PLEASE READ AND SIGN ALL PAGES

NP's Care, LLC
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npscare@outlook.com

PATIENT DEMOGRAPHIC INFORMATION:

PLEASE PRINT ALL INFORMATION

NAME:________________________ D.O.B.________________ SSN______-____-________

ADDRESS:____

PRIMARY PHONE:__________________ SECONDARY PHONE:________________________

WHERE WERE YOU BORN? ____

PRIMARY LANGUAGE: ____________________ SECONDARY LANGUAGE: _______________________

ETHNICITY:________________________ HISPANIC/ LATINO: __________________

BIRTH GENDER: M / F ORIENTATION: STRAIGHT / GAY / BI-SEXUAL / TG

GENDER IDENTIFICATION:_______________________

MARITAL STATUS: SINGLE / MARRIED / SEPARATED / DIVORCED / WIDOWED

ARE YOU EMPLOYED: YES / NO IF SO, WHO IS YOUR EMPLOYER:_____________________

ADDRESS:______________________________ PHONE:___________________________

EMERGENCY CONTACT INFORMATION:

NAME:____________________________ PHONE:_________________________________

RELATIONSHIP TO PATIENT:_____________________________________

DO YOU HAVE A LIVING WILL? YES / NO

____ ________________________________

SIGNATURE DATE

INSURANCE INFORMATION:

PRIMARY INSURANCE:____

NAME OF POLICY HOLDER:____

IS THIS A MEDICARE PLAN? YES / NO

IS THIS A MEDICAID PLAN? YES / NO

SECONDARY INSURANCE (IF APPLICABLE):________________________________

NAME OF POLICY HOLDER:____

IS THIS A MEDICARE PLAN? YES / NO

IS THIS A MEDICAID PLAN? YES / NO

I, hereby sign that the information provided in my paperwork is true to the best of my knowledge. I will keep the office staff of NP's Care, LLC., up to date on any changes to my personal demographics and/or medical history as it comes necessary.

____

SIGNATURE

____

DATE

DATE:____________________

MEDICAL HISTORY

NAME:________________________________ D.O.B.:____________

MEDICATION ALLERGIES:____
____
____

FOOD & SEASONAL ALLERGIES:____
____
____

TOBACCO USE: Y / N TYPE:________________ HOW LONG:__________ HOW MUCH:__________

ALCOHOL USE: Y / N TYPE:________________ HOW LONG:__________ HOW MUCH:__________

RECREATIONAL DRUG USE: Y / N TYPE:____________ HOW LONG:__________ HOW MUCH:__________

CAFFINE USE: Y / N TEA / COFFEE HOW MANY CUPS A DAY:____________

CURRENT MEDICAL PROBLEMS YOU ARE BEING TREATED FOR:
____
____
____
____

PREVIOUS RESOLVED MEDICAL CONDITIONS:
____
____

SURGICIAL HISTORY:
____
____

IMMUNIZATION/ DATE OF LAST SHOT:

TETANUS:______________ PNEUMOCOCCAL:______________ FLU:______________

SHINGLES:______________ TB TEST:______________ HEPATITIS A:______________

HEPATITS B:______________ PERTUSSIS:______________ MMR:______________

POLIO:______________ MENINGITIS:______________

MALE MEDICAL HISTORY:

LAST PROSTATE EXAM:__________________ WHERE:__________________________

PROSTATE BIOPSY: Y / N DATE:__________ RESULTS:__________________________

SEXUAL PREFORMANCE ISSUES:____

URINARY ISSUES: Y / N SYMPTOMS:____

PHYSICAL HOBBIES:____

____

____

FEMALE MEDICAL HISTORY:

AGE OF FIRST PERIOD:_____ # OF DAYS BETWEEN CYCLES:________ CYCLE LASTS ________ DAYS

PROBLEMS:____________ DATE OF LAST PAP:__________ DATE OF LAST MAMMOGRAM:________

~~DATE OF BONE DENSITY~~:__________ AGE OF MENOPAUSE:________ NATURAL OR SURGICIAL:______

ARE YOU CURRENTLY PREGNANT: Y / N TOTAL NUMBER OF PREGNANCIES:________

DELIVERY: NATURAL / C-SECTION TERM / PREMATURE IF BOTH, PLEASE LIST HOW MANY:________

LIVE BIRTHS / STILL BORN # OF CHILDREN CURRENTLY LIVING:________ MISCARRIAGES:________

SEXUAL PREFORMANCE ISSUES:____

URINARY ISSUES: Y / N SYMPTOMS:____

____

FAMILY HISTORY:

	SEX M OR F	ALIVE	DECEASED	AGE - PRESENT OR AT TIME OF DEATH	HEART DISEASE	HEART ATTACK	STROKE	BLEEDING / BLOOD DISOR	CANCER & TYPE	DIABETES	LUNG / BREATHING ISSUES	ASTHMA	REFLUX / HEARTBURN	BOWEL ISSUES	KIDNEY ISSUES	MENTAL ILLNESS
MOTHER																
FATHER																
SIBLING																
SIBLING																
SIBLING																
SIBLING																
CHILD																
CHILD																
CHILD																
CHILD																

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SIGNATURE:______________________________ DATE:______________________

CURRENT PRESCRIPTION MEDICATIONS:

NAME	DOSE	HOW OFTEN

OTC MEDICATIONS: VITAMINS, HERBS, SUPPLEMENTS, ETC.

