ADULT PRIMARY CARE SERVICES

176 Thomas Johnson Dr. Ste103 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:
Other: ______________

Full time	Student	Retired
Part time	Active Duty	Unemployed

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
___Recent Pathology Reports
___Last notes
___Imaging Reports
___Most recent EKG
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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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: _________________________