NEWMAN PRIMARY CARE
HEALTH & WELLNESS

MISHAUN NEWMAN FNP-C

NEW PATIENT REGISTRATION INFORMATION

DATE:_____

LAST NAME_____FIRST NAME_____

STREET Address

CITY_____ST_____ZIP_____

Birthdate_____Age_____SS#_____

Phone#_____Cell#_____

Male:_____Female:_____ Marital Status_____

Employment information:

Employer _____

Employer address:_____

_____

Employer phone: _____

Occupation:_____

Insurance Information:

Primary Insurance_____

Member policy #_____Group #_____

Policyholder's Name:_____SS#_____

DOB:_____ Employer_____

Relationship to Patient:_____

Emergency contact
information:_____
Phone#_____

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Medical Release of Information

HIPAA release form

Date:_____

To:_____

Address:_____

_____

I hereby request that my medical records be released to:

Mishaun Newman / Newman Primary Care Health and Wellness

3640 Hwy 95 Suite 100 Bullhead City, AZ 86442

Please fax to 928-224-5558

Patients
Name_____DOB:_____

___

Patients
address:_____

_____

_____

Patients last 4 of SS#

_____

Patients
Signature:_____Date:_____

Thank you and have a wonderful day!

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

I. **THE PATIENT**. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____
Date of Birth: _____, 20____
Social Security Number: _____-____-_____

II. **AUTHORIZATION**. I authorize _____ ("Authorized Party") to use or disclose the following: (check one)

☐ - All of my medical-related information.
☐ - My medical information ONLY related to: _____.
☐ - My medical-related information from _____, 20____ to _____, 20____.
☐ - Other: _____.

Hereinafter known as the "Medical Records."

III. **DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ - Any party that is approved by the Authorized Party.
☐ - ONLY the following party:
Name: _____
Address: _____
Phone: (____) ____-_____ Fax: (____) ____-_____
E-Mail: _____

IV. **PURPOSE**. The reason for this authorization is: (check one)

☐ - **General Purpose**. At my request (general).

☐ - **To Receive Payment**. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.

☐ - **To Sell Medical Records**. To allow the Authorized Party to sell my Medical Records. I understand that the Authorized Party will receive compensation for the disclosure of my Medical Records and will stop any future sales if I revoke this authorization.

☐ - **Other**: _____.

V. TERMINATION. This authorization will terminate: (check one)

☐ - Upon sending a written revocation to the Authorization Party.
☐ - On the following date: _____, 20____.
☐ - Other: _____.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ - **Being a Minor**. Patient is ____ years old and considered a minor under state law.

☐ - **Being Incapacitated**. Patient is incapacitated due to: _____.

☐ - **Other**: _____.

Signature of Representative: _____ Date: _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____.

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. **SENSITIVE INFORMATION**. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☐ - **I consent** to have the above information released.

☐ - **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

II. **HIV/AIDS**. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one)

☐ - **I consent** to have the above information released.

☐ - **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

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ASSIGNMENT AND RELEASE

I understand that any and all fees incurred for medical treatment are my total and ultimately my responsibility, regardless of any insurance I may have. It is ultimately my responsibility to know the guidelines of my insurance coverage. In the event that my insurance does not provide benefits or provides reduced benefits and / or I do not provide my insurance company needed information in a timely manner I will be financially responsible for full agreed upon fee schedule.

I agree to pay for all services rendered. If a collection agency's services are required, I further agree to pay collection agency's fees (35%) and interest at the rate of 1.5% monthly or 18% annually until the debt is paid. I further agree to pay for all legal fees, court costs, and reasonable attorney fees associated with collecting any outstanding debt. There will be a $75.00 fee per incident added to my bill for re deposit of returned checks.

I, the undersigned, assigned directly to Newman Primary Care Health and Wellness, Mishaun Newman, Mishaun PLLC medical benefits, if any, from my insurance carrier that would otherwise be payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by my insurance company. I hereby authorize Newman Primary Care Health and Wellness to release all information necessary to secure the payment of benefits and / or further medical treatments. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient responsible

Party signature:_____ Date:_____

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Tell us about your history!

Last physical:_____

Last mammogram:_____

Last labs:_____what lab?_____

Recent tests and at what facility?

1_____
2_____
3_____
4_____
5_____

SURGICAL HISTORY;

1_____
2_____
3_____
4_____
5_____
6_____
7_____

Any PERTINENT INFORMATION WE NEED TO KNOW?

Power of attorney name and information:_____

Do you have a medical or durable power of attorney?_____

Name:_____

Address:_____
Phone#_____

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Name:_____Date:_____

Domestic history and information

Parents: Father still living or deceased? Reason of death_____

Mother still living or deceased? Reason of death_____

Do you smoke or vape? If so how much per day?_____

Do you drink alcohol?_____ How much per day_____week_____?

Have you ever had a substance abuse or addiction problem?_____

MEDICAL HISTORY

CONDITION:	SELF	FATHER	MOTHER	SIBLING	OTHER / Describe
Diabetes					
High Blood Pressure					
Heart attack					
Heart problems					
Heart palpitations or irregular beats					
Heart disease					
Chest pain					
Stroke					
Asthma					
COPD / Emphysema					
Sickle Cell Disease					
Other blood disease / Problem					
Kidney disease					
Hepatitis A B OR C specify					
Jaundice					
Liver disease					
Gallbladder problems					
Meningitis viral or bacterial					
Thyroid problems					
Weight loss					
Weight gain					
Cancer specify					
Shingles					
Other:					

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Please list all your medications and supplements

Medications:_____

1_____

2_____

3_____

4_____

5_____

6_____

7_____

8_____

9_____

10_____

11_____

12_____

13_____

14_____

15_____

Supplements:

_____

_____

_____

_____

Recent Vaccinations:_____

_____

_____

_____

_____