MICHELLE COOPER NP, LLC

ADULT PRIMARY CARE SERVICES

176 Thomas Johnson Dr. Ste103 Frederick, MD 21702
P: (301) 644-3305 F: (301) 644-3308
Michelle Cooper, CRNP

Patient Information:

Name (Last, First, MI): _____ Phone: _____
Date of Birth: ____/____/_____ Sex: _____ Social Security #: _____
Address: _____ Apt: _____ City: _____
State: _____ Zip Code_____ Email: _____@_____
Employer: _____
Employment Status:

Full time	Student	Retired
Part time	Active Duty	Unemployed

Other: _____

Emergency Contact: _____ Relationship to patient: _____
Address: _____ Phone #_____

Insurance Information:

Primary Insurance: _____
Subscriber Name: _____ Date of Birth: _____ Relation: _____
Insurance ID# _____ Group # _____ Copayment $_____
Secondary Insurance: _____
Subscriber Name: _____ Date of Birth: _____ Relation: _____
Insurance ID# _____ Group # _____ Copayment $_____

Self-Pay:_____ **We accept** Visa/MasterCard/American Express Cash

Adult Primary Cares Services reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled within less than **24 hours notice** 2. Or **NO SHOW**

Cancellation Fee Schedule: **$35.00**

We reserve the right to discharge a patient after 3 no shows or repeated cancellations.

Patient's signature: _____ **Date:** _____

Are you under a Specialty Care? Yes☐ No ☐ If yes complete the following:

Doctor's Name: _____ **Specialty:** _____ **Phone:** _____

Doctor's Name: _____ **Specialty:** _____ **Phone:** _____

Are you currently receiving PAIN MANAGEMENT SERVICES? YES:_____ NO:_____
If yes, PROVIDER:_____ PHONE:_____
REASON FOR TREATMENT:_____

MICHELLE COOPER NP, LLC

ADULT PRIMARY CARE SERVICES

176 Thomas Johnson Dr. Ste103 Frederick, MD 21702
P: (301) 644-3305 F: (301) 644-3308
Michelle Cooper, CRNP

Health History Patient Information

Name:		Today's Date:
Date of Birth:	Age:	Date of Last Physical:

Medical Problems (check conditions you currently have or had in the past)

	Current	Past		Current	Past		Current	Past
Acid Reflux			Diabetes			Liver Disease/Hepatitis		
Alcoholism			Diverticulosis			Lyme Disease		
ADHD/ADD			Emphysema/COPD			Menstrual Problems		
Anemia			Epilepsy/Seizure Disorder			Migraine/Tension Headaches		
Anxiety/Depression			Fatigue			Miscarriage		
Arthritis			Glaucoma			Mononucleosis		
Asthma			Hay Fever/Allergies			Osteoporosis		
Back Pain			Heart Attack			Prostate Problems		
Bleeding Disorders			Heart Disease			Sexual Dysfunction		
Breast Lump (s)			Heart Murmur			Sleep Disorder		
Cancer			High Blood Pressure			Stomach Ulcers		
Chronic Cough			High Cholesterol			Stroke		
Constipation			HIV Positive/AIDS			Thyroid Problem		
Diarrhea			Kidney Disease/Stones			Urinary Problem		

Male	Yes	No	Female	Yes	No
Penile Discharge			Changes in Breast		
Other			Vaginal Discharge		
			Currently Pregnant		

Family History (Check those that apply)

Disease	Family Member (s) who
Blood Disorders	
Cancer (Include type)	
Heart Disease	
Dementia	
Depression	
Diabetes	
Stroke	
Thyroid or Endocrine	

MICHELLE COOPER NP, LLC

ADULT PRIMARY CARE SERVICES

176 Thomas Johnson Dr. Ste103 Frederick, MD 21702
P: (301) 644-3305 F: (301) 644-3308
Michelle Cooper, CRNP

Health History (Continuation)

Patient Name: _____Date of Birth: _____

Social History (Please Mark One)

Do you drink alcohol? No___ Yes____ How often _____how much_____
Do you smoke now or in the past? No___ Yes____ Packs daily_____ Are you interested in quitting? ____ When? _____
Do you exercise often? No____ Yes____ How often_____
Have you ever done Illicit Drugs? What kind? No___ Yes ____ Have drugs ever caused problems in your life? No____ Yes____.
Any exposure or known STD's? No____ Yes ____ Type_____ Treatments
_____

Long Term Medical Problems
No____ Yes ____ If yes please complete list below.

