NP Care Inc.

Patient Information Sheet

Thank you for choosing our office

In order to serve you properly, please provide us with the following information.

Patient Name:_____ Date of Birth:___/___/_____

M__ F__ Social Security Number_____-_____-_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone Number:_____ Cell _____ Work_____

Email:_____

Insurance Company Name:_____

ID#_____ Effective Date:_____/_____/_____

Secondary Insurance Company Name:_____

ID#_____ Effective Date:_____/_____/_____

Name of Insured:_____ Relationship to Patient:_____

Pharmacy Name:_____ Phone:_____ Fax:_____

Pharmacy Address:_____

City:_____ State:_____ Zip Code:_____

Primary Provider Name:_____ Phone:_____

Fax:_____

Primary Provider Address:_____

City:_____ State:_____ Zip Code:_____

Signature:_____ Date:_____/_____/_____

NP Care Inc

REQUEST FOR CONFIDENTIAL HANDLING OF HEALTH INFORMATION

I, _____ (PRINT NAME), REQUEST CONFIDENTIAL HANDLING OF CORRESPONDENCE REGARDING MY HEALTH INFORMATION FOR THE PERIOD:

D.O.B.___/___/___SOCIAL SECURITY#____-____-____PHONE#(____)_____-_____

FROM:	TO
_____	_____
FACILITY OF PHYSICIANS'S	FACILITY OF PHYSICIANS'S
_____	_____
ADDRESS	ADDRESS
_____	_____
CITY,STATE,ZIP CODE	CITY,STATE,ZIP CODE
_____	_____
PHONE NUMBER	PHONE NUMBER/ FAX NUMBER

THIS REQUEST APPLIES TO HEALTH INFORMATION INVOLVING:
PLEASE BE SPECIFIC AS POSSIBLE, E.G.,TREATMENT REGARDING A GIVEN ILLNESS OR DIAGNOSIS.

_____DISCHARGE SUMMARY _____H&P _____ LABORATORY
_____PROGRESS NOTES _____ CONSULTATION NOTES
_____ X-RAY/EKG
_____OTHER_____

PATIENT SIGNATURE_____

DATE_____

AUTHORIZATION TO RELEASE INFORMATION

I,_____, GIVE NPC CARE INC.

PRINT PATIENTS NAME

PERMISSION TO DISCLOSE INFORMATION TO

NAME _____RELATIONSHIP_____ DATE OF BIRTH_____

NAME_____RELATIONSHIP_____DATE OF BIRTH_____

NAME_____RELATIONSHIP_____DATE OF BRTH_____

THIS INFORMATION MAY BE IN REGARDS TO ANY APPOINTMENT, DIAGNOSTIC OR SURGERY SCHEDULING QUESTIONS OR FINANCIAL MATTERS. I REALIZE THAT THIS INFORMATION WILL ONLY BE SHARED WITH THE PERSON(S) LISTED ABOVE IN A BETTER ATTEMPT TO SERVE ME .

_____ _____

PATIENT OR GUARDIOAN SIGNATURE DATE

I have selected to receive confidential communications in the following way:

_____Patient will pick up communications at the provider's office.

_____Patient will receive any information at an alternate mailing address.

_____Patient will receive any information at an alternate fax number: (___) ____-____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information could be redisclosed without my authorization.

I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization.

I understand that I have the right to receive a copy of the authorization. Copy requested and received:

_____NO _____YES Initial:_____

I release the person/agency, disclosing this information from any liability arising from the release of information to the person/agency designated above.

X_____ X_____

Signature of Patient Date

_____ _____

Signature of Guardian/Representative Date

NP CARE INC.

FINANCIAL POLICY:

DEAR PATIENT

PLEASE BRING YOUR INSURANCE ID AND PICTURE ID WITH YOU EACH TIME YOU VISIT OUR OFFICE.

HEALTH PLAN OBLIGATION:

I UNDERSTAND THAT NP CARE INC. MAINTAINS CONTRACTS WITH VARIOUS HEALTH PLANS AND GOVERNMENT PROGRAMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR DETERMINING WHETHER MY HEALTH PLAN OR GOVERNHMENT PLAN CONTRACTS WITH NP CARE INC. FOR THE SERVICES I WILL BE PROVIDED. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ENSURING THAT APPROPRIATE AUTHORIZATIONS HAVE BEEN RECEIVED OR NOTIFICATIONS HAVE BEEN GIVEN, AS REQUIRED BY MY HEALTH PLAN. I ALSO UNDERSTAND THAT I AM OBLIGATED INDIVIDUALLY TO PAY ANY APPLICABLE CO PAYS, CO INSURANCES, DEDUCTIBLES, OR OTHER AMOUNTS AS WELL AS ANY CHARGES FOR SERVICES RENDERED TO ME TO THE EXTENT TRHAT HOSE SERVICES ARE NOT COVERED BY A CONTRACT BETWEEN NP CARE INC AND MY HEALTH PLAN OR GOVERNMENT PLAN.

