

# Jabari Healthcare

Phone 214-824-3333 Fax 214-736-9413

## PLEASE READ CAREFULLY

Along with paperwork, we **MUST** have copies of Medication List, Insurance Cards, Power of Attorney paperwork, Advanced Directives options and DNR status paperwork.

Packets will need to be filled out in their entirety.

- \* New Patient Information Sheet / please add facility name room # & check the appropriate → AL/IL/MC
- \* Authorization for Release of Medical Health Information Sheet
- \* Permission to use and disclose protected health information
- \* DNR/Living Will/Advanced Directives Sheet
- \* Medical and Surgical History Sheet (please include any additional records available)
- \* Medication List / please add which pharmacy patient will be using
- \* Copy of front & back insurance cards (patient will not be seen until this is obtained)
- \* Consent to treat (patient will not be seen until this is obtained)
- \* POA/Guardianship Paperwork if applicable
- \* POA/patient email for patient portal

**\*\*PLEASE UNDERSTAND THAT WE WILL NOT BE ABLE TO SCHEDULE PATIENT TO BE SEEN BY JABARI HEALTHCARE UNTIL COPIES OF INSURANCE CARDS ARE OBTAINED AND INSURANCE IS VERIFIED AND CONSENTS MUST BE SIGNED BY PATIENT OR POWER OF ATTORNEY \*\***

# Jabari Healthcare

Provider: Barikat Oderinde,FNP and collaborating physician Dr. Nguyen & Dr. Ogonna

Phone 214-824-3333 Fax 214-736-9413

## NEW PATIENT INFORMATION

(please check one)

Facility Name \_\_\_\_\_ Room # \_\_\_\_\_ AL \_\_\_\_\_ IL \_\_\_\_\_ Memory Care

Patients Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Home Phone \_\_\_\_\_

Patients Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's SSN# \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_

Marital Status M D W S Height \_\_\_\_\_ Weight \_\_\_\_\_ Pharmacy/ Phone: \_\_\_\_\_

Please List ALL Allergies to Medications and Foods \_\_\_\_\_

Race	Ethnicity	Language
____ American Indian / or Alaska	____ Hispanic or Latino	____ English
____ Native Asian	____ Non-Hispanic or Latino	____ French
____ Black / African American	____ Refuse to Report / Unreported	____ German
____ Native Hawaiian or Other Pacific Islander		____ Japanese
____ White		____ Russian
____ Refuse to Report / Unreported		____ Spanish

## INSURANCE INFORMATION PLEASE PROVIDE A COPY OF INSURANCE CARDS FRONT & BACK FOR OUR RECORDS

Primary Insurance Name \_\_\_\_\_ Policy ID# \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_ Policy ID# \_\_\_\_\_ Group# \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION (PLEASE FILL OUT COMPLETELY)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Number \_\_\_\_\_ Work Number \_\_\_\_\_ Cell Number \_\_\_\_\_

## FINANCIAL RESPONSIBLE PARTY INFORMATION & POWER OF ATTORNEY INFORMATION

Name \_\_\_\_\_ Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ Relationship \_\_\_\_\_

Home Number \_\_\_\_\_ Work Number \_\_\_\_\_ Cell Number \_\_\_\_\_

Power of Attorney Name \_\_\_\_\_ Phone# \_\_\_\_\_

POA email: \_\_\_\_\_

\_\_\_\_ (initial) I do hereby give my permission and consent for medical treatment by Jabari Healthcare. I also understand that I will be financially responsible for payment of services if Medicare or other insurance denies payment. In addition, I agree to be financially responsible for any testing or treatment ordered by the doctor that may not be considered by my insurance company to be medically necessary.

X SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# Jabari Healthcare

Provider: Barikat Oderinde, FNP and collaborating physician Dr. Nguyen & Dr. Ogbonna

## Authorization for Release of Medical Health Information

(In compliance with HIPPA this does not authorize release of Psychotherapy Information)  
(Entity/Person from Whom Records are Requested)

I hereby authorize \_\_\_\_\_

To disclose my individual identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient's Social Security Number

\_\_\_\_\_  
Date(s) of service (if known)

Description of Information to Be Released:

Entire Medical Records \_\_\_\_\_ Other (be specific):

The health information described herein shall be released to:

Jabari Healthcare  
(Physician Name)

214-824-3333  
(Phone)

214-736-9413  
(Fax)

office@jabarihealth.com  
(Email)

I further understand that I may revoke this authorization at any time by notifying Jabari Healthcare in writing at office@jabarihealth.com. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Legal Authority (attach supporting documentation)

# Jabari Healthcare

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Provider: Barikat Oderinde,FNP and collaborating physician Dr. Nguyen & Dr. Ogbonna

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## Consent to Treat

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1. I \_\_\_\_\_ (patient name) give permission for **Jabari Healthcare** to give me medical treatment.

