Lukner Medical Clinic

2545 Perryton Pkwy, Suite 31 & 32, Pampa, TX 79065

Ph: (806) 329-3050 Fax: (806) 419-1042

Patient Name: Carissa F. Leal DOB: 02-02-2009

Address: 1813 N Banks

City: Pampa State: TX Zip Code: 79065

Home Phone: _____ Cell Phone: 440-7768

E-Mail: christopher79065@gmail.com

Preferred method of contact: ____ Home Phone X Cell Phone X Email

Pharmacy: Walmart Social Security # : _____

Release Medical Records From:

Doctor/Hospital: New Life Wellness Center

Address: 701 N. Price Rd Pampa, TX

Phone Number: 806-688-5433 Fax Number: 806-688-6111

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or summary or narrative of my protected health information, to the person or entity listed below.

Limitation on the information you may release subject to this Release Form are as follows: _____

Release my protected health information to the following person/entity:

Lukner Medical Clinic, LLC

Dr. Ralf B. Lukner

2545 Perryton Pkwy Space 31 &32

Pampa, TX 79065

Fax Number: (281) 605-5697

[X] I DO [] I DO NOT Give permission for these records to be faxed to the above entity.

Patient Signature: _____ Date: 7-20-2020

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners:

Confidential Health Information Enclosed. Health care information is personal and sensitive. It is being faxed to you after appropriate authorization from the Individual or under circumstances that do not require Individual authorization. You, the recipient, are obligated to maintain this information in a safe, secure and confidential manner. Re-disclosure without additional consent or authorization of the Individual or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain the confidentiality of this information could subject you to penalties under Federal and/or State law.

Patient Demographic Form

Marital Status:	[] Married	[•] Single	[] Divorced	[] Separated	[] Widowed

Language (other than English): _____

Employer: _____

Spouse/Partner: _____ Phone #: 806-475-2015

Emergency Contact: Christopher Leal Phone #: 806-440-7768

How did you hear about us: Micheal Montgomery

INSURANCE INFORMATION

It is very important to fill in all the insurance information. So that we can bill your insurance correctly the first time. This will help ensure that you are billed correctly as well.

Ins Co Name: United Healthcare Policy/Member ID #: 951993151 Group #: 920730

Patient Relation to Insured: [] Self [] Spouse [•] Child [] Other

Policy Holder: Christopher Leal Sex [•] M [] F

Address: 1813 N. Banks SSN: 460-59-8489

City: Pampa State: TX Zip Code: 79065

Home/Cell #: 806-440-7768 DOB: 12-11-1973

Employer: SWM International

SECONDARY INSURANCE

Ins Co Name: _____ Policy/Member ID #: _____ Group #: _____

Patient Relation to Insured: [] Self [] Spouse [] Child [] Other

Policy Holder: _____ Sex [] M []

Address: _____ SSN: _____

City: _____ State: _____ Zip Code: _____

Home/Cell #: _____ DOB: _____

Employer: _____

Medical Information Release Form

(HIPAA Release Form)

Name: Carissa F. Leal **DOB:** 03/21/2009

Release of Information

[x] 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: Father

[] 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 [x] My Cell # 806.440.7768

- [x] You may leave a detailed message
- [x] Please leave a message asking me to return your call
- [] _____

The best time to reach me is (day) Mon - Tue between (time) 1 - 5 p.m.

Signed: _____ Date: 7-20-2020

Witness: Carissa Leal, II Date: 7-20-2020

[] Send Email message to: Christopher7406@gmail.com

PatientSignature: _____ Date: 7-20-20

LUKNER MEDICAL CLINIC

Cancellation and No Show Policy

We understand that situations may arise which makes it necessary to cancel your appointment. Accordingly, we request that you provide at least 24 hour notice of cancellation. This will enable the physician to offer that time slot to another patients who need to be seen. Appointments with our specialist are in high demand, and your early cancellation will give another person access to timely medical care.

Cancellation Fee

Office appointments, which are cancelled with less than a 24-hour notification, may be subject to a **$25.00** Cancellation Fee.

No Show Fee

Patients who do not show up for their appointment and who do not call to cancel or reschedule, will be considered a NO SHOW. No shows are also subject to a **$25.00** No Show Fee

Patients who do not show, for two or more appointments in a 12-month period may be **dismissed** from the practice.

The cancellation and no show fees are the sole responsibility of the guarantor and cannot be billed to the insurance company.

