



ADULT PRIMARY CARE SERVICES

176 Thomas Johnson Dr. Ste104 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 # _____

Demographics: Please X one

Marital Status: Married Single Divorced Widowed

Race: White/Caucasian Multiracial Asian/Pacific Islander Black
 American Indian/Alaskan Refuse

Ethnicity: Hispanic or Latino Asian Caribbean Islander Middle Eastern
 Refuse Other: _____ -

Insurance Information:

Primary Insurance: _____ Patient is Subscriber/Policy Holder Yes No

Subscriber Name: _____ Date of Birth: _____ Relation: _____

Insurance ID# _____ Group # _____ Copayment \$ _____

Secondary Insurance: _____ Patient is Subscriber/Policy Holder Yes No

Subscriber Name: _____ Date of Birth: _____ Relation: _____

Insurance ID# _____ Group # _____ Copayment \$ _____

Self-Pay: _____ **\$50.00 Deductible will be due at time of each visit until deductible is met.**

We accept Visa/MasterCard/American Express Cash

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

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

Cancellation Fee Schedule: **\$50.00**

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

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

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

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



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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	



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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	When Diagnosed	Hospitalized for this problem

Have you had any surgeries? No___ Yes ___ If, so when? _____

What was the reason for surgery? _____

Any complications with Anesthesia? No ___ Yes ___

Explain: _____



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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:** _____



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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 Imaging Reports
 Recent Pathology Reports Most recent EKG
 Last notes 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: _____



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Michelle Cooper, CRNP

Adult Primary Care Services Financial Disclosure Policy Date: _____

Thank you for choosing **Michelle Cooper, NP, LLC, Adult Primary Care Services**. The following are the financial policies for this office. If you have 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.

- Your insurance policy is a contract between you and your insurance company.
- It is the patient’s responsibility to know and understand their policy. Failure to notify our office of any changes in your insurance policy will result in you being responsibility for the bill.
- Benefits are verified at the time of the visit, however please note that this is not a guarantee of payment.
- For services rendered to patients who are minors, the accompanying parent or guardian is responsible for any payments due.
- It is the patient’s responsibility to understand and be aware of any co-payments, deductibles and co-insurance and is the patient’s responsibility to pay all payments as outlined in the insurance policy.
- **We collect \$50.00 toward the deductible of year plan at time of visit, until your deductible is met.**
- We will be happy to assist you with filing claims for any out-of-network benefits, however, charges for this type of benefit are due at the time of service. If your insurance deems a service as “not covered”, the patient is responsible for these charges.
- Patient balances are due within 30 days of the office visit, if there are any issues regarding payment, payment arrangements will be made. If payment arrangements are not met, your account will be turned over to a collection agency, and interest rates will apply.
- **If any laboratory services are necessary (pathologies, wound cultures or blood work), you may receive a separate bill from separate lab companies that are not connected to our practice.**
- If your insurance plan denies any service, it is your responsibility to pay any balances in full.

CANCELLATION POLICY

- A **24-hour notice of cancellation** is required. If you cancel or “no show” for your appointment less than 24 hours of your scheduled appointment, you will be **charged \$50.00 for a missed office visit**. This fee **IS NOT COVERED BY INSURANCES**. **All patients who missed appointments three times with no excuses, they will be disenrolled from the practice.**

FORMS

Due to the increase of requests for completed forms, i.e. (MVA, disability, durable medical equipment requests, etc.) There is a \$20 fee for completion of forms. Turnaround time for these forms is 48-72 hours. YOU WILL BE NOTIFIED WHEN THE FORMS ARE AVAILABLE FOR PICK UP.

PAYMENT POLICY

It is my responsibility to confirm that **Michelle Cooper, NP, LLC, Adult Primary Care Services**, is covered under my insurance plan. I hereby authorize the assignment of benefits (payments) directly to **Michelle Cooper, NP, LLC, Adult Primary Care Service** for all my insurance claims related to services received. I understand that I am financially responsible for services provided which are to be paid on the day on which services are rendered. This includes co-payments/deductibles with any managed care contract and non-covered services.

I have read, understand and agree to the financial disclosure and cancellation policies above.

Print Patient Name	Signature	Patient’s date of birth
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PATIENT CONSENT FORM FOR TREATMENT

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

Patient Signature

Date

Witness Signature

Witness print Name

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 If I am paid directly by my carrier.



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Name: _____ Date of Birth: _____

Medical Information Release Form

(HIPAA Release Form)

I, do ___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:

Spouse _____ Ph: _____

Child(ren) _____ Ph: _____

Other _____

Information is not to be released to anyone.

This **Released of Information** will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell number: _____

If unable to reach me: you may leave a detailed message

please leave me a message asking me to call back

The best time to reach me is (day) _____ Between (time) _____

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Adult Primary Care Services Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Adult Primary Care Services Notice of Privacy Practices, please do not hesitate to contact a clinic representative as indicated on your Notice.

Signed: _____ Date: ___/___/_____

Witness: _____ Date: ___/___/_____



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Missed appointment policy

To serve our patients better, we request your consideration of the physician's time by asking that you give us 24 hours notice if you cannot attend a scheduled appointment. This allows other patients who are waiting for a cancellation to be notified. We understand that sometimes situations arise that are out of your control, and 24-hour advance notices may not be sufficient. However, in these circumstances, we ask that you notify the office as soon as possible. When a patient repeatedly misses scheduled appointments, it becomes an inconvenience to the practice. Therefore, if patient misses three consecutive appointments without proper notification, he or she may be subject to dismissal from our clinic, at the discretion of the treating physician. A letter will be sent to the patient informing him or her of the decision and/or process.

Patient Name: _____ Date: _____

Patient Signature: _____