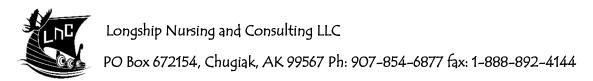


### Direct Pay Agreement

	er "Longship") does not contract with or submit for mies, Medicaid, or Tricare at this time. The patient has agreed (initials).
A Direct Pay Fee schedule is available online at L schedules every calendar year and will provide wr	congship's website. Longship reserves the right to update fee ritten notice of a fee schedule change. A paper fee schedule is upon request. The patient has received and read a copy of the
Full payment for rendered services is required at c	completion of each appointment (initials).
will provide a detailed invoice (aka Superbill) with held liable for any non-reimbursed costs. Longshi	reimbursement with insurance or medical payers. Longship hin 30 days of appointment completion. Longship will not be ip highly encourages all patients to discuss out-of-network ne insurance company or medical payer prior to the first
	reement with Longship. The patient may choose to terminate notice that is signed and dated (initials).
	ces to the patient and may choose to terminate the relationship ce of termination 60 days prior to effective date
	d by either Longship or the patient, all resulting services will scription refills, renewal of other healthcare services, specialty
Longship or a designated entity will retain medica	al records as required by applicable law (initials).
credit card information, whether physically or electronic appointment with appropriate means to tender a packets, or cash. Venmo, PayPal, and other digital	t. To enhance precautions, it is not routine practice to store ctronically. Longship requests patients arrive at every ayment. Longship accepts most major credit cards, personal I systems are not acceptable means of payment due to ons. Longship reserves the right to refuse personal checks bunced checks), errors, or late payments occur.
Name:	Date of Birth:
Signature:	Date:



### **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

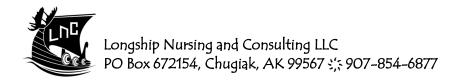
Consultation for client-driven topics that require direct care management. Direct care involves a physical exam, prescription management, laboratory orders, radiology orders, etc.

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.

Date/				
Last Name:	Fi	rst Name:	MI:	_
Gender:	SSN:	- Birthda	te://	=
Home Phone:	Cell Phone:	Preferre	ed Contact (circle one	e): Home or Cell
Street Address:				
City:		State:	Zip:	
Mailing Address:				
			Zip:	
Circle One: Married Sin	ngle Partnered Widowed	1 Name of significant	other:	
Occupation/Employer:		E	Business Phone:	
Emergency Contact:		Relation:	Contact Phone: _	
Responsible Party (need o	only if patient is a minor	):		
Responsible Party SSN: _		Contact Phone:		<del> </del>
Responsible Party Occupa	ation/Employer:			
Patient Preferred Pharmac	ey:			
	urance? Circle One: No			
Longship does not bill con and ordering labs/imaging	mmercial insurance, Trica		formation is used for	referrals, prescriptions,
Name of Primary Insuran	ce:	ID #		Group #
*Subscriber's Name:		*Birt	hdate://	
Insurance Address				
	rance:			
*Subscriber's Name:		*]	Birthdate://	/
Insurance Address				



privacy notice

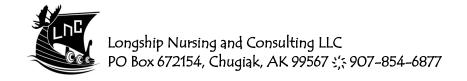
### **Notice of Privacy Rights**

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. • You can ask to see or get an electronic or paper copy of your medical record Get an electronic or and other health information we have about you. Ask us how to do this. paper copy of your medical record • 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. • You can ask us to correct health information about you that you think is Ask us to correct your medical record 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 • You can ask us to contact you in a specific way (for example, home or office communications phone) or to send mail to a different address. • We will say "yes" to all reasonable requests. Ask us to limit what • You can ask us **not** to use or share certain health information for treatment, we use or share 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 • You can ask for a list (accounting) of the times we've shared your health whom we've shared information for six years prior to the date you ask, who we shared it with, information 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 • You can ask for a paper copy of this notice at any time, even if you have

copy promptly.

agreed to receive the notice electronically. We will provide you with a paper



### 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

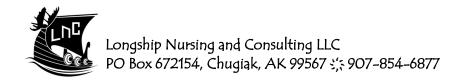
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

