THE NURSE'S OFFICE

Primary Care & Walk-in Center

Last Name: _____First Name: _____ M.I: _____

Preferred Name_____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security #: _____ Sex: M / F / Transgender

Marital Status: _____ Email Address: _____

Emergency Contact Name: _____ Phone #: _____

Employer Name and Contact Number: _____

Can we leave a message regarding your medical care & test results? Yes / No

Pharmacy Name: _____ Address: _____ Phone: _____

How did you hear about us?_____

Race (please select):

- White
- Hispanic
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific Islander
- Declined

Ethnicity (please select) :

- Hispanic or Latino
- Non-Hispanic or Latino
- Decline

Preferred Language (please select one):

- English
- Spanish
- Other: _____
- Decline

Responsible Party-If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name: _____ First Name: _____ M.I: _____
Address of Person Responsible: _____
Home Phone: _____ Date of Birth: _____ Social Security #: _____

Primary Insurance:

Ins. Co. Name: _____
Policy Holder Name: _____
Policy Holder DOB: _____
Policy Number: _____
Relationship to Patient: _____

Secondary Insurance:

Ins. Co. Name: _____
Policy Holder Name: _____
Policy Holder DOB: _____
Policy Number: _____
Relationship to Patient: _____

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____ Date: _____

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Patient Information Sheet

Patient Name: _____ Date of Birth: _____

Reason for Today's Visit_____

Allergies: _____

List ALL MEDICATIONS you take, **including over-the-counter medications and vitamins**. Please include specific doses.

	Medication	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	Alcoholism	Allergies, seasonal	Anemia
Anxiety	Arrhythmia	Arthritis	Asthma
Bipolar	Bladder Problems	Bleeding Problems	Cancer
Headaches	Crohn's Disease	COPD	Dementia
Depression	Diabetes	Diverticulitis	DVT
GERD	Glaucoma	Heart Disease	Heart Attack
Hiatal Hernia	High Blood Pressure	Kidney Stones	Kidney Disease
High Cholesterol	HIV	Hepatitis	Irritable Bowel Disease
Lupus	Liver Disease	Macular Degeneration	Neuropathy
Osteopenia	Osteoporosis	Parkinson's Disease	Peripheral Vascular Disease
Peptic Ulcer	Psoriasis	Pulmonary Embolism	Rheumatoid Arthritis
Seizure Disorder	Sleep Apnea	Stroke	Thyroid Disorder

Other medical problems that are not listed above: _____

Surgical History: _____
_____
_____

SOCIAL/CULTURAL HISTORY:

Education Level: Elementary High School Vocational College Graduate/Professional

Are there any vision problems that affect your communication? Yes / No

Are there any hearing problems that affect your communication? Yes / No

Are there any limitations to understanding or following instruction (either written or verbal)? Yes / No

Are you sexually active? Circle one male female both Yes / No

Are there any personal Problems or concerns at home, work or school you wish to discuss Yes / No

Are there any cultural or religious concerns you have related to our delivery of care? Yes / No

Are there any financial issues that directly impact your ability to manage your health? Yes / No

Current living situation (check all that apply):

____ Single Family Household ____Multi-generational Household ____ Homeless
____ Shelter ____ Skilled Nursing Home ____ Other

FREQUENCY USE	Never	ALL DAY EVERY DAY	DAILY	WEEKLY	OCCASIONALLY	RARELY
Example:						
TOBACCO						
TOBACCO						
ALCOHOL						
CAFFEINE						
Recreational DRUGS (Identify specifically)						

FAMILY HISTORY:

Father: Living / Deceased

Father's Medical History: (circle all that apply)

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer:	Diabetes	High Blood Pressure	Stroke
Asthma	COPD	DVT	Kidney Disease	Thyroid Disease
Arthritis	Dementia	Heart Disease	Migraines	

Mother: Living / Deceased

Mother's Medical History: (circle all that apply)

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer:	Diabetes	High Blood Pressure	Stroke
Asthma	COPD	DVT	Kidney Disease	Thyroid Disease
Arthritis	Dementia	Heart Disease	Migraines	

Patient's Name: _____ Social Security Number: _____

Date of Birth: _____ Address: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below for the purposes of handling their medical care.

