Park NP Clinic Registration Form

Date _____

Patient information:

First name_____**Last name** _____**MI**_____

Preferred name _____ **male/female** _____

Date of Birth_____**Age** _____

Address _____

City_____**State** _____**ZIP** _____

Preferred phone _____

Email address _____

Marital Status (circle) Single Married Widowed Divorced Separated Committed

Patient Employment Status: Employed Y/N _____**Student Y/N** _____

Occupation _____

Referred By _____

Emergency Contact:

Relative/Friend_____**Phone** _____

Relationship _____

Pharmacy Information:

Pharmacy Name_____

Phone _____

May we contact you regarding your protected health information?

Email: Y/N _____

Cell phone: Y/N _____

Leave Voicemail: Y/N _____

Name of Primary Care Provider _____ **Last visit** _____

Please list another specialists you see _____

_____

Please provide a list of your current medications:

MEDICATION	DOSE	FREQUENCY	PRESCRIBING PROVIDER

Please provide a list of current supplements:

SUPPLEMENT	DOSE	YEARS OF USE	SOURCE

Please list any drug allergies:

Medication	Reaction

Park NP Clinic does not accept insurance. You may use your insurance for any testing ordered. If your insurance does not cover certain tests, a cash pay price may be more affordable with particular vendors.

Pricing of visits:

New patient appointments $250 (40 mins)

Follow up visits are $200 (30 mins)

Monthly check-ins are highly recommended during your weight loss phase. Those visits are $100. Once you have entered weight maintenance, we can discussed a customized follow up plan for you with follow up visits every 3 months ($200). Payments are due at the time of service. While the clinic does access FSA/HSA/and credit cards, a processing fee of 3.5% will be added to the total. You can avoid those fees by using Zelle to phone number 615-557-7585.

Telehealth Consent:

I authorize Julie Park, APRN to use a HIPAA compliant telehealth practice platform for consultations, evaluation, order testing, and diagnosing my medical condition.

I understand that technical difficulties may occur before or during my telehealth sessions and my appointment cannot be started or ended as intended.

I accept, if technical requirements cannot be met, my visit can be conducted via a regular phone communication.

I understand if a telehealth visit is appropriately indicated, that visit will be charged like an in-person office visit. Payment will be due at the time of service.

I agree that my medical records can be kept for further evaluation, analysis, and documentation. My information will be kept private in all of these circumstances.

Park NP Clinic is not an urgent care facility. It is a sole provider practice and by appointment only. If you have a medical issue that requires immediate attention, please proceed to the nearest emergency room or urgent care center. If you need to make an appointment or request a refill, you may call or text the office at 615-557-7585 or email Julie directly at Julie@parknpclinic.com.

I have received a copy of the Notice of Privacy Practices _____

Signature_____

Women's Health Intake Form

Name _____ **Date** _____

DOB _____

What is the reason for your visit today? _____

_____

_____

_____

Who is your primary care provider? _____ **last visit** _____

When was the first day of your last menstrual period? _____

Have you every been sexually active? Y/N _____ **currently sexually active? Y/N** _____

How do you prevent pregnancy? _____

Do you desire pregnancy? Y/N _____ **I have completed my family Y/N** _____

Are your periods (please check all that apply):

_____ **painful**
_____ **heavy flow**
_____ **light flow**
_____ **moderate flow**
_____ **irregular**
_____ **frequent**
_____ **infrequent**
_____ **absent**

Have you ever been diagnosed with a sexually transmitted disease?

_____ **HPV**
_____ **herpes**
_____ **trich**
_____ **gonorrhea**
_____ **chlamydia**
_____ **syphilis**
_____ **genital warts**
_____ **gonorrhea**
_____ **HIV**

Do you have a history of:

_____ **addiction**
_____ **disordered eating**
_____ **mental health concerns**
_____ **smoking**
_____ **alcohol intake**
_____ **regular exercise**

Past Medical History (please check all that apply):

_____ **breast cancer**
_____ **seizures/epilepsy**
_____ **Endometriosis**
_____ **Fibrocystic breast disease**
_____ **Polycystic Ovarian Syndrome**
_____ **History of endometrial polyps**
_____ **history of uterine fibroids**
_____ **Hoshimotos Thyroiditis**
_____ **anemia**
_____ **liver disease**
_____ **depression/anxiety**
_____ **DVT/pulmonary embolus**
_____ **GI problems**
_____ **Migraines**
_____ **high cholesterol**
_____ **heart disease**
_____ **kidney disease**
_____ **stroke**
_____ **thyroid problems**
_____ **other**

Surgical history:

_____

_____

_____

_____

Family Medical History (please check all that apply)