# 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.



### **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	<ul> <li>We can use your health information and share it with other professionals who are treating you.</li> </ul>	<b>Example:</b> A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization	<ul> <li>We can use and share your health information to run our practice, improve your care, and contact you when necessary.</li> </ul>	<b>Example:</b> We use health information about you to manage your treatment and services.
Bill for your services	<ul> <li>We can use and share your health information to bill and get payment from health plans or other entities.</li> </ul>	<b>Example:</b> 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	<ul> <li>We can share health information about you for certain situations such as:</li> <li>Preventing disease</li> <li>Helping with product recalls</li> <li>Reporting adverse reactions to medications</li> <li>Reporting suspected abuse, neglect, or domestic violence</li> <li>Preventing or reducing a serious threat to anyone's health or safety</li> </ul>
Do research	• We can use or share your information for health research.
Comply with the law	<ul> <li>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.</li> </ul>
Respond to organ and tissue donation requests	<ul> <li>We can share health information about you with organ procurement organizations.</li> </ul>
Work with a medical examiner or funeral director	<ul> <li>We can share health information with a coroner, medical examiner, or funeral director when an individual dies.</li> </ul>
Address workers' compensation, law enforcement, and other government requests	<ul> <li>We can use or share health information about you:</li> <li>For workers' compensation claims</li> <li>For law enforcement purposes or with a law enforcement official</li> <li>With health oversight agencies for activities authorized by law</li> <li>For special government functions such as military, national security, and presidential protective services</li> </ul>

### Respond to lawsuits and legal actions

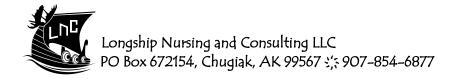
• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **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.



### 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.

<u>Informed Consent</u>: 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.

<u>Privacy and Confidentiality</u>: 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.

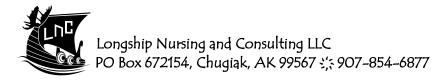
**Nondiscrimination**: Patients will be treated with fairness, respect, and without discrimination based on age, color, disability, genetic information, marital status, national origin, pregnancy, race, religion, gender, gender identity or expression, sex, sexual orientation, veteran status, or any other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

<u>Right to quality care</u>: 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.

<u>Right to access to pain management</u>: 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.

<u>Advanced Directives</u>: 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.

<u>Invoice Rights/Good Faith Estimate</u>: 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.

<u>Patient Demands</u>: 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.

<u>Patient Responsibilities</u>: 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.

Effective Date of Form: July 2023

Name:	BIRTHDATE:
	NOTICE OF PRIVACY RIGHTS
	received the Notice of Privacy Rights packet. The copy received is provided for may be requested at any time (initials).
I	NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES
	received the Patient Rights and Responsibilities packet. The copy received is another copy may be requested at any time (initials).
	NOTICE OF AGREEMENT
•	received either the Medicare or Direct Pay Agreement (circle which applies). e, a copy may be requested at any time (initials).
	CANCELLATION/NO SHOW/LATE POLICY
expects patients to provide a minimposed when appointments ar reschedule patients who arrive	ch individual and strives to respect the time appointed to each person. Longship inimum of 24 hours' notice when cancelling appointments. A \$50.00 fee may be e cancelled with less than 24 hours. Longship staff reserve the right to late for any appointment as this may affect another person's allocated time. Any y be charged \$75.00 (initials)
AUTHORIZA'	TION REGARDING MESSAGES (PLEASE INITIAL ALL THAT APPLY)
Longship may leave a de regarding appointments.	etailed message on the preferred contact number (listed on demographics form)
Longship may leave a decare, test results, or billing info	etailed message on the preferred contact number regarding medical treatment, rmation.
Longship may leave a m	essage with anyone who answers the preferred contact number.
Longship may only leave	e messages with:
Longship or Office Ally number with appointment remi	(electronic medical record business associate) may text the preferred contact nders.
Longship may only leave	e a generic message indicating a request for return phone call.

