LIBERTY MEDICAL SURGICAL CLINIC
720 TRAVIS, LIBERTY, TEXAS, 77575 PHONE: 936-336-6439 FAX: 936-336-6517

STEVEN C. ELLERBE, D.O. DON S. CALLENS, M.D. ABRAHAM WANG, PA-C

ADULT PATIENT

PATIENT NAME:_____ DOB:____/____/_____
(LAST) (FIRST) (MI)

TX DRIVER'S LIC:_____ SSN_____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED OTHER SEX: M / F
CIRCLE ONE

MAILING ADDRESS:_____

CITY:_____ STATE_____ ZIP_____

HOME PHONE: _____ WORK:_____ CELL:_____

AT WHICH PHONE NUMBER WOULD YOU PREFER TO BE CONTACTED: HOME WORK CELL

EMAIL ADDRESS: _____

PREFERRED LANGUAGE: _____

SOME DISEASES AFFECT POPULATIONS IN DIFFERENT WAYS. PLEASE PROVIDE THE FOLLOWING INFORMATION TO HELP US MONITOR POTENTIAL HEALTH ISSUES.

RACE: AMERICAN INDIAN/ ALASKAN NATIVE **ASIAN** BLACK/ AFRICAN AMERICAN **HISPANIC** PACIFIC ISLANDER
CIRCLE ONE
WHITE OR CAUCASIAN OTHER **PREFER NOT TO ANSWER**

ETHNICITY: **AFRICAN** ARAB **CHINESE** GERMAN **HISPANIC/LATINO** NOT HISPANIC OR LATINO **INDIAN** IRANIAN
CIRCLE ONE
JAPANESE JEWISH-ASHKENAZI **JEWISH-SEPHARDIC** MEDITERRANEAN **PACIFIC ISLANDER**

SCANDINAVIAN **SLAVIC** SLOVAK **OTHER** PREFER NOT TO ANSWER

EMPLOYER:_____PHONE:_____

EMPLOYER'S ADDRESS:_____CITY:_____STATE_____ZIP_____

SPOUSE'S NAME:_____ DOB:____/____/_____ SSN_____

In case of an emergency, who should we contact?_____ PHONE_____

ALTERNATE NAME & PHONE NUMER OF FAMILY/FRIEND: _____PHONE_____

INSURANCE INFORMATION

DO YOU HAVE INSURANCE? CIRCLE ONE YES NO

IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION

1) PRIMARY INSURANCE COMPANY:_____

NAME OF INSURED:_____

EMPLOYER OF INSURED:_____

RELATIONSHIP TO PATIENT:_____ DOB:____/____/_____ SSN_____

ADDRESS (IF DIFFERENT):_____

2) SECONDARY INSURANCE COMPANY:_____

NAME OF INSURED:_____

EMPLOYER OF INSURED:_____

RELATIONSHIP TO PATIENT:_____ DOB:____/____/_____ SSN_____

ADDRESS (IF DIFFERENT):_____

The information provided is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any change in the above mentioned patient's status. I authorize Liberty Medical Surgical Clinic to provide medical services to the above mentioned patient. I authorize my insurance company to pay all benefits otherwise payable to me for services rendered. I authorize Liberty Medical Surgical Clinic to release any information needed to secure payment of benefits. I authorize the use of this signature on all insurance submissions:

SIGNATURE OF PATIENT:_____ DATE:_____

Liberty Medical Surgical Clinic
Liberty Medical Rural Health Clinic
720 Travis, Liberty, Texas, 77575

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. In order to clarify issues regarding patient and insurance responsibility for services rendered, we ask that you review the following policy. Please sign in the designated space. A copy will be provided to you upon request.

Insurance
We participate in many insurance plans, including Medicare, Medicaid, and CHIP. If you are not insured by a plan we do business with payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles
All co-payments and deductibles must be paid at time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please pay your co-payment at each visit to help us uphold the law and adhere to the terms of our contract with your insurance company.

Methods of payment
We accept cash, personal check, most debit cards, MasterCard, Visa, and Discover as payment options.

Non-covered services
Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare, Medicaid or private insurers. For example, many insurance companies, including Medicare, do not pay for vitamin B12 injections. You must pay for such services in full at the time of visit

Proof of insurance
All patients must complete our patient information form before their appointment. We must obtain a copy of your driver's license for identification and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for all of the charges incurred as a result of your visit.

Claims submission
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are part of a contract between you and your insurance company; we are not a party to that contract.

PLEASE TURN OVER TO CONTINUE READING AND SIGN ACKNOWLEDGMENT

Coverage changes
If your insurance changes, please notify us so we can update your information.