1. I allow **Jabari Healthcare** to file for insurance benefits to pay for the care I receive.

I understand that:

- **Jabari Healthcare** will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
- For pain management medications Barikat Oderinde,FNP will collaborate with Dr. Nguyen & Dr. Ogbonna and pain management specialist to manage my pain medications.
- I have the right to refuse any procedure or treatment.
- have the right to discuss all medical treatments with my provider.

2. **E-MAIL, TEXTING, VIDEO, PATIENT/FACILITY PORTAL AND OTHER ELECTRONIC FORMS OF COMMUNICATION:** Technologies today have many different levels of encryption and protection. I understand that my healthcare provider will use encrypted E-mail system, but many times the consumer end is not protected like email system or phone system.

☐ I Authorize to receive my healthcare information from the e-mail, texting, video, or fax number that I provided to doctor's office. I acknowledge it would be my own responsibility to protect my own healthcare information in receiving information from my provided email, cellphone number, or fax number.

**\*\*OR\*\***

☐ I declined to be communicated by e-mail, texting, fax, or other video technology on my smart phone, desktop, laptop, or tablet

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Patient or Guardian Signature

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Date

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Print name

# Jabari Healthcare

Provider: Barikat Oderinde,FNP and collaborating physician Dr. Nguyen & Dr. Ogbonna

## Permission To Use And Disclose Protected Health Information

Under the Health Insurance Portability and Accountability Act 1996, as amended, I understand that I have the right to determine whether or not I wish to have my protected health information ( PHI) given out throughout the course of my treatment with Jabari Healthcare. The PHI listed in my medical records may include: my name, location, insurance information, a brief description of my medical condition( i.e.,course of treatment, physician visits, medication, diagnostic testing and results, referral's for miscellaneous specialists, Home Health Agency Information, DME paperwork, past history, etc.) I understand that I have the right to ask that such information not be given to other non-medical entities or family members or anyone other than me. I have indicated my choice below.

☐ I DO Wish my information to be given when questioned to other non-medical entities, family members, or any other persons requiring medical related information.

☐ I DO NOT wish my information to be given to anyone.

Persons you are authorizing to receive or discuss medical information regarding your health care:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Active Provider List:

Please list "ALL" that apply. Please list the names of the current Physicians you are seeing at this time.

1. Previous PCP Name: \_\_\_\_\_ Phone Number \_\_\_\_\_ Specialty: \_\_\_\_\_  
2. Physician Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Specialty: \_\_\_\_\_  
3. Physician Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Specialty: \_\_\_\_\_

Do you have a DNR? \_\_\_\_ Yes \_\_\_\_ No

Do you have a Living Will? \_\_\_\_ Yes \_\_\_\_ No

Enrolled in Hospice? \_\_\_\_ Yes \_\_\_\_ No

If Yes, Name of the Hospice Company/Phone #: \_\_\_\_\_

# Jabari Healthcare

Provider: Barikat Oderinde,FNP and collaborating physician Dr. Nguyen & Dr. Ogbonna

## Medical History

Do you now or have you ever had any of the following illness? (Check all that apply)

<b>CANCER</b> <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Esophageal Cancer <input type="checkbox"/> Stomach Cancer <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Pancreatic Cancer <input type="checkbox"/> Endometrial Cancer <input type="checkbox"/> Liver Cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma  Other _____	<b>LIVER</b> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Jaundice <input type="checkbox"/> Fatty Liver <input type="checkbox"/> Liver Failure  Other _____	<b>NEUROLOGICAL</b> <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Migraines <input type="checkbox"/> Neuropathy <input type="checkbox"/> Gait Abnormality <input type="checkbox"/> Memory Loss <input type="checkbox"/> Speech Difficulties <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Tremors  Other _____
<b>RENAL</b> <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Dialysis  Other _____	<b>BLOOD</b> <input type="checkbox"/> VonWillebrands <input type="checkbox"/> Hemophilia <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Bleeding or clotting abnormalities  Other _____	<b>INTEGUMENTARY</b> <input type="checkbox"/> Eczema <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Melanoma <input type="checkbox"/> Psoriasis <input type="checkbox"/> Acne  Other _____
<b>RESPIRATORY</b> <input type="checkbox"/> COPD <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis(TB) <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Tobacco use _____ years  Other _____	<b>ENDOCRINOLOGY</b> <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Hypothyroid  Other _____	<b>PSYCHOLOGICAL</b> <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Dementia <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Schizophrenia  Other _____
<b>HEART</b> <input type="checkbox"/> High Blood Pressure (Hypertension) <input type="checkbox"/> Heart Attack <input type="checkbox"/> Angina <input type="checkbox"/> Congestive Heart Failure (CHF) <input type="checkbox"/> Heart Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Elevated Cholesterol/Hyperlipidemia <input type="checkbox"/> Heart Valve Disease <input type="checkbox"/> Endocarditis <input type="checkbox"/> Atrial Fibrillation (A-fib)  Other _____	<b>MUSCULOSKELETAL</b> <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Raynaud's Syndrome <input type="checkbox"/> Chronic Back Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Lupus <input type="checkbox"/> Gout <input type="checkbox"/> Sciatica  Other _____	<b>GASTROINTESTINAL</b> <input type="checkbox"/> Irritable Bowel Syndrome (IBS) <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Chronic Gastritis <input type="checkbox"/> Gallstones <input type="checkbox"/> GERD <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Constipation <input type="checkbox"/> Dysphagia  Other _____