### 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:

	y' s Date:		
Today	v' a Datai		
1000	V S DAIE		
i oaa	y J Dutt.		

### **HEALTH HISTORY QUESTIONNAIRE**

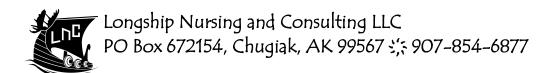
All information obtained in this questionnaire is confidential and will become part of your medical record.

Name (Last, First, M.I.):							□ M □ F		DOB:
Marital status:	Single	□ Partnered		Married	☐ Separated		Divorced □ W	idow	ed
Previous or referring pr	ovider:						Date of last p	hys	ical exam:
Please list any current spec	cialty prov	viders							
□ Cardiology:				Derma	atology:				Orthopedics:
□ Pulmonology:				Endoc	rinology:				Behavioral Health:
□ OB/Gyn:				Gastro	enterology:				Urology:
□ Oncology:				Other:					Other:
				PERS	SONAL HEALT	н н	ISTORY		
Childhood illness:	□ Mea	asles   Mum	ps	□ Rubel	lla □ Chickenp	ox l	☐ Rheumatic Fe	ver	☐ Polio
Immunizations and date	es:	☐ Shingles					□ Pneumonia		
Please check boxes of know immunizations, write date i		☐ Hepatitis A	١	□ Chickenpox					
of most recent, or number received in series		☐ Hepatitis E	3				☐ MMR Measles,	Mum	ps, Rubella
☐ Tetanus/Tdap:		☐ IPV/Polio					□ Covid		
		□ HPV		□ Influenza					
Please check the box fo	r any ac	ute or chroni	c me	edical pr	oblems, if chro	nic p	lease write ap	prox	kimate year of diagnosis
□ Visual changes/los				Shortn	ness of breath				Acute change in muscle strength
☐ Head injury/traum		n iniury			sema or COPD	)			Joint pain/issues
☐ Headaches	acic brain	ir irijar y		Asthm				_	Back pain/issues
□ Seizures					plood pressure				Skin lesions, rashes, precancerous moles
☐ Memory problems/	/Dement	ia		Chest	pain or angina				Sexually Transmitted Infections
☐ Hearing changes/lo	OSS			Heart	attack/myocard	dial ir	nfarction		Elevated cholesterol
Recent unintention over 10lbs	Recent unintentional weigh			Pacem	naker/internal o	lefibr	illator		Diabetes/Prediabetes/abnormal glucose levels
☐ Throat or swallowi	ng disor	ders		Abnori	mal heart rhyth	ım			Thyroid disorder
□ Allergies				Consti	pation				Cancer- specify on next page
□ Recent unintention	nal weigh	nt changes		Diarrh	ea				Benign tumors/growths/cysts
□ Gynecologic proble	ems			Difficu	lty controlling	oowe	l		Difficulty with sleep
☐ Hepatitis A, B or C				Difficu	lty controlling	oladd	er		Chronic pain – specify on next page
NAME			_			۲,	TE OF BIDT'		
NAME						$\nu_F$	ATE OF BIRTH	1.	

Other problems not listed on prior page or additional information for problems on prior page:						
Surgeries						
Year	Reason	Date/Year				
Other hospitali	_					
Year	Reason	Date/Year				
Have you ever	had a blood transfusion?		□ Yes		No	
Please list any pro	oblems with blood transfusion:					

DATE OF BIRTH: \_\_

List your prescribed medications/inhalers, over-the-counter drugs, and vitamins/supplements				
Name	Strength/Dose	Frequency Taken		
Allergies to medications/Other pertinent all	ergies			
Name of Drug or Environmental Material	Reaction			
NAME	DATE OF BIRTI	<del>1</del> :		