NAME	DOSE	HOW OFTEN

PATIENT PORTAL-YOUR HEALTH FILE ACCESS

Eager for test result? Can't remember what was said during your appointment? With the patient portal you can access your health information, online after your appointment. This service is optional, and FREE! The choice is yours!

- Yes, I want the portal

  Email____________________________________
- No, I don't want the portal

Patient signature______________________________ Date______________

MEDICATION REFILL POLICY

As a part of your health care team we ask that you are seen at least every four (4) to six (6) months to ensure your medication and dosing are correct, and effective. We understand life happens, in which case within 24-48 hours we may be willing to give a temporary refill until you are able to be seen for an appointment, and pending lab-work. By signing below you acknowledge that you agree to and understand our policy. Copies can be given upon request. Thank you for allowing NP's Care LLC to be part of your healthcare team.

Patient signature______________________________ Date______________

Staff signature______________________________ Date______________

NP'S CARE LLC- FINANCIAL POLICY AND BENEFITS AUTHORIZATION

Thank you for choosing **NP'S CARE, LLC** as your health care provider. We are committed to providing quality patient care at the lowest possible cost to you as our patient. The following is a statement of your financial policy that we require you to read, acknowledge and sign prior to any services being rendered. Your signature verifies that you have read the document, understand its meaning and agree to comply with the rules and stipulations set forth.

Please be aware that some and perhaps all services provided may not be covered under your insurance plan, they may be seen as not being reasonable or necessary to your insurance carrier.

PARTICIPATING PLANS: For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service. To properly bill you insurance company and avoid untimely delays, we require that you provide us with the accurate insurance information and allow us to maintain a copy of your insurance card on file. In the event that your insurance coverage changes to a plan in which we do not participate, refer to the following paragraph.

NON-PATICIPATING PLANS: For those insurance plans with which we do not participate, we do not accept assignment of insurance benefits and **we do not bill your insurance company for you.** Your policy is a contract between you and the insurance company, not us. Payment is expected at the time of service, **we can accept CASH, CHECK, VISA, MASTERCARD, and DISCOVER.** You can file for reimbursement with your insurance company and you see fit.

MINORS: A minor must be accompanied by a parent and/or legal guardian at each visit. An unaccompanied minor will be denied non-emergency treatment unless a plan has been pre-approved with the office and the minor's parent and/or legal guardian. There is an exception to this policy for a minor, if the minor is married or self-supporting regardless of income, and if the minor is a parent consenting for treatment for his/her child even if the parent is under the age of 18.

I hereby authorize and assign payment directly to NP's Care, LLC for medical and/or surgical benefits, if any, otherwise payable to me for services provided at the office (not to exceed my indebtedness to the practice for those services). I understand that I am fully, financially responsible for any and all charges no covered by my insurance. I authorize the release of any and all information acquired in the course of my examination or treatment to any consulting and/or referring health care provider as well as my insurance company. By signing this form, I agree that I read and understood the above Financial Policy and Benefits Authorization Statement, and any questions have been answered to my satisfaction. I therefore agree to comply with all provisions as outlined within this stated policy.

COLLECTION POLICY & AGREEMENT

If the undersigned fail(s) to make any payments due hereunder, NP's Care, LLC may at any time thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. The undersigned promise(s) to pay all the cost of collection equal to thirty-five (35%), including, but not limited to, court costs, attorneys' fees equal to fifteen percent (15%0 of any amount due and owing to NP's Care, LLC, and any other collection fees which are incurred by or on behalf of NP's CARE, LLC in enforcing payment after default.

Patient Signature: ______________________________ Date: ______________

Staff Signature: ______________________________ Date: ______________

NO SHOW/ MISSED APPOINTMENT POLICY AS OF 01/01/2022

We require a 24 hour notice to cancel appointments. If less than 24 hour notice is given, this will be documented as a **"NO SHOW"**. Recurrent missed appointments will result in a **$25.00 fee for each offense**. After a third **"NO SHOW"** offense, there will be a third $25.00 fee and dismissal from the practice will then be considered.

Written notice will be sent for breach in policy and approved dismissal

Patient signature____________________ **Date:**_______________

HIPAA COMPLIANCE PATIENT CONSENT FORM

You have the right to restrict how your protected health information is used for disclosure of treatment, payment, or healthcare operations. The HIPAA (Health Insurance and Portability and Accountability act of 1996) law allows for the use if the information for treatment, payment, or healthcare operations.

May we call, leave voice mail, or email about upcoming appointment?

Yes No

May we discuss your medical conditions, and treatment plans with anyone other than yourself such as family and/or friends?

Yes No

If yes, please list below

Name	Relationship	Contact number
________________	________________	________________
________________	________________	________________
________________	________________	________________

Signature:____________________ **Print name**____________________ **Date**_____________

Staff signature:__________________ **Date:**_______________