rheumatoid Arthritis	( )	5.	(A)	(B)	(C)	(D)	(E)	(F)
6.	Systemic Lupus Erythematosis	( )	6.	(A)	(B)	(C)	(D)	(E)	(F)
7.	Osteoporosis	( )	7.	(A)	(B)	(C)	(D)	(E)	(F)
8.	Juvenile Arthritis	( )	8.	(A)	(B)	(C)	(D)	(E)	(F)

PERSONAL SURGICAL HISTORY
(Gallbladder, Tonsils, Hysterectomy, C-Section, Breast, Hernia, Prostate, Bladder, Shoulder, Hip, Knee, foot, Neck, Back)

Type Of Surgery	When	Surgeon

Other Important Medical Diagnosis

Sleep History Questionnaire

I Have The Following Concerns About My Sleep Habits: (Check Where Applicable)

____	I Snore In My Sleep	____	Bedtime Varies A Lot
____	I Have Been Told That I Stop Breathing In My Sleep	____	Teeth Grinding In Sleep
____	Restless/Disturb Sleep	____	Irregular/Rapidly Pounding Heart
____	Difficulty Maintaining Sleep	____	Poor Quality Sleep
____	Nasal Blockage During Sleep	____	Excessive Daytime Sleepiness
____	At Bedtime, I Worry About Things	____	Falling Asleep At Inappropriate Times
____	Difficulty Initiating Sleep	____	Wakeup With Dry Mouth
____	My Snoring Bothers Others	____	Sweat In My Sleep
____	Wake Up Gasping	____	Getting Too Little Sleep

What time do you go to bed each night? _____

How long does it take for you to go to sleep? _____

How many times do you wake up at night? _____

What Wakes You Up? ____Snoring ____External Noises ____Choking Sensation ____Urge To Urinate ____Unknown Reason

How Many Naps Do You Take Per Day?_____ **For How Long?**_____

What Time Do You Get Up On Weekdays? _____ **On Weekends?**_____

How many caffeinated drinks per day? _____

Do You Work Different Shifts? _____ **If So, For How Many Years?**_____

Name:________________________
D.O.B.: ________________________

Review of Systems

General

No problems ☐

	N	Y
Gain or loss of 10 pounds in past year	☐	☐
Fever	☐	☐
Chills	☐	☐
Anorexia	☐	☐
Tiredness without effort	☐	☐
Increased thirst or appetite	☐	☐

Endocrine

No problems ☐

	N	Y
Tendency to feel too hot	☐	☐
Tendency to feel too cold	☐	☐
Frequent need to urinate	☐	☐
Markedly increased thirst	☐	☐
Hands shaking or trembling	☐	☐

Eyes

No problems ☐

	N	Y	Right	Left	Both
Decreased vision	☐	☐	☐	☐	☐
Near sightedness	☐	☐	☐	☐	☐
Far sightedness	☐	☐	☐	☐	☐
Dry eyes	☐	☐	☐	☐	☐
Itchy eyes	☐	☐	☐	☐	☐
Watery eyes	☐	☐	☐	☐	☐
Thick discharge from eyes	☐	☐	☐	☐	☐
Frequent Conjunctivitis	☐	☐	☐	☐	☐
Pain in eyes	☐	☐	☐	☐	☐
Sensitive to light	☐	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	☐
Spots in vision	☐	☐	☐	☐	☐
Halos around lights	☐	☐	☐	☐	☐

Skin

No problems ☐

	N	Y
Itching	☐	☐
Rash	☐	☐
Change in mole	☐	☐
Persistent skin problem	☐	☐

Ears

No problems ☐

	N	Y	Right	Left	Both
Decreased hearing	☐	☐	☐	☐	☐
Ringing in ear(s)	☐	☐	☐	☐	☐
Drainage from ear(s)	☐	☐	☐	☐	☐
Pain in ear(s)	☐	☐	☐	☐	☐