### **HEALTH HABITS AND PERSONAL SAFETY**

INFORMAT	1	JESTIONNAIRE IS CONFIDEN	ITIAL, INFORMATION IS US	SED TO AID IN MEDICALTR	EATMEN <sup>*</sup>	T DECI	SION	IS.					
Exercise	☐ Sedentary (No exerc	□ Sedentary (No exercise)											
	☐ Mild exercise (i.e., c	☐ Mild exercise (i.e., climb stairs, walk 3 blocks)											
	☐ Occasional vigorous	exercise (i.e., work or recrea	tion, less than 4x/week for	30 min.)									
		ercise (i.e., work or recreation	n 4x/week for 30 minutes)										
	Any health goals regarding exercise?												
Diet	Are you restricting any	food types or food categories	s, please list restricted food	ls.		Yes		No					
	If yes, is this a provide	r 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?	Do you drink alcohol?						No					
	If yes, what type?	If yes, what type?											
	How many drinks per v	How many drinks per week?											
	Are you concerned abo	Are you concerned about the amount you drink?						No					
	Has a family member or friend expressed concerns about the amount?							No					
	Have you ever experienced blackouts?							No					
	Are you prone to "bing	Are you prone to "binge" drinking?											
Tobacco	Tobacco products use-	current or prior				Yes		No					
	☐ Cigarettes – pks./da	ау	☐ Chew - #/day	☐ Pipe - #/day	□ Ciga	ars - #/	'day						
	☐ # of years	☐ Year quit if applicable											
Drugs	Do you currently use re	ecreational drugs, ?				Yes		No					
	Have you ever used str	reet drugs with a needle?				Yes		No					
Sex	Are you sexually active	Are you sexually active?						No					
	If yes, are you trying for	or a pregnancy?				Yes		No					
	If not trying for a preg	nancy list contraceptive or ba	rrier method used:										
	Any discomfort with int	tercourse?				Yes		No					
	problem. Risk factors for	uman Immunodeficiency Viru or this illness include intraven your provider about your risk	ous drug use and unproted		uld	Yes		No					
		•											

NAME\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_



## F Longship Nursing and Consulting LLC PO Box 672154, Chugiak, AK 99567 5; 907-854-6877

Personal Safety and advanced	Do you live alone?	Yes	No
	Do you have frequent falls?	Yes	No
planning	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

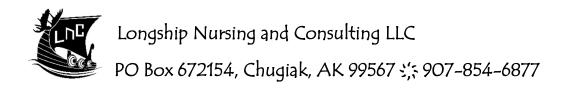
### **FAMILY HEALTH HISTORY**

	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		Grandfather Paternal		

NAME	DATE OF BIRTH:

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?								
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	3 year	s):					

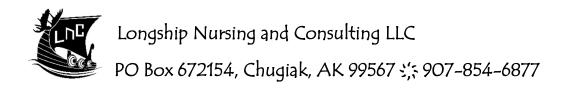
NAME	DATE OF BIRTH:
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### AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name:			Date of Birth:					
Previous N	Name:		Social Security #:					
I request as		rize  Information of the patient named above to:	<u> </u>				to	
	Name	: Longship Nursing and Consultin	σLLC					
Mail	Fax	PO Box 672154	is EEC	Office Fax	: 1-888-892-4144			
Address	Phone				ne: 907-854-6877			
raaress	THOM	onagian, The 22207		Office I no	10. 707 03 1 0077			
	City:	Chugiak	State:	AK	Zip Code:	99567		
This reque	est and au	thorization applies to:						
☐ Healthc	are infor	nation relating to the following treatment	t. condition.	or dates:				
		en reasons to the rone wing treasurem	, condition,	or <b>auto</b>				
☐ All heal	lthcare in	formation						
_ / thi neur	idicare in	ioniation						
☐ Other:								
		ly Transmitted Disease (STD) as defined						
		irus, wart, genital wart, condyloma, Chlar						
		venereuem, HIV (Human Immunodeficier	ncy Virus), A	AIDS (Acqui	red Immunodefici	ency Syndroi	me), and	
gonorrhea.	•							
□ Yes □	l 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				hat I must gi	ve	
		specific written permission before disclo	osure of these	e test results	to anyone.			
□ Yes □	l No	I authorize the release of any records reg	garding drug	, alcohol, or	mental health treat	ment to the		
		person(s) listed above.						
Patient Signature:				_ Date Sig	ned:			

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.



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