Patient Name: \_\_\_\_\_

# Jabari Healthcare

Provider: Barikat Oderinde,FNP and collaborating physician Dr. Nguyen & Dr. Ogbonna

## PAST SURGICAL/PROCEDURE HISTORY

Please indicate the year of any surgeries you have had

<b>GASTROINTESTINAL</b> <input type="checkbox"/> Appendectomy <input type="checkbox"/> Hernia Repair <input type="checkbox"/> Gallbladder Removal <input type="checkbox"/> Exploratory Surgery <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Colon Resection, Partial <input type="checkbox"/> Colon Resection, Complete <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Splenectomy <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Upper Endoscopy <input type="checkbox"/> ERCP <input type="checkbox"/> Whipple  Other _____	<b>GENITOURINARY</b> <input type="checkbox"/> TURP <input type="checkbox"/> Bladder Surgery <input type="checkbox"/> Inguinal Hernia <input type="checkbox"/> Cystectomy with legal conduit <input type="checkbox"/> Kidney Removal <input type="checkbox"/> Prostate Removal <input type="checkbox"/> Radiation for Prostate Cancer  Other _____	<b>GYNECOLOGICAL</b> <input type="checkbox"/> Vaginal Hysterectomy <input type="checkbox"/> Abdominal Hysterectomy <input type="checkbox"/> Ovary Removal <input type="checkbox"/> C-Section <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Mastectomy Right/Left/Bilateral <input type="checkbox"/> Cystectomy  Other _____
<b>CARDIAC</b> <input type="checkbox"/> Heart Stent Placement <input type="checkbox"/> CABG <input type="checkbox"/> Abdominal Aneurysm Repair <input type="checkbox"/> FemPop Bypas (Leg Arteries) <input type="checkbox"/> Heart Valve Replacement <input type="checkbox"/> Pacemaker Placement <input type="checkbox"/> Heart Monitor Implant <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Lymph node Surgery  Other _____	<b>OTHER</b> <input type="checkbox"/> Hip Replacement __ R __ L <input type="checkbox"/> Knee Replacement __ R __ L <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Sinus Surgery <input type="checkbox"/> Glaucoma Surgery <input type="checkbox"/> Cataract Surgery <input type="checkbox"/> Laser Surgery <input type="checkbox"/> Chemo Therapy / Radiation  Other _____	<b>DERMATOLOGY</b> <input type="checkbox"/> Tumor Removal <input type="checkbox"/> Skin Tag Removal <input type="checkbox"/> Skin Graft <input type="checkbox"/> Moh's Surgery <input type="checkbox"/> Skin Biopsy  Other _____

Patient Name \_\_\_\_\_

# Jabari Healthcare

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## MEDICATION HISTORY

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Please list **ALL** medications you are currently taking. Even over the counter medications

Medication Name	Dosage	Times/Day	Comments

I give Jabari Healthcare permission to pull my medication history from pharmacies for medical treatment \_\_ Yes \_\_ No  
(check one)

**Patient Name:** \_\_\_\_\_

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## Credit Card Payment Consent Form

Patient Name \_\_\_\_\_  
*Print Last First*

Name on Card if different \_\_\_\_\_

**I authorize Jabari Healthcare to charge my credit/debit card for professional services as**

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☐ Visa, ☐ MasterCard, ☐ Discover

Credit Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_,

CVV Number \_\_\_\_\_ A 3-digit number in reverse italics on the **back** of the credit card

Expiration Date \_\_\_\_\_

Card Holder's Billing Address for Credit Card Statements

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*Street*

*City*

*State*

*Zip*

If I have questions about these charges, I agree to contact my provider. I agree that I will not pursue actions to yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

**Card Holder Signature** \_\_\_\_\_, Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ *Charges*

*will appear on your credit card statement as Jabari Healthcare*