IN ADDITION, BE AWARE OF THE FOLLOWING REGULATIONS SET BY THE FOLLOWING PAYERS:

MEDICARE PATIENTS

WE ARE PARTICIPATING PROVIDERS AND BILL MDICARE AND MEDIGAP INSURANCE. ALL BALANCES AND DEDUCTIBLES ARE DUE WITHIN 30 DAYS AFTER MEDICARE HAS PAID.

In addition, be aware of the following regulations set by the following payers.

Medicare Patients

We are participating providers and bill Medicare and Megi-Gap insurance. All balances and deductibles are due within 30 days after Medicare has paid.

COMMERCIAL

We will bill your insurance and send a statement showing the remaining balance. If your insurance does not pay within 60 days the balance will be your responsibility.

SELF PAY PATIENTS

Be prepared to pay a minimum of $100 deposit for each office visit. You will be billed for the balance, if any.

MEDICAID PATIENTS

You must bring your current card with you each visit. We cannot bill for services correctly without it.

We accept all forms of payment.

Patient or Guardian Signature _____
Date_____

COMMERCIAL INSURANCE

WE WILL BILL YOUR INSURANCE AND SEND A STATEMENT SHOWING THE REMAINING BALANCE. IF YOUR INSURANCE DOES NOT PAY WITHIN 60 DAYS THE BALANCE WILL BE YUR RESPONSIBILITY.

SELF PAY PATIENTS

PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT

MEDICAID PATIENTS

PLEASE BRING YOUR CARD WITH YOU TO EACH VISIT

ASSIGNMENT OF INSURANCE BENEFITS: I AUTHORIZE DIRECT PAYMENT TO NP CARE INC.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT PAID PURSUANJT TO THIS ASSIGNMENT. FOR MY CONVENIENCE, I INTEND THAT THIS SIGNED FORM WILL SERVE AS A SINGLE ASSIGNMENT OF EBENFITS AND AUTHORIZATION TO BILL FOR ALL PARTIES PROVIDING CARE TO ME.

AUTHROIZATION FOR USE OF EMAIL COMMUNICATION: I AUTHORIZE NP CARE INC., FOR THE USE OF MY EMAIL ADDRESS FOR FOR THE PURPOSE OF HEALTH RELATED PRODUCTS/SERVICES OR MEDICAL BILLING INFORMATION. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME. I UNDERSTAND THAT I HAVE THE RIGHT TO MAKE A COMPLAINTS REGARDING THE USE OF THIS INFORMATION. I MAY CONTACT ANY EMPLOYEE IN THE BILLING DEPARTMENT TO MAKE A COMPLAINT OR INQUIRE ABOUT NP CARE INC.

PRIVACY POLICIES. THIS AUTHORIZATIONJ IS EFFECTIVE ON THE DATE OF SIGNING AND ENDS AT THE TIME THE PATIENT REQUESTS. NP CARE INC IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF PHI. NP CARE INC. WILL NOT RELEASE/SELL YOUR EMAIL TO A THIRD PARTY.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS PATIENT CONSENT AND FINANCIAL AGREEMENT, HAVE RECEIVED A COPY HEREOF, AND THAT I AM THE PATIENT OR I AM ACTING ON BEHALF OF THE PATIENT AS HIS/HER DULY AUTHORIZED AGENT.

PRINTED NAME OF PATIENT OR REPRESENTATIVE RELATIONSHIP

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE/TIME

SIGNATURE OF WITNESS DATE/TIME

NP CARE INC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES FROM NP CARE INC.

SIGNATURE OF PATIENT_____

DATE_____

IN LIEU OF PATIENTS SIGNATURE, I, _____A STAFF MEMBER OF NP CARE INC., STATE THAT _____ HAS BEEN GIVEN OUR NOTICE OF PRIVACY PRACTICES.

_____ DATE_____

NP CARE INC.