Nonpayment
If your account is past due, you will receive a letter stating that you are responsible for paying the balance. Negotiations for partial payment may be accepted on an individual basis. Please be aware that if a balance remains unpaid, we may refer your account to an outside agency for collection.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____
Patient Name – Please Print **Date of Birth**

_____ _____
Signature of patient or responsible party **Date**

_____
Relationship to patient

LIBERTY MEDICAL SURGICAL CLINIC
CONFIDENTIAL COMMUNICATIONS DIRECTIVE

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 communication or that a communication of PHI is made by alternative means.

PLEASE MAKE SURE YOU REVIEW THIS FORM CAREFULLY. IF SOMEONE OTHER THAN PATIENT IS TO CALL FOR OR PICK UP INFORMATION AND/OR MEDICATION, THEIR NAME MUST BE SPECIFIED OR THE REQUEST WILL BE DENIED.

I wish to be contacted in the following manner:

PHONE COMMUNICATIONS – (Initial all that apply)

Home Telephone ( ) _____

____ Leave detailed message on answering machine
____ Leave call back number only
____ Leave detailed message with _____ only
____ Discuss my protected health information with me only

Work Telephone ( ) _____

____ Leave detailed message on answering machine
____ Leave call back number only
____ Leave detailed message with _____ only
____ Discuss my protected health information with me only

WRITTEN COMMUNICATIONS - (Initial all that apply)

____ Mail to my home address
____ Mail to an alternate address: _____
Address City State Zip
____ Fax to ( ) _____

OTHER MEANS OF COMMUNICATIONS

Persons other than myself that may call for or pick up records, reports or medication
(Initial all that apply and specify names)

____ Spouse _____
____ Children _____
____ Parents _____
____ Siblings _____
____ Grandparents _____
____ Friends _____
____ Other _____

_____
Printed Patient Name

_____ _____
Patient or Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICES

Effective Date: February 1, 2013

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.

If you have any questions about this Notice, please contact:

Shannon Gardner at 936-336-6439.

WHO WILL FOLLOW THIS NOTICE?

- ✓ Liberty Medical Surgical Clinic
- ✓ Liberty Medical Rural Health Clinic
- ✓ All physicians, physician assistants, nurse practitioners, and staff

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at Liberty Medical Surgical Clinic, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

We shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;

- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- We will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your specialists to whom you are referred for care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run Liberty Medical Surgical Clinic in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, Liberty Medical Surgical Clinic may provide a written or telephone reminder of your next appointment.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations. This could include action such as notifying the Texas Department of State Health Services of a disease or condition we are required by state law to report.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:

  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

  All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

  - In response to a court order or subpoena; or
  - If we determine there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a

deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.

- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for Liberty Medical Surgical Clinic. If you request a copy of the information, Liberty Medical Surgical Clinic may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

  Liberty Medical Surgical Clinic may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Liberty Medical Surgical Clinic will review your request and denial. The person conducting the review will not be the person who denied your request. Liberty Medical Surgical Clinic will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask your health care provider to amend the information. You have the right to request an amendment for as long as the information is kept by Liberty Medical Surgical Clinic.

  To request an amendment, your request must be made in writing and submitted to the Privacy Officer who will consult your health care provider. In addition, you must provide a reason that supports your request.

  Your request may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the request may be denied if you ask us to amend information that:

  - Was not created by Liberty Medical Surgical Clinic, its staff or professional health care providers, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by Liberty Medical Surgical Clinic;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes **other** than treatment, payment, or health care operations.

  To request this list you must submit your request in writing to Shannon Gardner, Privacy Officer. Your request must state a time period, which may not be longer than six (6) years.). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Liberty Medical Surgical Clinic will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information Liberty Medical Surgical Clinic uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information Liberty Medical Surgical Clinic discloses about you to someone who is involved in your care or the payment for your care.

  Liberty Medical Surgical Clinic is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which we have been paid out of pocket in full. Should Liberty Medical Surgical Clinic agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions you must make your request in writing to Shannon Gardner, Privacy Officer . In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Liberty Medical Surgical Clinic's use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request that Liberty Medical Surgical Clinic communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only at work or by mail.

  To request that Liberty Medical Surgical Clinic communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. Liberty Medical Surgical Clinic will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer, Shannon Gardner.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with Liberty Medical Surgical Clinic or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with Liberty Medical Surgical Clinic, contact the Privacy Officer, Shannon Gardner at 936-336-6439. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

ACKNOWLEDGEMENT

Patient Name: _____
Please use your legal name and print legibly.