Mouth

No problems ☐

	N	Y
Dry mouth	☐	☐
Excessive saliva	☐	☐
Bleeding gums	☐	☐
Ulcers in mouth	☐	☐
Pain in mouth	☐	☐
Change in tastes	☐	☐

Respiratory

No problems ☐

	N	Y
Breathing problems	☐	☐
Coughing spells	☐	☐
Wheezing	☐	☐
Coughing up blood	☐	☐
Painful cough	☐	☐
Frequent chest congestion	☐	☐
Coughing up phlegm (mucous, cold)	☐	☐

Cardiovascular

No problems ☐

	N	Y	Without exertion	With exertion	Relieved with rest	Relieved with nitro
Shortness of breath	☐	☐				
Awakening at night breathless	☐	☐				
Unable to sleep lying flat	☐	☐				
Lightheadedness/Dizziness	☐	☐				
Rapid heart beat (Palpitations)	☐	☐				
Decreased exercise tolerance	☐	☐				
Chest pain	☐	☐	☐	☐	☐	☐
Chest pressure	☐	☐	☐	☐	☐	☐
Chest discomfort	☐	☐	☐	☐	☐	☐
Painful fingers/toes when in cold room	☐	☐				
Fainting spells	☐	☐				

	N	Y	Right	Left	Both
Pain/Cramps in legs while at rest	☐	☐	☐	☐	☐
Pain/Cramps in legs while walking	☐	☐	☐	☐	☐
Swollen feet and ankles	☐	☐	☐	☐	☐

Musculoskeletal

No problems ☐

	N	Y		Right shoulder	Left shoulder	Right arm	Left arm	Right elbow	Left elbow	Right forearm	Left forearm	Right wrist	Left wrist	Right hand	Left hand	Right hip	Left hip	Right thigh	Left thigh	Right knee	Left knee	Right leg	Left leg	Right ankle	Left ankle	Right foot	Left foot
Pain in neck	☐	☐																									
Pain in high back	☐	☐																									
Pain in low back	☐	☐																									
Pain in mid back	☐	☐																									
Pain in sacrum	☐	☐																									
Joint pain	☐	☐	in	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Joint swelling	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Joint stiffness	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle pain	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Morning stiffness	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Weakness in muscles	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequent muscle spasms	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequent cramps	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Name:_____
D.O.B: _____

Review of Systems

	N	Y
Allergy/Immunologic		
No problems ☐		
Spontaneous wheals on skin (Urticaria)	☐	☐
Runny nose	☐	☐
Sinus congestion	☐	☐
Sneezing	☐	☐
Seasonal runny nose, eyes or sore throat	☐	☐
Asthma	☐	☐
Allergies	☐	☐
Many infections	☐	☐
Prolonged time to heal	☐	☐
Prolonged time to fight off infections	☐	☐
Frequent illnesses (“sickly”, “poorly”	☐	☐
Nose		
No problems ☐		
Abnormal odors	☐	☐
Nose bleeding	☐	☐
Nasal drainage	☐	☐
Pain in nose	☐	☐
Congestion	☐	☐
Throat		
No problems ☐		
	☐	☐
Hoarse voice without a cold	☐	☐
Sore throat with fever	☐	☐
Problems swallowing	☐	☐
Lumps or swelling in throat	☐	☐
Neurological		
No problems ☐		
Frequent headaches	☐	☐
Convulsions	☐	☐
Loss of consciousness	☐	☐
Paralysis	☐	☐
Strokes	☐	☐
Muscles wasting away	☐	☐
Involuntary movements	☐	☐
Problems with walking	☐	☐
Problems with coordination	☐	☐
Hands shaking or trembling	☐	☐
Numbness or tingling in hands or feet	☐	☐
Problems with memory	☐	☐
Dizziness	☐	☐
Genitourinary		
No problems ☐		
Painful urination	☐	☐
Bloody urine	☐	☐
Incontinence (uncontrolled urination)	☐	☐
Urinary urgency	☐	☐
Urinary frequency	☐	☐
For Men Only		
No problems ☐		
	☐	☐
Scrotal swelling	☐	☐
Mass or lump in scrotum	☐	☐
Penile discharge	☐	☐
Decreased urinary stream	☐	☐
Impotence	☐	☐
Excessive testicular tenderness	☐	☐
Lesions on genitals	☐	☐
Swelling in groin	☐	☐

