Longship Nursing and Consulting LLC
PO Box 672154, Chugiak, AK 99567 Ph: 907-854-6877 Fax: 1-888-892-4144

Direct Pay Agreement

Longship Nursing and Consulting LLC (hereinafter "Longship") does not contract with or submit for reimbursement with commercial insurance companies, Medicaid, or Tricare at this time. The patient has agreed to contract with Longship under Direct Pay. _____ (initials).

A Direct Pay Fee schedule is available online at Longship's website. Longship reserves the right to update fee schedules every calendar year and will provide written notice of a fee schedule change. A paper fee schedule is provided at onset of agreement, after updates, or upon request. The patient has received and read a copy of the fee schedule. _____ (initials).

Full payment for rendered services is required at completion of each appointment. _____ (initials).

It is the responsibility of the patient to submit for reimbursement with insurance or medical payers. Longship will provide a detailed invoice (aka Superbill) within 30 days of appointment completion. Longship will not be held liable for any non-reimbursed costs. Longship highly encourages all patients to discuss out-of-network reimbursement or acceptance of Superbills with the insurance company or medical payer prior to the first appointment. _____ (initials)

The patient is under no obligation to remain in agreement with Longship. The patient may choose to terminate the relationship at any time by providing written notice that is signed and dated. _____ (initials).

Longship is under no obligation to continue services to the patient and may choose to terminate the relationship at any time. Longship will provide a written notice of termination 60 days prior to effective date. _____ (initials).

Once a direct pay relationship has been terminated by either Longship or the patient, all resulting services will cease. This may include, but is not limited to prescription refills, renewal of other healthcare services, specialty coordination, etc. _____ (initials).

Longship or a designated entity will retain medical records as required by applicable law. _____ (initials).

Longship strives to maintain a secure environment. To enhance precautions, it is not routine practice to store credit card information, whether physically or electronically. Longship requests patients arrive at every appointment with appropriate means to tender a payment. Longship accepts most major credit cards, personal checks, or cash. Venmo, PayPal, and other digital systems are not acceptable means of payment due to inadequacy with meeting HIPAA/privacy regulations. Longship reserves the right to refuse personal checks after any incidents of non-sufficient funds (aka bounced checks), errors, or late payments occur. _____ (initials).

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Form effective date July 2023

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DIRECT PAY FEE SCHEDULE

Primary Care Management

Longship functions as the primary care provider while working with the client to manage overall health and client-driven goals. Annual visits, chronic disease management, prescription medication refills, and other problem/symptom management. Longship does not manage or prescribe chronic pain medications.

Initial intake or annual exam - 75 min $225.00

In-depth health review with physical exam to appropriately address client's health goals and management needs. Review of preventative health & screening recommendations, medication review & prescription management, specialty referrals, lab recommendations, imaging orders, etc.

Follow-up/chronic management/new concerns 30 min $90.00

Continuing attention to client's health goals and management needs. Follow-up diabetes, hypertension, hyperlipidemia, heart disorders, asthma/COPD, sleep disorders, weight loss, anxiety, depression, etc. New concern/symptom evaluation.

Example: Client "A" may need a 30-minute appointment only covering 1 chronic issue due to complexity of care, while client "B" may be able to cover 2 chronic issues in one 30-minute appointment. Individualized care to optimize positive impacts.

Follow-up/chronic management/new concerns 60 min $150.00

Longship's goal is QUALITY CARE and appointment times will vary based on client needs. See above description.

Same Day Needs/Minor Illness or Injury

Available for established patients and non-established patients

Single issue care visit/focused exam $45.00-$150.00

Appointment for one urgent issue (i.e. urinary tract infection, upper respiratory illness, acute gastrointestinal illness, etc.). Price variability is due to testing cost variability and acuity of issue.

Please call to discuss your needs, there may be appointment times available outside the normal operating hours. A good faith estimate can be discussed during phone scheduling.

Consultations

Basic Consultation - 30 min $70.00

A hands-free consultation for client-driven topics such as diabetic education, anxiety/depression concerns, focus/concentration concerns, weight loss, medication review, polypharmacy concerns, laboratory review, and more. No direct care needed (physical exam, referrals, prescriptions, lab orders, imaging orders).

Example: A client had labs drawn at a health fair. I can review laboratory results, discuss implications, and educate on recommendations.

Advanced Consultation - 30 min/45 min $100.00/$135.00

Consultation for client-driven topics that require direct care management. Direct care involves a physical exam, prescription management, laboratory orders, radiology orders, etc.

Example: Cognitive behavioral health consultation with medication management (ADHD, depression, anxiety, etc.), diabetic medication or device management, weight loss medication management, issues that require referral to specialties, etc. Longship is not the client's primary care provider.

