NAIL NURSE
SPECIALISTS, PLLC
MOBILE NAIL & WOUND CARE

New Patient Intake Form

Full Name: _____

Date of Birth: _____ SSN: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Primary Physician: _____

Phone: _____ Fax: _____

Medical History:

_____

_____

_____

_____

Allergies: _____

Current Medications:

_____

_____

_____

I certify that all of the above information is true and correct to the best of my knowledge.

Print: _____Sign: _____ Date: _____

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Consent for Services

I, _____, authorize Nail Nurse Specialists, PLLC to provide in-home care services as outlined in the Plan of Care. I understand that participation is voluntary and I may revoke this consent at any time in writing.

I have received or have been offered a copy of the Patient Bill of Rights and Privacy Notice.

Signature of Patient/Legal Guardian: _____ Date: _____

HIPAA Privacy Acknowledgment

I acknowledge that I have received or have been offered a copy of Nail Nurse Specialists, PLLC Notice of Privacy Practices, which explains how my health information will be used and disclosed, and describes my right regarding my health information.
I understand that:

- The Notice of Privacy Practices may be updated at any time.
- I may request an additional copy at any time.

☐ I received a copy of the Notice of Privacy Practices.
☐ I declined a copy but understand I may request one at any time.

Patient/Guardian Signature: _____ Date: _____

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Service Agreement / Plan of Care Summary

Services to be provided:

☐ Nail Care ☐ Wound Care ☐ Other: _____

Frequency: _____ Days per week: _____

Start Date: _____ Review Date: _____

Patient Signature: _____

RN/Agency Representative: _____

Emergency Preparedness Plan

In case of emergency, I authorize Nail Nurse Specialists, PLLC to notify emergency contacts

Primary Emergency Contact: _____

Backup Contact: _____

Patient Signature: _____ Date: _____

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Advance Directives Notification

Do you have an advance directive (living will, DNR, health care POA)?

☐ Yes ☐ No If yes, please provide a copy.

Patient Signature: _____ Date: _____

Financial Agreement

I agree to the fees and billing terms outlined by Nail Nurse Specialists, PLLC. I understand I am financially responsible for any services as Nail Nurse Specialists, PLLC does not bill insurance.

Patient/Responsible Party Signature: _____

Date: _____ Staff Witness: _____

Medical Records Release

I authorize Nail Nurse Specialists, PLLC to release or obtain my medical records from/to:

Name: _____ Phone: _____

Purpose: Care coordination

Signature: _____ Date: _____