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. Ogbonna

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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_____

CityState_____ 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_____

revised 06/30/2024

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 214-824-3333 214-736-9413 office@jabarihealth.com

(Physician Name) (Phone) (Fax) (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

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

Consent to Treat

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**

_____

Patient or Guardian Signature

Date

_____

_____

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)

CANCER Colon Cancer _____Esophageal Cancer Stomach Cancer Breast Cancer _____Pancreatic Cancer _____Endometrial Cancer _____Liver Cancer Leukemia _____Lymphoma Other_____	**LIVER** Cirrhosis _____Hepatitis A _____Hepatitis B _____Hepatitis C _____Jaundice _____Fatty Liver Liver Failure Other_____	**NEUROLOGICAL** _____Stroke Seizures _____Migraines _____Neuropathy _____Gait Abnormality _____Memory Loss _____Speech Difficulties _____Hearing Loss _____Parkinson's Disease _____Tremors Other_____
RENAL _____Kidney Stones _____Kidney Failure _____Dialysis Other_____	**BLOOD** VonWillebrands _____Hemophilia _____HIV/AIDS _____Bleeding or clotting abnormalities Other _____	**INTEGUMENTARY** _____Eczema _____Skin Cancer Melanoma _____Psoriasis _____Acne Other_____
RESPIRATORY _____COPD _____Asthma _____Tuberculosis(TB) _____Sleep Apnea _____Tobacco use _____years Other_____	**ENDOCRINOLOGY** _____Diabetes Type I _____Diabetes Type II _____Thyroid Disease _____Hypothyroid Other_____	**PSYCHOLOGICAL** _____Alzheimer's Disease Dementia _____Anxiety _____Bipolar _____Depression Insomnia _____Obsessive Compulsive Disorder _____Schizophrenia Other_____
HEART _____High Blood Pressure (Hypertension) _____Heart Attack _____Angina _____Congestive Heart Failure (CHF) Heart Disease _____Mitral Valve Prolapse _____Elevated Cholesterol/Hyperlipidemia _____Heart Valve Disease Endocarditis _____Atrial Fibrillation (A-fib) Other_____	**MUSCULOSKELETAL** _____Fibromyalgia _____Osteoarthritis Rheumatoid Arthritis _____Raynaud's Syndrome _____Chronic Back Pain _____Osteoporosis _____Carpal Tunnel Syndrome _____Lupus _____Gout _____Sciatica Other_____	**GASTROINTESTINAL** _____Irritable Bowel Syndrome (IBS) Diverticulitis Diverticulosis _____Ulcers _____Chronic Gastritis _____Gallstones _____GERD _____Pancreatitis _____Crohn's Disease Ulcerative Colitis _____Constipation _____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

GASTROINTESTINAL _____Appendectomy _____Hernia Repair _____Gallbladder Removal _____Exploratory Surgery _____Gastric Bypass _____Colon Resection, Partial _____Colon Resection, Complete _____Hemorrhoidectomy _____Splenectomy _____Colonoscopy _____Upper Endoscopy ERCP _____Whipple Other_____	**GENITOURINARY** _____TURP _____Bladder Surgery _____Inguinal Hernia _____Cystectomy with legal conduit _____Kidney Removal Prostate Removal _____Radiation for Prostate Cancer Other_____	**GYNECOLOGICAL** _____Vaginal Hysterectomy _____Abdominal Hysterectomy _____Ovary Removal C-Section _____Breast Biopsy _____Mastectomy Right/Left/Bilateral _____Cystectomy Other_____
CARDIAC _____Heart Stent Placement _____CABG _____Abdominal Aneurysm Repair _____FemPop Bypas (Leg Arteries) _____Heart Valve Replacement Pacemaker Placement _____Heart Monitor Implant _____Heart Surgery _____Lymph node Surgery Other_____	**OTHER** _____Hip Replacement ___R ___L _____Knee Replacement ___R ___L _____Thyroidectomy _____Tonsillectomy _____Sinus Surgery _____Glaucoma Surgery _____Cataract Surgery _____Laser Surgery _____Chemo Therapy / Radiation Other_____	**DERMATOLOGY** Tumor Removal _____Skin Tag Removal Skin Graft _____Moh's Surgery _____Skin Biopsy Other_____

Patient Name_____

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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:

_____

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

_____

☐ 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

_____
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