	N	Y
Psychiatric		
No problems ☐		
Problems with depression	☐	☐
Problems with anxiety	☐	☐
Phobias (extreme fears)	☐	☐
Seeing things	☐	☐
Hearing things	☐	☐
Memory problems	☐	☐
Alcohol abuse	☐	☐
Substance abuse	☐	☐
Insomnia (problems sleeping)	☐	☐
Changes in sleep pattern	☐	☐
Changes in behavior	☐	☐
Hematologic/Lymphatic		
No problems ☐		
Swollen lymph nodes or lumps in neck	☐	☐
Swollen lymph nodes or lumps in armpits	☐	☐
Swollen lymph nodes or lumps in groin	☐	☐
Dusky color (pale lips, gums, skin)	☐	☐
Itching everywhere	☐	☐
Easy bruising	☐	☐
Prolonged bleeding	☐	☐
Extreme fatigue	☐	☐
Gastrointestinal		
No problems ☐		
Difficulty swallowing	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Reflux	☐	☐
Frequent belching	☐	☐
Bloating	☐	☐
Flatulence (Gas)	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Vomiting of blood	☐	☐
Constipation	☐	☐
Frequent loose or watery stools	☐	☐
Recent change in bowel habits	☐	☐
Rectal bleeding	☐	☐
Tarry black stools	☐	☐
Maroon colored stools	☐	☐
Blood on stool	☐	☐
Pain in rectum	☐	☐
Abdominal pain	☐	☐
For Women Only		
No problems ☐		
Vaginal discharge	☐	☐
Vaginal itching	☐	☐
Abnormal menstrual periods	☐	☐
Bleeding between periods	☐	☐
Repeated pain during intercourse	☐	☐
Bleeding after intercourse	☐	☐
Post-menopausal bleeding	☐	☐
Hot flashes	☐	☐
Are you pregnant, or think you might be?	☐	☐
Lumps in breasts	☐	☐
Discharge or bleeding from either nipple	☐	☐
Are you using birth control?	☐	☐

BARRY LIBERONI, M.D., P.A.
720 Avenue F. North. Suite. 3
Bay City, Texas 77414
Phone - (979) 245-9797
Fax – (979) 245-9789

NOTICE TO ALL PATIENTS

EFFECTIVE 05/01/2018

We would like to inform you of additional charges that may be incurred from this office that are separate from the standard fees for an office visit.

1. **Cancelled Office Visit With Less Than 24 Hours Notice**
   OR IF NO SHOW FOR AN APPOINTMENT
   (Please Note If You are In The Emergency Room or an Inpatient at a Hospital we will waive the fee)

   Routine Appointment…… $25.00 Fee

2. **Forms that need to be filled out……. $40.00 (Minimum Fee)**
   FMLA or Other Work-Related Forms
   Personal Disability (Non-Federal)
   Leave of Absence Forms or Letters
   PLEASE NOTE: There is No Charge with an office visit

3. **A request for any Letter that has to be drawn up and typed by this office… (such as an exemption from jury duty, refund for a flight cancellation or cruise, a tax savings letter for the purchase of a new mattress or hot tub)**
   There will be a $50.00 MINIMUM CHARGE for the Letter

THE ABOVE FEES ARE NOT COVERED BY YOUR INSURANCE COMPANY

I Acknowledge Receipt of this Notice

_____
Patient's Signature

_____ _____
Patient's Name (Please Print) **Today's Date**

Barry J. Liberoni, M.D., P.A.