PLEASE INITIAL EACH LINE:

_____ I HAVE READ AND UNDERSTAND THE HIPAA POLICY.

_____ I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY.

_____ I HEREBY AUTHORIZE NP CARE INC. TO APPEAL ANY AND ALL CLAIMS WITH MY INSURANCE COMPANY ON MY BEHALF.

_____ I AUTHORIZE THE USE OF MY E-MAIL ADDRESS.

EMAIL ADDRESS: _____@_____

_____ I DECLINE THE USE OF MY EMAIL ADDRESS.

PATIENT SIGNATURE:_____

PARENT GUARDIAN SIGNATURE:_____

PLEASE LIST ANY FAMILY MEMBER OR OTHERS, IN WHICH WE CAN COMMUNICATE WITH INVOLVING YOUR CARE OR PAYMENT. ALSO, PLEASE SPECIFY WHAT KIND OF INFORMATION WE CAN RELEASE. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL NOTIFICATION OF CHANGES ARE MADE.

NAME	RELATIONSHIP TO PATIENT	ALL	TYPE OF INFORMATION SCHELUDING/ APPOINTMENT	MEDICAL/ PRESCRIPTION	BILLING/ INSURANCE
_____		( )	_____	_____	_____
_____		( )	_____	_____	
_____					
_____		( )	_____	_____	
_____					

PATIENT

SIGNATURE_____DATE_____

PRINT NAME _____

WITNESS SIGNATURE_____

DATE_____

NPCARE INC.

NAME_____SEX_____AGE_____

DOB_____

REASON FOR VISIT_____

PAST MEDICAL HISTORY

CHECK ALL THAT APPLY

DIABETES____ HIGH BLOOD PRESSURE_____ HEART DISEASE_____

HEART ATTACK_____ ASTHMA_____ EMPHYSEMA

LIVER DISEASE_____KIDNEY DISEASE_____ BLEEDING PROBLEMS

BLOOD CLOTS_____THYROID DISORDERS_____

STROKE_____HIGH CHLOESTEROL_____DEPRESSION_____

HEART RHYTHM PROBLEMS_____ANGINA_____HEPATITIS_____

SEIZURES_____MIGRAINE_____BACK PROBLEMS_____

GLAUCOMA_____IMMUNE SYSTEM_____OSTEOPOROSIS_____

ANESTHESIA PROBLEMS_____ ARTHRITIS_____

GERD/ACID REFLUX_____ SLEEP APNEA_____

IRRITABLE BOWEL SYNDROME_____CONSTIPATION_____

CANCER_____

OTHER_____

MEDICATIONS:

List *all* current medications you are taking and the dosages.

MEDICATION	DOSE	FREQUENCY	FOR WHAT CONDITION

Are you up to date on all of your immunizations? ___ Yes ___ No

ALLERGIES:

Please list *any* allergies you have, including allergies to chemicals and foods.

Type of Reaction

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Single___ Married___ Divorced___ Widowed___ Partnered___

Occupation_____

Tobacco Use ___ No Yes___ Former___ Amount____ Start Age___ Stop Age___

Alcohol Use ___ No Yes___ Former___ Amount____ Start Age ___ Stop Age___

IV Drug Use ___No Yes___ Former___ Start Age ___ Stop Age___

GYNECOLOGIC HISTORY:

Number of Pregnancies___ Number of Live Births ____ Abortions___

Age at 1st Pregnancy___ Age of 1st Menstrual Cycle___ Age of Menopause___

Have you ever taken Birth Control Pills or Hormone Replacement Treatment?

Yes____ No____

If so, what is the age you started:_____ age stopped: _____

BREAST FEEDING HISTORY:

Have you ever breast fed your children? Yes___ No___

How many children have you breast fed? _____ For how long? _____

FAMILY MEDICAL HISTORY:

Check all that apply, list the affected relative on the line below.

Anesthesia Problems ___No ___Yes Type_____ Affected Relative_____

Bleeding Disorders ___No ___Yes Type_____ Affected Relative_____

Cancer ___No ___Yes Type_____ Affected Relative_____

_____ _____

Heart Disease	___No	___Yes	Type_____	Affected Relative_____
Diabetes	___No	___Yes		Affected Relative_____
Seizure	___No	___Yes		Affected Relative_____
Stroke	___No	___Yes		Affected Relative_____
Arthritis	___No	___Yes		Affected Relative_____
Asthma	___No	___Yes		Affected Relative_____
Heart Attack	___No	___Yes		Affected Relative_____
High Cholesterol	___No	___Yes		Affected Relative_____
High Blood Pressure	___No	___Yes		Affected Relative_____
Obesity	___No	___Yes		Affected Relative_____
Renal Disease	___No	___Yes		Affected Relative_____
Thyroid Disease	___No	___Yes		Affected Relative_____

Other_____ Affected Relative:_____

PAST SURGICAL HISTORY:

Please list any surgical procedures you have had including the year it was performed.

PROCEDURE YEAR

_____

_____

_____

_____

_____

_____