Full payment will be due at the time of service for direct pay clients.

Fee schedule current through December 31, 2023.

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Date ___/___/_____

Last Name: _____ First Name: _____ MI: ___

Gender: _____ SSN: _____-_____-_____ Birthdate: ____/____/_____

Home Phone: _____ Cell Phone: _____ Preferred Contact (circle one): Home or Cell

Street Address: _____

City: _____ State: _____ Zip:_____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Circle One: Married Single Partnered Widowed Name of significant other: _____

Occupation/Employer: _____ Business Phone: _____

Emergency Contact: _____ Relation: _____Contact Phone: _____

Responsible Party (**need only if patient is a minor**): _____

Responsible Party SSN: _____-_____-_____ Contact Phone: _____

Responsible Party Occupation/Employer: _____

Patient Preferred Pharmacy: _____

Do you have medical Insurance? Circle One: No Yes

Longship does not bill commercial insurance, Tricare, or Medicaid. This information is used for referrals, prescriptions, and ordering labs/imaging:

Name of Primary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birthdate: ____/____/____

Insurance Address _____

Name of Secondary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birthdate: ____/____/____

Insurance Address _____

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Notice of Privacy Rights

This HHS.gov notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review and read carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

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Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Minors Privacy Rights: Alaska statutes (AS 25.20.025) permit a minor to obtain certain health care services without the consent of a parent or guardian. When the minor can consent to the services their health information cannot be released to anyone without the consent of the minor.

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PATIENT RIGHTS AND RESPONSIBILITIES

Longship Nursing and Consulting LLC (hereinafter "Longship") understands the ethical and legal obligation it has to a patient regarding their rights when receiving medical care or treatment. These rights are designed to help ensure a patient receives appropriate and ethical healthcare while respecting their autonomy, dignity, and well-being. Alternatively, Longship requests patients recognize their unique role and responsibilities.

Informed Consent: Patients have the right to receive relevant and understandable information about their medical condition, proposed treatments, potential risks and benefits, and alternative options. Patients can then make informed decisions about their care after understanding the information provided. A patient has the right to ask questions at any point, change a decision, and seek second opinions.

Privacy and Confidentiality: Patients have the right to expect that their personal medical information will be kept confidential. Longship works hard to maintain the privacy of patient records and will only disclose information from the patients record either with consent or as required by law. To protect the confidential relationship, Longship representatives will not identify that a relationship exists while in public unless the patient initiates an interaction. Longship provides a separate Notice of Privacy Practices form.

Access to medical records: In general patients have the right to access medical records and obtain copies of their health information. Records are available to the patient or other medical/healthcare entities after a medical release of information (ROI) form that is compliant with Health Insurance Portability and Accountability Act (HIPAA) regulations has been signed by the patient. Records requested by the patient's other healthcare providers will be sent electronically free of charge. Printed or electronically copied (CD/DVD/USB) records requested by the patient will cost $5.00 per copy. Each entity requesting a medical record copy will require a separate ROI.

Nondiscrimination: Patients will be treated with fairness, respect, and without discrimination based on age, color, disability, genetic information, marital status, national origin, pregnancy, race, religion, gender, gender identity or expression, sex, sexual orientation, veteran status, or any other protected characteristic. Longship requests patients treat other patients and Longship representatives with similar respect.

Right to refuse or withdraw treatment: Patients have the right to refuse or discontinue treatment, even if it goes against medical advice, to the extent permitted by law. Patients have a right to make decisions about their own bodies and have the autonomy to accept or decline treatment. There are exceptions in certain circumstances, outlined by laws, such as when it may pose a risk to self or others.

Right to quality care: Patients have the right to receive high-quality, competent, and appropriate medical care that meets the standards of the healthcare profession. This includes being treated by qualified healthcare professionals in a safe and clean environment. Patients have the right to appropriately voice concerns about the service and care received.

Right to access to pain management: Longship understands patients have the right to have their pain assessed and manage appropriately. Longship does not manage chronic pain or chronic pain medications such as narcotics. Longship will assist patients in accessing specialties that manage chronic pain.

Advanced Directives: Patients have the right to choose an Advance Directive to designate the kind of care one wishes to receive should the patient be unable to express wishes. Longship does not prepare or draft Advanced

Directives, but recommends copies be kept on file with Longship records.

Invoice Rights/Good Faith Estimate: Patients have a right to receive an itemized statement and detailed explanation of the bill, aka Superbill. Longship will provide a detailed invoice within 30 days of appointment completion. Upon request, Longship can provide a good faith estimate prior to an appointment. A good faith estimate is based on details provided by the patient before the appointment and before a clinical examination is done. Please be aware other costs may be incurred based on additional needs found during an exam, Longship seeks to keep patients informed of any additional costs or changes.

