Patient Information

Patient Name: (First, Middle, Last) _____

Today's date: _____ Date of Birth: _____

Social security number (SS#): _____

Gender: Male Female Other (Please specify): _____

Home Address _____

City _____ State _____

ZIP _____

Home Number _____ Cell phone: _____

Email _____

Occupation _____

Marital Status _____

Referral source _____

Emergency Contact name _____

Emergency contact number _____

Employer/school _____

Address _____ City _____ State _____

Zip _____ Phone _____

HIPAA 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 terms 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 information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this 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 information for treatment, payment, or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected healthcare information 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 information 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 information 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 confirm appointments?

YES NO

May we leave a message on your answering machine at home or on your cell phone?

YES NO

May we discuss your medical condition with any member of your family?

YES NO

If YES, please name the members allowed: _____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Insurance Information

Responsible Party Name _____

Relationship to patient _____

Insurance Company _____

Subscriber name _____

Group Number _____ SS# _____

Birthday _____

Other coverage ☐ Yes ☐ No

If Yes,

Insurance Company _____

Subscriber name _____

Group Number _____ SS# _____

Birthday _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the company(ies) listed above and assigned directly Advanced NP Solutions, llc d/b/a Best Health Primary Care all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named Primary care practice may use my health care information and may disclose such information in the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signed _____ Date _____

Patient Name_____DOB_____

Preferred Pharmacy: Store/Location/Phone number

_____

Medication List:

Drug	Dose	Frequency

Medical history / Surgical history: Please write any diagnosis you have received prior to today's visit

Diagnosis	Date	Notes/Details

Providers: Please write the name, location, and phone number of all of your providers

Name	Location	Number

Allergies: (Food or medication)

Office: Best Health Primary Care
Mailing:
2875 Main Street Suite 2A
Stratford Medical Center at Spinelli Plaza
Stratford, CT 06614

phone: 203.375.6320

fax: 203.383.2564

CONSENT TO RELEASE

PSYCHIATRIC / MEDICAL and/or ALCOHOL / DRUG ABUSE

RECORDS

I, _____, BIRTH DATE ____/____/____,
hereby authorize Louis D'Onofrio, FNP-C, to have bilateral exchange of information that is contained in my medical record with: _____

_____

under the conditions listed below:

1. This information will be limited to:
   ____ Psychiatric/medical/alcohol/drug abuse evaluation.
   ____ Psychiatric/medical/alcohol/drug abuse discharge summary.
   ____ Progress notes. ____Hospitalization Records
   ____ Psychotherapy notes. ____ Medical tests/studies.
   ____ Lab studies. ____Other:

2. Purpose or need for such disclosure: Continuing care/ Treatment, and/or _____
   _____.

3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon _____
   _____.

4. An 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 Signature Date

_____ _____
Signature of Parent, Guardian or other Person authorized by law to sign in lieu of Patient (where required). Indicate which. Date

_____ _____
Witness (if applicable) Date

Best Health Primary Care

2875 Main St Suite 2A Stratford, CT 06614 | 203.375.6320 |

Starting January 1st, 2019

Medical Appointment Cancellation/No Show Policy

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 where 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 thirty-five ($35) fee; this will not be covered by your insurance company.

Scheduled 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 patient 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:_____

Printed name _____