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

[ ] Spouse_____

[ ] Child (ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my Cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ **between (time)**_____

Signed: _____ **Date:** ____/____/_____

Witness:_____ **Date:** ___/____/_____

720 Avenue F North. STE 3, Bay City, TX. 77414 (979) 245-9797

BARRY J. LIBERONI, M.D.,P.A

AUTHORIZATION FOR: ☐ Disclosure ☐ Inspection ☐ Amendment

Of Protected Health Information

Patient Name	D.O.B	SS #
Address		Telephone #

Previous Physicians Information

I hereby authorize:

Previous Physician (s) Name	Phone Number	Address

To release the information from the medical records of: _____
Patients Name

RELEASE MEDICAL RECORDS TO
Barry J. Liberoni, M.D.,P.A.
720 Ave F North, Ste. 3
Bay City, Texas 77414
Phone# (979) 245-9797 / Fax # (979) 245-9789

For The Treatment Dates: **ALL TREATMENT DATES**

For The Following Purpose: ☐ Continued Medical Care ☐ Legal ☐ Insurance ☐ Other _____

Select One Of The Following

- ☐ Abstract/Pertinent Information
- ☐ Lab
- ☐ Emergency
- ☐ Imaging/Radiology
- ☐ H & P
- ☐ Cardiac Studies
- ☐ MD Progress Notes
- ☐ MD Orders
- ☐ Operative/Procedure Report
- ☐ Entire Record EXCLUDING - HIV Testing & Chemical Dependency
- ☐ Entire Record INCLUDING - HIV Testing & Chemical Dependency
- ☐ Entire Record INCLUDING - HIV Testing Only
- ☐ Entire Record INCLUDING - Chemical Dependency Only
- ☐ Other _____

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment (s) for the date specified above.

I, the undersigned, have read the above and authorized the staff of _____ to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action have been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and my no longer be protected. I hereby release and hold harmless the above mentioned name facility and its parent company from any and all liability and damages resulting from the lawful release of my Protected Health Information.

Date _____ Signature of Patient/Parent/Conservator/Guardian _____ Authority/Relationship to _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

[ ] Home Telephone: _____

[ ] O.K. to leave message with detailed information
[ ] Leave message with call-back number only

[ ] Written Communication Via Email: _____

[ ] O.K. to leave message with detailed information
[ ] Leave message with call-back number only

[ ] Cellphone: _____

[ ] O.K. to leave message with detailed information
[ ] Leave message with call-back number only

[ ] Work Telephone: _____

[ ] O.K. to leave message with detailed information
[ ] Leave message with call-back number only

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to make reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosure. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures to TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type Code: T= Treatment Records: P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

PATIENT RECORD OF DISCLOSURES

Record of Disclosures of Protected Health Information Continued

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type Code: T= Treatment Records: P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice took effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your right regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide my be revoked at any time by writing to us.

FOR TREATMENT**:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

Example: You are in the hospital with a broken leg. You also have diabetes.
A number of health care and support staff need to know about your diabetes during

your stay:

* The doctor treating you for the broken leg needs to know if you have diabetes because diabetes may slow the healing process.
* The dietitian needs to know about your diabetes to arrange for proper meals.
* The pharmacy needs to know about possible medicines that you may need as a diabetic.
* The information about your diabetes may help in diagnostics, testing, and x-ray work.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

Example: You are treated in the hospital for a broken leg.

* We may need to give your health insurance information about surgery you received at our organization so that your health plan will pay us or repay you for any surgery that you paid for.
* We may also tell your health plan about a treatment you are going to receive to get approval or to determine if your plan will pay for the treatment.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share, or give you opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

NOTICE OF PRIVACY PRACTICES

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitabililty determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

NOTICE OF PRIVACY PRACTICES

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $10.00 for research and retrieval, $15.00 for the first 25 pages, and $0.25 per page for each additional page, and postage if you want the copies mailed to you. If sent via facsimile we will charge you $1.00 per faxed page. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.

5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted change. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the changes in any future sharing of that information.

5. QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

BARRY J. LIBERONI, M.D.,P.A.
720 AVENUE F, NORTH
BAY CITY, TEXAS 77414
(979) 245-9797

PRIVACY PRACTICE ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have viewed the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____