Minors Rights: A parent or legal guardian must provide consent on behalf of a minor (under age 18) before health care services are provided, with several important exceptions. These exceptions are based on status (i.e. legal independence from parents/guardians) or type of service (certain sexual health and reproductive health issues, emergency services, and certain instances when a parent or guardian cannot be reached). A minor's right to privacy and confidentiality may be legally overridden in certain circumstances. These situations include suspicion of abuse or neglect, including physical injury or neglect, mental injury, sexual abuse, sexual exploitation, maltreatment.

Patient Demands: A right to make decisions about health care does not mean that a patient can demand treatment and/or services that are medically inappropriate, unsafe, unlawful, or unnecessary.

Patient Responsibilities: Patients are responsible for asking questions and making sure the instructions given are understood. Patients are responsible for following the suggestions and advice prescribed in a course of treatment by Longship (this does not supersede a patient's right to refuse treatment or withdraw treatment). Patients are responsible for keeping appointments and arriving on time. Patients are responsible for notifying Longship of demographic updates or changes in insurance status. Patients are responsible for being open and honest with Longship about health history, health changes, substance use, medications or changes, and over-the-counter vitamins/supplements or changes.

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NAME:_____ BIRTHDATE: _____

NOTICE OF PRIVACY RIGHTS

I acknowledge I have read and received the Notice of Privacy Rights packet. The copy received is provided for personal records, another copy may be requested at any time. _____ (initials).

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge I have read and received the Patient Rights and Responsibilities packet. The copy received is provided for personal records, another copy may be requested at any time. _____ (initials).

NOTICE OF AGREEMENT

I acknowledge I have read and received either the Medicare or Direct Pay Agreement (circle which applies). The original will be kept on file, a copy may be requested at any time. _____ (initials).

CANCELLATION/NO SHOW/LATE POLICY

Longship dedicates time for each individual and strives to respect the time appointed to each person. Longship expects patients to provide a minimum of 24 hours' notice when cancelling appointments. A $50.00 fee may be imposed when appointments are cancelled with less than 24 hours. Longship staff reserve the right to reschedule patients who arrive late for any appointment as this may affect another person's allocated time. Any no-show to an appointment may be charged $75.00. _____ (initials)

AUTHORIZATION REGARDING MESSAGES (PLEASE INITIAL ALL THAT APPLY)

_____ Longship may leave a detailed message on the preferred contact number (listed on demographics form) regarding appointments.

_____ Longship may leave a detailed message on the preferred contact number regarding medical treatment, care, test results, or billing information.

_____ Longship may leave a message with anyone who answers the preferred contact number.

_____ Longship may only leave messages with: _____

_____ Longship or Office Ally (electronic medical record business associate) may text the preferred contact number with appointment reminders.

_____ Longship may only leave a generic message indicating a request for return phone call.

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TEXT/EMAIL MESSAGE DISCLOSURE

Texts and emails have become a staple of messaging as an easy, quick, and effective method of communication. Unfortunately, text messages are generally not secure and lack the HIPAA protection requirements. Longship cannot guarantee privacy or security with text messages. If a patient opts to send text messages, the patient acknowledges that Longship will not be held liable for any breach of privacy. Longship advises against sending protected information over email, if a patient opts to use email, Longship recommends using encryption. A patient choosing to send an email message acknowledges that Longship will not be held liable for any breach of privacy with email use. _____ (initials).

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many patients allow family members such as a spouse, significant other, parent, or child to call and request the results of tests, procedures, appointment notes, or billing information. Under HIPAA requirements Longship is not allowed to give this information to anyone without a patient's consent. If you wish to have your medical information, lab results, appointment data, diagnostic results, or billing information released to any family members please designate and sign below.

***Minors and guardians: Alaska statutes (AS 25.20.025) permit a minor to obtain certain health care services without the consent of a parent or guardian. When the minor can consent to the services their health information cannot be released to anyone without the consent of the minor.

I, _____, authorize Longship Nursing and Consulting LLC ("Longship") to release my records and information requested to the following individuals. I understand that I may change my authorizations at any time, Longship requests changes be done in person to verify identity.