Please sign that you have read and are aware of the above Cancelation and No Show Policy

Patient Name (Please Print): Carissa Leal. ij

Patient signature: Carissa Leal. ij

Parent of guardian name (for minor patient):

Parent or guardian signature (for minor patient):

Date: 7-20-2020

Lukner Medical Clinic LLC

Medical History

Patient Name: Carissa F. Leal DOB: 03-02-2009

Reason for visit?: New Patient

Do you now or have you ever had any of the following? Please check yes or no

[] yes [x] no Arthritis
[] yes [x] no Osteoporosis
[] yes [x] no High blood pressure
[] yes [x] no Heart Disease
[] yes [x] no Heart Attack
[] yes [x] no Vascular Disease
[] yes [x] no Stroke
[] yes [x] no Asthma
[] yes [x] no Shortness of breath
[] yes [x] no Chronic Cough
[] yes [x] no Fainting spells
[] yes [x] no Diabetes
[] yes [x] no Anemia
[] yes [x] no Swelling in ankles
[] yes [x] no Seizures/Epilepsy
[] yes [x] no Cancer/Tumor

[] yes [x] no Recent weight loss or gain
[] yes [x] no Tuberculosis
[] yes [x] no Hepatitis
[] yes [x] no Thyroid problems
[] yes [x] no Headaches
[] yes [x] no Hernia
[] yes [x] no Kidney problems
[] yes [x] no Depression
[] yes [x] no Anxiety
[] yes [x] no Mammogram
WHEN?_____
[] yes [] no Prostate check
WHEN?_____
[] yes [x] no Vision problems

Do you have any allergies? [x] no [] yes, please list all allergies_____

_____

I have answered the above questions to the best of knowledge. I will notify my primary doctor of any health and or medication changes that I take.

Patient Signature: Carissa F. Leal Jr **Date:** 7-20-2020

GAD-7

Patient Name: Carissa F. Leal DOB: 03-02-1999

Over the **last 2 weeks**, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	(0)	1	2	3
Not being able to stop or control worrying	(0)	1	2	3
Worrying too much about different things	(0)	1	2	3
Trouble relaxing	0	(1)	2	3
Being so restless that it is hard to sit still	0	1	(2)	3
Becoming easily annoyed or irritable	(0)	1	2	3
Feeling afraid as if something awful might happen	(0)	1	2	3
For office coding: Total Score	____	= ____	+ ____	+ ____

Patient Health Questionnaire (PHQ-9)

Patient Signature: _____ **Date:** _____

Patient Name: Carissa F. Leal DOB: [redacted] 03-02-2009

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the day	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Felling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Column Totals Add totals together	+	+	+	+

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

[] Not difficult at all [■] Somewhat difficult [] Very difficult [] Extremely difficult

Patient Signature: Carissa F. Leal **Date:** 8-20-2020

Lukner Medical Clinic Patient Agreement for Long-term Opioid Therapy

1. I,(PRINT) Kristopher Leal agree that Dr. Lukner will be the **only Physician** prescribing OPIOID (also known as NARCOTIC) pain medications for me and that I will obtain all of my prescriptions for opioids at **one pharmacy**. The exception would be an emergency situation or in the unlikely event that I run out of medications. Should such occasions occur, I will inform my physician as soon as possible.
2. I will take the medication **at the dose and frequency prescribed** by my physician. I agree not to increase the dose of opioid without first discussing it with my physician. I will not request earlier prescription refills.
3. I will **attend** all reasonable appointments, treatments and consultations as requested by my physician. I agree to **other pain consultations/management strategies** as necessary.
4. I understand that the common **side effects** of opioids therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to **refrain from driving a motor vehicle** or operating dangerous machinery until such drowsiness disappears.
5. I understand that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of **opioid withdraw**. I understand that opioid withdrawal is uncomfortable but not life threatening.
6. I understand that there is a **high risk** that I may become addicted to the opioids I am being prescribed. There is also a **high risk** that someone (including family member, friends, and children) may try to take my medication and that this is **AGAINST THE LAW** for me to give or sell my prescription medication to someone else.
7. If for some reason, I suspect that someone else took some of my medication, I will notify my physician. As such, my physician may require that I have blood, urine or hair testing and /or see a specialist in addiction medicine should a concern about addiction arise. Stolen medications will be replaced only when a police report is provided.
8. I understand that the use of a **mood-modifying substance**. Such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.
9. **Any evidence of ongoing high risk behavior** (Hospitalization for drug overdose, positive drug screens for street drug other than marijuana is an acute care setting, unsanctioned dose changes, obtaining opioid medication from outside providers, pharmacy reports of prescription tampering or other aberrant behavior, etc.) **will result in termination of the Opioid Pain Management Agreement, and no further opioids will be provided by Dr. Lukner.**
10. I understand that I should check with my physician or pharmacist before taking other medications including over-the-counter and herbal products.
11. I agree to be responsible for the **secure storage** of my medication at all times. I agree not to give or sell my prescribed medication to any other person. Depending on the circumstances, lost medication may not be replaced until the next regular renewal date.
12. Consent to **open communication** between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.
13. I understand that **if I break this agreement**, my physician reserves the right to stop prescribing opioid medications for me.

