NURSE PRACTITIONER CONSULTANTS

PLEASE DO NOT LEAVE FIELDS BLANK

Date

PERSONAL INFORMATION

Legal First Name	Middle Initial	Last Name	Preferred Name

Street and Apt #	City	State	Zip Code

Primary Telephone	Birth Date	Social Security Number

E-mail:

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Dependent
- ☐ Widow

Race

- ☐ White/Caucasian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Prefer Not to Disclose
- ☐ Other_____

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer Not to Disclose

Gender

- ☐ Male
- ☐ Female
- ☐ Transgender

Emergency Contact Full Name	Relationship	Phone #

Parent/Spouse/Partner Full Name	Relationship	Phone #

BILLING INFORMATION

PRIMARY INSURANCE	
Insurance Company	
Subscriber Name	
Birthdate	
Group #	
ID #	
Subscriber's Employer	

SECONDARY INSURANCE	
Insurance Company	
Subscriber Name	
Birthdate	
Group #	
ID #	
Subscriber's Employer	

BILLING CONTACT | Complete *only if* the person responsible for the bill is *not the patient*.

First Name	Middle Initial	Last Name	Relationship

Street and Apt #	City	State	Zip Code

Primary Telephone	Employer	Employer Phone #

Employer Address

MEDICATION LIST/ALLERGIES/PHYSICAN & PHARMACY INFORMATION

Medications/Supplements	Dosage/Frequency	Condition/Reason

Allergies (Medication, Food, Cosmetics, Etc.)	Cause/Nature of Reaction

Physician and Pharmacy Information	
Primary Care Provider (Name/Phone/Fax):	**Preferred Pharmacy** (Name/Phone/Fax):
Referring Physician (Name/Phone/Fax): ❑ Same as PCP	**Other Physician to send records to** (Name/Phone/Fax):
Specialty:	Specialty:
Other Physician to send records to (Name/Phone/Fax):	**Other Physician to send records to** (Name/Phone/Fax):
Specialty:	Specialty:

FAMILY & SOCIAL HISTORY

Family History: **Mother**	Family History: **Father**	Family History: **Siblings**	Family History: **Children**
❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type): ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type): ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type): ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type): ❑ Other:

Do you drink **Alcohol**?	Do you **Smoke**?	Do you use recreational **Drugs**?
❑ Never ❑ Yes. I drink: ❑ wine ❑ beer ❑ liquor ❑ I have _____ drink(s) per week ❑ I used to drink but quit in _____ (year)	❑ I never smoked ❑ Yes. I smoke: ❑ cigarettes ❑ cigars ❑ pipes. ❑ I currently smoke and I don't want to quit ❑ I currently smoke but I'm ready to quit. ❑ I smoke _____ pack(s) per day for _____ years ❑ I used to smoke but quit in _____(year) ❑ I use chewing or smokeless tobacco	❑ Never ❑ No, but I have used _____ ❑ Yes, I use _____

Do you eat or drink foods containing **Caffeine?**	Have you taken any **Aspirin, Advil, Nuprin** (NSAIDs) in the last 7 days?
❑ Yes ❑ No	❑ Yes (if so, what medication? _____) ❑ No

Do you **Exercise**?	**If yes, how often and what type?**
❑ Yes ❑ No	

Date of most recent flu shot (age 6 months+):	Date of most recent pneumonia shot (age 65+):

PERSONAL HEALTH HISTORY

Have you EVER HAD, or do you have, any of the following? Circle yes or no. If yes, specify by number and explain:

1. Chicken pox or shingles.....	Yes	No	25. Broken bones.....	Yes	No
2. Measles.....	Yes	No	26. Bone or joint problems.....	Yes	No
3. Mumps.....	Yes	No	27. Arthritis/gout.....	Yes	No
4. Skin problems or chronic rash.....	Yes	No	28. Back pain/injury.....	Yes	No
5. Eye problems.....	Yes	No	29. Numbness/tingling legs or feet.....	Yes	No
6. Hearing loss or ear problems.....	Yes	No	30. Knee pain/injury.....	Yes	No
7. Chronic cough.....	Yes	No	31. Foot pain/injury.....	Yes	No
8. Asthma.....	Yes	No	32. Neck pain/injury.....	Yes	No
9. Shortness of breath.....	Yes	No	33. Loss of limb.....	Yes	No
10. Lung problems.....	Yes	No	34. Severe headaches.....	Yes	No
11. Tuberculosis or positive TB test.....	Yes	No	35. Dizziness or fainting.....	Yes	No
12. Chest pain.....	Yes	No	36. Epilepsy or seizures.....	Yes	No
13. Heart trouble/attack.....	Yes	No	37. Severe weakness or tiredness.....	Yes	No
14. Palpitations/irregular heartbeat.....	Yes	No	38. Depression or anxiety.....	Yes	No
15. Heart murmur.....	Yes	No	39. Emotional or psychiatric problems..	Yes	No
16. High blood pressure.....	Yes	No	40. Drug or alcohol dependency.....	Yes	No
17. Stroke or paralysis.....	Yes	No	41. Eating disorder.....	Yes	No
18. Stomach or intestinal problem.....	Yes	No	42. Bleeding or blood disorder.....	Yes	No
19. Liver disease/hepatitis.....	Yes	No	43. Immune suppression.....	Yes	No
20. Kidney disease.....	Yes	No	44. Chronic/recurrent infection.....	Yes	No
21. Weight Change.....	Yes	No	45. Tumor/cancer.....	Yes	No
22. Thyroid problems.....	Yes	No	46. Anemia.....	Yes	No
23. Shoulder/elbow/wrist/hand pain.....	Yes	No	47. Diabetic.....	Yes	No
24. Numbness/tingling or arms or hands...	Yes	No	48. Any other illness not listed.....	Yes	No

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 252-744-2426.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

NURSE PRACTITIONER CONSULTANTS

PATIENT PORTAL /PHONE/E-MAIL

I understand that my healthcare information at Nurse Practitioner Consultants is protected and I have received a copy of their Notice of Privacy Practices. In order for NPC to leave detailed messages on my voicemail or answering machine, I need to give permission to NPC to do so.

Consent for Leaving Messages/Access to Patient Portal

By signing below, I consent to information regarding my lab test results or appointment reminders/ instructions be left on my voicemail or answering machines. I also consent to have access to the patient portal. This includes receiving emails where I will be able to confirm, schedule, and cancel appointments. I understand that "sensitive" information as noted below will be excluded unless specifically requested by myself or my medical power of attorney.

IF **NOT**,
INITIAL HERE → *I **do not** give consent for NPC to leave messages* initials _____

Would you like access to our **patient portal** and to receive lab notifications on-line?

Consent for Shared Information with Family & Friends

By signing below, I wish family members or friends to have access to my healthcare information. The name(s) listed below are family members or friends to whom I grant access to my healthcare information. I will rely on the judgment of my provider or his/her designee to release any "sensitive" information. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

Family/Friend Name	Relationship	Phone #	E-mail

I understand that some information is "sensitive". I understand that **I must check** the specific boxes in order for my provider or his/her designee to release any "sensitive" information.

- ☐ Mental Health/Psychiatric Disorders (including depression)
- ☐ Chemical Dependency (drug and/or alcohol abuse/treatment)
- ☐ HIV/AIDS Virus
- ☐ Sexually Transmitted Diseases
- ☐ Pregnancy Information

IF **NOT**,
INITIAL HERE → *I **do not** give consent for NPC to share information with family/friends* initials _____

Patient Name (PRINT)	Date of Birth
Signature of Applicant	Date

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

FINANCIAL CONSENT FORMS

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance to be paid directly to my provider. I also authorize my provider or insurance company to release any information for processing my claims.

Patient Name (PRINT)	Date of Birth
Signature of Applicant	Date

CO-PAYMENTS

Co-payments are due at the time of service. These payments are part of your contracted benefits with your insurance company. We are happy to accept your payment in the form of cash, credit card, or check.

BILLING

We make every effort to file the appropriate code(s) encountered and documented in your medical record. Our office is given Service Codes and guidelines to follow to prevent inappropriate charges being billed to you and your insurance company. We are unable to bill for services other than those documented in your medical record. We cannot change a code after a visit, as this can be construed as fraud by the insurance company or Medicare.

As a courtesy, Nurse Practitioner Consultants will file a claim with your primary insurance on your behalf. Any questions regarding your benefits and coverage should be directed to your insurance carrier. Our goal at Nurse Practitioner Consultants is to ensure your clinic bill is processed correctly and in a timely manner. Please make sure you notify us of any changes to your insurance coverage.

If you are self-pay/noninsured; payment for your visit is due at time of service.

By signing below, I acknowledge receipt of the Notice of Clinic Policies.

Patient Name (PRINT)	Date of Birth
Signature of Applicant	Date

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our administration team at Nurse Practitioner Consultants.

Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Patient Name (PRINT)	Date of Birth
Signature of Applicant	Date