Date of Birth: _____

I acknowledge that Liberty Medical Surgical Clinic provided me with a written copy of the Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature (if applicable) Relationship to Patient

History & Physical

Medi-Forms™ BY MEDI-SCRIPTS®

Name _____

Date _____ SS# _____

Address _____

Occupation _____ Phone (Home) _____

(Work) _____ Date of Birth _____

Chief Complaint _____

Insurance# _____

Hospitalization or Surgery

Date	Reason	Date	Reason

Drug Allergies

Medications

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus		Pneumonia		Rectal/Stool		Tuberculosis	
Flu		Other_____		Cholesterol		Other_____	

Medical History

- ❑ Ringing In Ear_____
- ❑ Ear Infections - *Frequent* _____
- ❑ Dizziness/Fainting _____
- ❑ Hair Loss_____
- ❑ Failing Vision _____
- ❑ Eye Infections _____
- ❑ Nose Bleeds_____
- ❑ Sinus Trouble _____
- ❑ Sore Throats - *Frequent* _____
- ❑ Hayfever/Allergies_____
- ❑ Pneumonia _____
- ❑ Bronchitis/Chronic Cough_____
- ❑ Asthma/Wheezing _____
- ❑ Chest Pain _____
- ❑ Hair Loss_____
- ❑ High Blood Pressure _____
- ❑ Heart Murmur _____
- ❑ Swollen Ankles _____
- ❑ Leg Pain - *Walking*_____
- ❑ Varicose Veins/Phlebitis _____
- ❑ Loss of Appetite _____
- ❑ Difficulty Swallowing _____
- ❑ Indigestion or Heartburn _____
- ❑ Persistent Nausea/Vomiting _____
- ❑ Peptic Ulcers _____
- ❑ Abdominal Pain - *Chronic*_____
- ❑ Gall Bladder Trouble _____
- ❑ Jaundice/Hepatitis _____
- ❑ Change in Bowel Habits _____
- ❑ Diarrhea ❑ Constipation _____
- ❑ Diverticulosis ❑ Crohn's/Colitis ____
- ❑ Bloody or Tarry Stools _____
- ❑ Hemorrhoids _____
- ❑ Hernia _____
- ❑ Urine Infections - *Frequent* _____
- ❑ Blood In Urine _____
- Urination-❑ Overnight > than twice
  - ❑ Painful ❑ Loss of Control
  - ❑ Decrease in Force/Flow
- ❑ Kidney Stones _____
- ❑ Venereal Disease_____
- ❑ Urethral Discharge _____
- ❑ Chronic Fatigue _____
- ❑ Weight Loss - *Recent*_____
- ❑ Anemia ❑ Bruise Easily _____
- ❑ Cancer_____
- ❑ Diabetes _____
- ❑ Thyroid Disease _____
- ❑ Convulsions/Seizures _____
- ❑ Stroke _____
- ❑ Tremor/Hands Shaking _____
- ❑ Muscle Weakness _____
- ❑ Numbness/Tingling Sensations _____
- ❑ Headaches - *Frequent* _____
- ❑ Arthritis/Rheumatism_____
- ❑ Osteoporosis _____
- ❑ Back Pain - *Recurrent* _____
- ❑ Bone Fracture/Joint Injury _____
- ❑ Gout _____
- ❑ Foot Pain ❑ Cold Numb Feet _____
- ❑ Rashes ❑ Hives _____
- ❑ Psoriasis ❑ Eczema_____
- ❑ Nervousness ❑ Depression_____
- ❑ Memory Loss _____
- ❑ Moodiness - *Excessive* _____
- ❑ Phobias _____
- ❑ Mental Illness_____
- ❑ Lactose Intolerance _____
- ❑ Prostate Disease_____
- ❑ Sexual/Menstrual Dysfunction ____
- ❑ Frequent Infections _____
- ❑ Diphtheria _____
- ❑ Tetanus _____
- ❑ Chicken Pox ❑ Polio ❑ Mumps ❑ Measles ❑ Rubella ❑ Rheumatic Fever
- ❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
- ❑ Other _____
- ❑ Other _____

Females - *Please Complete*

Pregnant? ❑ Yes ❑ No

Planning Pregnancy? ❑ Yes ❑ No

Menstrual Flow:

❑ Regular ❑ Irregular ❑ Pain/Cramps

____Days of Flow ____Length of Cycle

Date-1st day of last period_____

❑ Pain/Bleeding during or after sex

Number of:

____Pregnancies ____Abortions

____Miscarriages ____Live Births

Birth Control Method_____

B.C. Pill (Name) _____

❑ Flushing/Menopause

Date of Last PAP Test _____

❑ Normal ❑ Abnormal

Date of Last Mammogram _____

Normal ❑ Abnormal

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Hair Loss	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High Blood Pressure	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Migraine	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Other_____						

Habits

- ❑ Alcohol: Type _____
  - Amount_____
- ❑ Diet: Salt Intake _____
  - Fat Intake _____
  - Other _____
- ❑ Sleep: Difficulty Falling Asleep _____
  - Continuity Disturbances _____
  - Early Morning Awakening _____
  - Daytime Drowsiness _____
  - Other_____
- ❑ Smoke: Packs Daily _____
  - How Long _____
  - Interested in Stopping?_____
- ❑ Exercise Routine: _____
- ❑ Coffee: Cups Daily_____
  - Other Caffeine _____