Print Patient Name: Carissa. P. Leal DOB: 03-08-2004 PatientSignature: Carissa. P. Leal

Date: 7-20-22 PhysicianSignature: _____

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

Last Name: MARISSA F HEAD

First Name: LEAH

Middle Name: FAITH

Date of Birth: 03/02/2009

Gender: ☐ Male ☒ Female

Address: 1813 W BANKS

Apartment #:

Telephone: 806-440-7768

City: PAMPA

State: TX

Zip Code: 79065

County: GRAY

Mother's First Name: LAURA

Mother's Maiden Name: Kimble

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7). The ImmTrac2 Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry, ImmTrac2. Once in ImmTrac2, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

I understand that I may withdraw this consent at any time.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative):

Printed Name: Marissa F. Leal

Date: 2-20-2020

Signature: Marissa F Leal

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See [illegible] for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • [illegible]

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and affirm that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

Stock No. F11-12366 [illegible]

Lukner Medical Clinic

Dr. Ralf Lukner MD PhD
2545 Perryton Pkwy ~ Suite 31 & 32
Pampa, TX 79065

Patient Fees and Payment Policies

We plan for your experience with Dr. Lukner to be an excellent one. To further that goal, we want you to be fully informed about our fees and payment policies.

PAYMENT

• Accepted forms of payment include cash, check, MasterCard and Visa

• Checks denied for lack of funds will incur a fee of $35.00.

□ Any patient seen during nonbusiness hours will be charged an additional fee of $85.00 which will be due at time of service in addition to the patients co-pay

• All balances must be paid within 30 days of the invoice date. Balances over 30 days may incur finance charges.

• A minimum billing fee of 1.5% will be added to any unpaid balance that is over 30 days past invoice date.

• Payment plans are available upon request, though balances over $500 will continue to incur interest.

• We reserve the right to make changes to our fees and/or policies without advance notice.

INSURANCE

All charges incurred at our office are your responsibility, regardless of insurance coverage. You are responsible to know your coverage.

• Dr. Lukner is an in-network provider with Blue Cross Blue Shield, United Health Care, Cigna, Aetna and First Choice Health Network.

You are responsible for your copay at the time of service. Dr. Lukner's staff will submit, on your behalf, to your insurance company for reimbursement for services. You are responsible for all remaining deductible and coinsurance amounts.

• Dr. Lukner is happy to see patients as an out-of-network provider, with full payment taken at the time of service. He will provide courtesy billing for patient with out of-network benefits.

COMMUNICATION

• Off Hours – All after hours phone calls and text messages needing the Doctor's response will be charged at $85.00 per incident, these charges are not billable to insurance.

• Phone consults – Phone consults are available for established clients. There is minimum of $55 per 15 minutes fee for this service.

CANCELLATION

Dr. Lukner requires 24 hours notice, received for any established patients to cancel or change an appointment. Appointments cancelled with less than 24 hours notice or those missed entirely will be charged the appropriate fee of $25.00 per occurrence. This applies regardless of whether or when you received an email/text reminder. 48 hours notice is required for new patient appointments.

Normal Business Hours: Dr. Lukner's business hours are Mon ~ Thurs 9am to 5pm and close for lunch from 12pm to 1pm. Dr. Lukner's business hours are subject to change. Urgent messages left at Lukner Medical Clinic, outside of the clinics business hours may not be responded to until the next business day. If you have an urgent medical need, you may choose to contact Dr. Lukner and pay the contact fee.

I agree to make payment according to the policies of Dr. Ralf Lukner MD PhD. I understand that payment is due according to the terms of my physician's practice and my insurance coverage. By receiving a service from Dr. Lukner MD PhD, I am agreeing to pay for that service even if my insurance company denies payment.

****

Patient Name (Please Print): Carissa F. Legl

Patient / Representative: Christopher Legl

Parent Signature: _____ Date: 7-20-2020

CREDIT CARD INFORMATION

Cardholder Name: _____ Date: _____

Card Number: _____ Exp: _____/_____

CCV: _____ Billing Zip Code: _____

I authorize Lukner Medical Clinic PLLC to charge the portion of my bill that is my financial responsibility to this credit or debit card.

Cardholder Signature: _____

*This information is stored securely on your chart and will only be used in the event of unpaid balances over30-days past due, per the terms of our payment policy. Patients with no card on file will be billed monthly; overdue balances will incur a late fee.

I decline to keep a card on file _____