1. _____ Relation to patient: _____
2. _____ Relation to patient: _____
3. _____ Relation to patient: _____
4. _____ Relation to patient: _____

Name: _____ Date: _____

Signature: _____

Longship Nursing and Consulting LLC
PO Box 672154, Chugiak, AK 99567 ⁘ 907-854-6877

Today' s Date:

HEALTH HISTORY QUESTIONNAIRE

All information obtained in this questionnaire is confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring provider:	**Date of last physical exam:**

Please list any current specialty providers

☐	Cardiology:	☐	Dermatology:	☐	Orthopedics:
☐	Pulmonology:	☐	Endocrinology:	☐	Behavioral Health:
☐	OB/Gyn:	☐	Gastroenterology:	☐	Urology:
☐	Oncology:	☐	Other:	☐	Other:

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates: Please check boxes of known immunizations, write date if known of most recent, or number received in series	☐ Shingles	☐ Pneumonia
	☐ Hepatitis A	☐ Chickenpox
	☐ Hepatitis B	☐ MMR *Measles, Mumps, Rubella*
☐ Tetanus/Tdap:	☐ IPV/Polio	☐ Covid
	☐ HPV	☐ Influenza

Please check the box for any acute or chronic medical problems, if chronic please write approximate year of diagnosis

☐	Visual changes/loss	☐	Shortness of breath	☐	Acute change in muscle strength
☐	Head injury/traumatic brain injury	☐	Emphysema or COPD	☐	Joint pain/issues
☐	Headaches	☐	Asthma	☐	Back pain/issues
☐	Seizures	☐	High blood pressure	☐	Skin lesions, rashes, precancerous moles
☐	Memory problems/Dementia	☐	Chest pain or angina	☐	Sexually Transmitted Infections
☐	Hearing changes/loss	☐	Heart attack/myocardial infarction	☐	Elevated cholesterol
☐	Recent unintentional weigh loss/gain over 10lbs	☐	Pacemaker/internal defibrillator	☐	Diabetes/Prediabetes/abnormal glucose levels
☐	Throat or swallowing disorders	☐	Abnormal heart rhythm	☐	Thyroid disorder
☐	Allergies	☐	Constipation	☐	Cancer- specify on next page
☐	Recent unintentional weight changes	☐	Diarrhea	☐	Benign tumors/growths/cysts
☐	Gynecologic problems	☐	Difficulty controlling bowel	☐	Difficulty with sleep
☐	Hepatitis A, B or C	☐	Difficulty controlling bladder	☐	Chronic pain – specify on next page

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Other problems not listed on prior page or additional information for problems on prior page:

Surgeries		
Year	Reason	Date/Year

Other hospitalizations		
Year	Reason	Date/Year

Have you ever had a blood transfusion?	☐ Yes	☐ No
Please list any problems with blood transfusion:		

NAME_____ DATE OF BIRTH: _____

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List your prescribed medications/inhalers, over-the-counter drugs, and vitamins/supplements		
Name	Strength/Dose	Frequency Taken

Allergies to medications/Other pertinent allergies	
Name of Drug or Environmental Material	Reaction

NAME_____ DATE OF BIRTH: _____

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HEALTH HABITS AND PERSONAL SAFETY

INFORMATION OBTAINED IN THIS QUESTIONNAIRE IS CONFIDENTIAL, INFORMATION IS USED TO AID IN MEDICALTREATMENT DECISIONS.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
	Any health goals regarding exercise?					
Diet	Are you restricting any food types or food categories, please list restricted foods.				☐ Yes	☐ No
	If yes, is this a provider recommended/medical diet?				☐ Yes	☐ No
	# of meals you eat on an average day?					
	Rank salt intake	☐ High	☐ Med	☐ Low		
	Rank fat intake	☐ High	☐ Med	☐ Low		
	Any health goals regarding diet?					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola/Energy drinks		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what type?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Has a family member or friend expressed concerns about the amount?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
Tobacco	Tobacco products use- current or prior				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Year quit if applicable				
Drugs	Do you currently use recreational drugs, ?				☐ Yes	☐ No
	Have you ever used street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No

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Personal Safety and advanced planning	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Any concerns with ADLs or activities of daily living (personal hygiene, toileting, eating, mobility issues)	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with the provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

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MENTAL HEALTH

Is stress a major concern?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you have panic symptoms when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor or received behavioral health treatment?	☐ Yes	☐ No

OTHER PROBLEMS OR CONCERNS

Please use the space below to list any other concerns:

HEALTH GOALS

Please use the space below to list two short term health goals (6-12 months) and two long term health goals (1-3 years):

NAME_____ DATE OF BIRTH: _____

Longship Nursing and Consulting LLC
PO Box 672154, Chugiak, AK 99567 ⁘ 907-854-6877

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

	Name:	**Longship Nursing and Consulting LLC**	
Mail	Fax	PO Box 672154	**Office Fax:** 1-888-892-4144
Address	Phone	Chugiak, AK 99567	**Office Phone:** 907-854-6877

City: Chugiak State: AK Zip Code: 99567

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Longship Nursing and Consulting LLC
PO Box 672154, Chugiak, AK 99567 ⁘ 907-854-6877

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