Medical Problems or Surgeries	Diagnosis and Date	Were you Hospitalized?

Any complications with Anesthesia? No ____ Yes ____
Explain: _____

MICHELLE COOPER NP, LLC

ADULT PRIMARY CARE SERVICES

176 Thomas Johnson Dr. Ste103 Frederick, MD 21702
P: (301) 644-3305 F: (301) 644-3308
Michelle Cooper, CRNP

Patient Name: _____ **Date of Birth:** _____

Attention patients!

We do not refill or prescribe ADHD medication, Xanax, Ativan, Valium or narcotics

List of Current Medications taking:

Name of Medicine and Dosage	How often
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

Pharmacy Name: _____ **Phone:** _____

Medication

Are you Allergic to any Medication? No ____ Yes____

If yes Explain: _____

Are you Allergic to Latex? No____ Yes ____ Reaction: _____

Any other Allergies? No____ Yes ____

Are you taking any Supplements? _____**How often:** _____

MICHELLE COOPER NP, LLC

ADULT PRIMARY CARE SERVICES

176 Thomas Johnson Dr. Ste103 Frederick, MD 21702
P: (301) 644-3305 F: (301) 644-3308
Michelle Cooper, CRNP

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: ____/____/_____
Please Print

Address: _____ Apt: _____ City: _____

State: _____ Zip Code_____ Telephone No: (_____) _____-_____

I hereby Authorize: Adult Primary Care Services – Michelle Cooper CRNP
176 Thomas Johnson Dr. Ste 104
Frederick, MD 21702
Ph: (301) 644-3305 F: (301) 644-3308

To acquire from:
Name of Prior Physician or Organization: _____

_____ _____
Address Telephone Number

_____ _____
City State Zip Code Fax Number

Information Requested: Please mark

___Recent Lab Reports
___Recent Pathology Reports
___Last notes
___Imaging Reports
___Most recent EKG
Other: _____

I, understand that STD stands for Sexually Transmitted Disease, as defined by law, RCW 70.24. This include: Herpes simplex, Human Papilloma Virus, Wart, Genital Wart, Condyloma, Chlamydia, Non-specific Urethritis, Syphilis, VDRL, Chancroid, Lymphogranuloma Venereuem, HIV, AIDS, and Gonorrhea.

I, Do ____ Do Not____ authorize **Michelle Cooper, CRNP**, the release of any STD's results even if negative, OR otherwise, an specific written permission before disclosure.
I, Do ____ Do Not____ authorize, **Michelle Cooper, CRNP**, to obtain any records regarding Drug, Alcohol, or Mental Health.

Patient Name: _____ **Date:** _____

Patient Signature: _____

MICHELLE COOPER NP, LLC

Certified Registered Nurse Practitioner
176 Thomas Johnson Dr. Ste103
Frederick, MD 21702
P: (301) 644-3305 F: (301) 644-3308
Website: www.adultprimarycareservices.com

CONSENT FOR TREATMENT:

I, _____(print your name) am voluntarily seeking Medical Care, and Treatment from Michelle Cooper, CRNP at Adult Primary Care Services, permission to examine, provide treatment, medical advice, and make diagnoses for my health wellbeing.

CONSENT TO BILL:

If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with Adult Primary Care Services Financial Disclosure Policy.