2. The following individuals or organizations are authorized to make the disclosure: all persons with knowledge of my medical history.

3. The following persons or class of persons may receive disclosure or protected health information about the above-named person:

The Nurse's Office Primary Care and Walk-In Center, LLC
179 Linwood Ave
Colchester, CT 06415
P- (860) 603-3541 F: (860) 603-3544

The type of information to be disclosed includes: **(Please initial ALL the items below authorizing the release of these medical records, if such records exist)**

_____ All medical records (all information) Clinician office chart notes

_____ All hospital records (including nursing records and progress reports)

_____ Medical records needed for continuity of care

_____ Transcribed medical records

_____ Dental Records

_____ Most recent history

_____ Laboratory reports

_____ Emergency and urgent care records

_____ Pathology reports

_____ billing statements

_____ Diagnostic imaging reports

_____ Other:

5. _____ By initialing this area I understand that the information in my health records may include information relating to sexually transmitted disease Acquired Immune Deficiency Syndrome (AIDS), or Human Immune Deficiency Virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

6. I also understand that I can revoke this authorization at any time by notifying The Nurse's Office, in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations the information described above may be re-disclosed and no longer protected by these regulations.

_____ _____

Signature of patient or authorized Legal Guardian, Date

THE NURSE'S OFFICE
Primary Care & Walk-in Center

THE NURSE'S OFFICE PRIMARY CARE & WALK-IN CENTER

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to undersigned patient ("Patient"):

The Nurse's Office Primary Care & Walk-in Center ("Private Practice"), is required to provide Patient with a copy of Private Practice's Notice of Privacy Practices ("Notice"), which states how Private Practice may use and/or disclose Patient's health information.

Please sign this form to acknowledge receipt of the Notice.

Patient may refuse to sign this acknowledgment, if Patient wishes.

I acknowledge that I have received a copy of Private Practice's Notice of Privacy Practices.

Patient's name (please print): _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

Private Practice made every effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices from Patient but it could not be obtained because:

☐ Patient refused to sign.

☐ Due to an emergency situation, it was not possible to obtain an acknowledgment.

☐ Private Practice was unable to communicate with Patient.

☐ Other: _____

_____

_____

THE NURSE'S OFFICE
Primary Care & Walk-in Center

Patient Payment Policy

Thank you for choosing The Nurse's Office Primary Care & Walk-In Center, LLC. We are committed to providing you with the highest quality of health care and strive to keep healthcare affordable in our office. As such, we provide this document to ensure your understanding of the payment policies. Please read the following office payment policy carefully and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

Payment Policy

- At the time of service, you are required to pay any applicable copay or deductible. If you do **not** pay your balance before your next visit we will **NOT** be able to see you until the balance is paid in **full**. After your insurance is billed, you are responsible for any remaining balance.
- A Payment for service of $150 is due prior to being seen for self pay patients. You may be responsible for additional charges depending upon services rendered.
- There will be a No Show/Cancellation fee of $35 if appointments are missed or not cancelled within 24 hours.
- For all printed Medical Records there will be a fee of $0.64 per page.
- We accept Debit/Credit cards, Cash, money order, banker's cashier check. We DO NOT accept personal checks.
- Please note that your insurance company will not cover any of the additional fees listed above.
- Prior to procedures, you must pay a pre-procedure deposit, predetermined by your insurance.
- If you are in need of a payment plan, you can discuss options with the office staff.
- If your account is overdue for longer than 90 days, it may be referred to a collection agency. Payments over 30 days past due from the date of the invoice will include a 10% APR billing fee.

Insurance

As a courtesy, we file your insurance claims. It is your responsibility to notify us of any changes to your insurance coverage. It is your insurance policy. It is your responsibility to know your policy in regards to benefits, maximums, waiting periods, benefit year, and patient responsibility. We will provide information required by your insurance company regarding the treatment provided by us. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays.

_____

Patient/Guarantor Signature