_____ **dementia**
_____ **addiction**
_____ **depression/anxiety**
_____ **diabetes**
_____ **medullary thyroid cancer**
_____ **heart disease**
_____ **high cholesterol**
_____ **pancreatic cancer**
_____ **osteoporosis**
_____ **stroke**
_____ **heart attack**
_____ **breast cancer**
_____ **ovarian cancer**
_____ **endometrial/uterine cancer**
_____ **colorectal cancer**
_____ **blood clot/DVT/PE**
_____ **Multiple Endocrine Neoplasia Syndrome Type 2 (MEN 2)**

Date of last colorectal cancer screening and result

Cologuard _____

Colonoscopy _____

When were you instructed to follow up? _____

When was your last mammogram? _____ **Result** _____

Do you have a history of abnormal mammograms? Y/N _____ If yes, please explain

_____

Do you have a history of any procedures on the breast? Y/N _____ If yes, please explain _____

When was your last bone density scan? _____ Result _____

When was your last pap? _____ Result _____

Have you ever had a procedure on your cervix? Y/N _____ Date _____

Please explain _____

Have you ever taken hormone replacement therapy? Y/N _____ If so, what forms?

_____

_____

Please indicate any symptoms you are currently experiencing:

Symptoms	None	Mild	Moderate	Severe	Very severe
Physical exhaustion (fatigue, energy, stamina, motivation)					
Sleep problems (Difficulty falling asleep or sleeping through the night)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (feeling overwhelmed, panicky, or nervous)					
Decline in drive or interest (loss of “zest for life”, feeling sad or down)					
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)					
Difficulties with memory (concentration, finding the right word, or retaining information)					
Vaginal dryness or difficulty with sexual intercourse					
Sexual problems (change in desire, activity, orgasm and/or satisfaction)					
Sweating (night sweats or increased episodes of sweating)					
Hot flashes (bursts that start in the chest and last for a short duration)					
Hair loss, thinning or change in texture of hair					
Feeling cold all the time, having cold hands and feet					
Headaches or migraines (increase in frequency or intensity)					
Weight (difficulty losing weight despite diet and exercise)					
Bladder problems (difficulty urinating, increased need to urinate, incontinence					

Any other considerations _____

_____

NOTICE OF PRIVACY PRACTICES

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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following: Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer. Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment. Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice. Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following: • To avoid a serious threat to your health or safety or the health or safety of others. • As required by state or federal law such as reporting abuse, neglect or certain other events. • As allowed by workers compensation laws for use in workers compensation proceedings. • For certain public health activities such as reporting certain diseases. • For certain public health oversight activities such as audits, investigations, or licensure actions. • In response to a court order, warrant or subpoena in judicial or administrative proceedings. • For certain specialized government functions such as the military or correctional institutions. • For research purposes if certain conditions are satisfied. • In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes. • To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below. • To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment. NOTICE OF PRIVACY PRACTICES - 2

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below. • You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer. • We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests. • You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may
charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others. • You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete. • You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period. • You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices,

we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.
6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying julie@parknpclinic.com. All complaints must be in writing. We will not retaliate against you for filing a complaint.

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____

Date of Birth: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's or father's side). Behind each statement, please list the relationship to you of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) and their age at diagnosis. Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes, if you circle Y to any statements below, you MAY be appropriate for genetic testing. Ask your healthcare provider for additional information.

			RELATIONSHIP	AGE AT DIAGNOSIS
BREAST AND OVARIAN CANCER				
Y	N	Breast cancer before age 50		
Y	N	Ovarian cancer		
Y	N	Breast cancer in both breasts or multiple primary breast cancers		
Y	N	Both breast & ovarian cancer (in an individual or a family)		
Y	N	Male breast cancer		
Y	N	2 or more breast or ovarian cancers (in an individual or a family)		
Y	N	Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer		
Y	N	Pancreatic cancer w/ breast or ovarian cancer in same person or side of family		
COLON AND UTERINE CANCER				
Y	N	Uterine cancer before age 50		
Y	N	Colorectal cancer before age 50		
Y	N	Both uterine & colorectal cancer (in an individual or a family)		
Y	N	2 or more uterine or colorectal cancers (in an individual or a family)		
Y	N	Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or a family)		
Y	N	10 or more colon polyps found in a lifetime		

☐ Candidate for further risk assessment and/or genetic testing
☐ Information given to patient to review
☐ Follow up appointment scheduled Date: _____

☐ Patient offered genetic testing
☐ Accepted ☐ Declined
☐ Genetic Testing Not Warranted

_____ _____
Patient's Signature Date Health Care Provider's Signature Date