If my Insurance is accepted, I authorize payment of benefits to Michelle Cooper, CRNP or will reimburse Michelle Cooper, CRNP. It is my responsibility to confirm that Michelle Cooper, NP, LLC. Adult Primary Care Services, is participating under my insurance plan. I hereby authorize the assignments of benefits (payments) to be sent directly to Michelle Cooper, NP, LLC, Adult Primary Care Services for all my insurance claims related to services received. I understand that I am financially responsible for Co-Pays on the day of service. I also understand that I will be responsible for any balance after insurance payment or payment in full for denied claims due to no insurance at time of service.

Patient Initials:_____

PRESCRIPTION RE-FILLS:

YOU MUST CONTACT YOUR PHARMACY FOR ALL RE-FILL REQUEST

IF IT HAS BEEN MORE THAN 90 DAYS SINCE YOUR LAST OFFICE VISIT, YOUWILL NEED TO BE SEEN IN FOLLOW-UP BEOFRE A REFILL WILL BE PRESCIBED. (UNLESS OTHERWISE NOTED BY YOUR PROVIDER)

Patient Initials:_____

NON-PRESCIBED MEDICATIONS:

OUR OFFICE DOES NOT TO PRESCIBE THE FOLLOWING MEDICATIONS, DUE TO CHANGES IN STATE/FEDERAL MONITORING POLICIES.

ADHD TREATMENT: EXAMPLES – ADDERALL, VYVANSE, AND CONCERTA

ANXIETY TREAMENT: EXAMPLES – XANAX, ATIVAN, VALIUM

NARCOTICS OF ANY KIND

Patient Initials:_____

MICHELLE COOPER NP, LLC

Certified Registered Nurse Practitioner
176 Thomas Johnson Dr. Ste103
Frederick, MD 21702
P: (301) 644-3305 F: (301) 644-3308
Website: www.adultprimarycareservices.com

HIPAA RELEASE:

Patient Name:_____ Date of Birth:_____

I do _____ I do not _____ want a copy of HIPAA form.

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

_____ I DO NOT want any information released to anyone. (I do understand that I will have to give a verbal/written permission for release of information to outside providers)

I understand that I may change my HIPAA release information at any time – in writing or in person.

The office is to contact me at _____ with all messages.

_____ The office can leave a detailed message.

_____ The office is to leave a message to contact the office ONLY.

FORM COMPLETION:

Our office requires a visit for the completion of all forms (MVA, disability, durable medical supplies, etc). This will insure all information is current and records are updated. Turn around for form completion is 72 hours.

REFERRALS:

It is the responsibility of the patient to request a referral no less than 72 hours before an appointment with a specialist.

Patient Initials:_____

MICHELLE COOPER NP, LLC

Certified Registered Nurse Practitioner
176 Thomas Johnson Dr. Ste103
Frederick, MD 21702
P: (301) 644-3305 F: (301) 644-3308
Website: www.adultprimarycareservices.com

Financial Disclosure Policy:

The following are the financial police for Adult Primary Care Services. If you have any questions, please contact our office for further assistance. We are committed to provide the best care to you and your understanding of the following protocols is essential to that goal.

- Patients are to have a photo id and insurance card with them at each visit – this will help to assure proper billing and thus payment from your insurance company(ies).
- An insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand your policy. You need to be aware of co-pays, co-insurance, and deductibles. You will be responsible for any balance after insurance payment or denials.
- It is your responsibility to update the office with any changes to your insurance. Failure to do so may result in patient payment in full for services.
- Benefits are verified before each visit – per insurance companies "this is not a guarantee of payment or coverage".
- Balances are due within 30 days of statement date. We do except payments for balances. Accounts not paid upon are subject to collections and will be subject to fees and interest charges. (Our office is currently using an outside billing service.)
- Outside laboratory and imaging is billed through the provider of the service. (example: FMH or CRA)
- Medical Records: $20 fee for your records to be given to you, attorney, or other agency. We will gladly transfer records to other providers at no charge. All record transfers require a completed request form – from our office or the transferring entity.

Patient Name PRINTED	Patient SIGNATURE	DATE