

HIPPA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose Protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The tems of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health infomation is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with is restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the infomation for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare infomation and potentially anonymous usage in publications. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I have read the office copy of the HIPPA Laws and understand that:

- Protected health infomation may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the infomation but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confim appointments? ☐ YES ☐ NO	
May we leave a message on your answemg machine at home or on your YES NO	ur cell phone?
May we discuss your medical condition with any member of you family YES NO	?
If YES, please name the members allowed:	
This consent was signed by (Print Name):	
Signature:	Date:
Witness:	Date:



PATIENT INFORMATION INTAKE FORM

	Date:
Patient Name: (First, Middle, Last):	
Date of Birth:	
Social Security Number (SS#):	
Home Address:	
City, State Zip:	
Home Phone Number:	
Cell Phone Number:	
Email:	
Occupation:	
Marital Status:	
Referral Source:	
Emergency Contact Name:	
Emergency Contact Number:	
Employer/School:	
Employer/School Address:	
Employer/School City, State,Zip:	
Employer/School Phone Number:	



INSURANCE INFORMATION

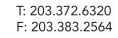
Responsible Party Name	: :	
Relationship to Patient:_		
Insurance Company:		
Subscriber Name:		
Group Number:		SS#:
DOB:		
Other Coverage	☐ YES	□NO
If YES,		
Insurance Company:		
Subscriber Name		
Group Number:		SS#:
DOB:		
Assignment and Release	5	
and assigned directly Ac benefits. If any, otherwis responsible for all charge all insurance submission tion and may disclose su	dvanced NP Solutions, L se payable to me for sel es whether or not paid s. The above name Prin uch information in the all of obtaining payment for	surance coverage with the company(ies) listed above LLC d/b/a Best Health Primary Care all insurance rvices rendered. I understand that I am financially by insurance. I authorize the use of my signature on mary Care Practice may use my health care informations bove-named Insurance Company(ies) and their or services and determining insurance benefits or the
Signature:		Date:



PATIENT INTAKE FORM

Patient Name:	lame: DOB:	
Preferred Pharmacy: Store/Lo	ocation/Phone N	umber:
Allergies (Food or Medicatio	ns:	
Medication List Drug	 Dose	Frequency
Medical history/Surgical histo Diagnosis	ory: Please write Date	any diagnosis you have received prior to today's visit Notes/Details
Providers: Please write the n Name	ame, location an Location	nd phone number of all your providers Phone Number

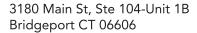
3180 Main St, Ste 104-Unit 1B T: 203.372.6320 Bridgeport CT 06606





CONSENT TO RELEASE OF PSYCHIATRIC/MEDICAL AND/OR **ALCHOL/DRUG ABUSE RECORDS**

1,	Birth Date:	
	orize Louis D'Onofrio, FNP-C, to have bilate	eral exchange of information that is contained
in my med	ical record with:	
under the	conditions listed below:	
1.		
	—— Psychiatric/medical/alcohol/drug—— Psychiatric/medical/alcohol/drug	
	Progress notes:	· ·
	Medical test/studies	
	Lab Studies	Other:
2.	Purpose or need for such disclosure: Continuing Care/Treatment and/or	
3.	This consent is subject to revocation at a	ny time except to the extent that action has
0.		eviously revoked, this consent will terminate
	upon:	-
4.	As additional consent must be obtained for any other transfer or disclosure of this information.	
5.	I understand that i may receive a copy of	this release.
Patient's Si	gnature:	Date:
Signature (of Parent/Guardian/Other Person	Date:
Witness (If	applicable):	Date:





T: 203.372.6320 F: 203.383.2564

MEDICAL APPOINTMENT CANCELLATION / NO SHOW POLICY

Effective January 1, 2019

Cancellation/No Show Policy for Provider Appointments.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a sixty five dollar (\$65) fee; this will not be covered by your insurance company.

Schedule Appointments

We understand that delays can happen however we must try to keep the other patients and providers on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

If a Second No Show or Cancellation/Reschedule with no 24 hour notice should occur, the patient may be dismissed from Advanced NP Solutions, LLC d/b/a Best Health Primary Care.

Any new patients who fails to show for their initial visit will not be rescheduled.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature:	Date:
Print Name:	