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Authorization to Release Information and Payment

I authorize Your Family and Heart Care Center Care with Personalized Prevention LLC to bill my insurance carrier on my behalf for services rendered. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize Your Family and Heart Care Center Care with Personalized Prevention LLC to release to my insurance carrier any information concerning my health care, advice, treatment, or supplies provided which may be necessary to secure payment of these claims.

Patient Printed Name: _____

Patient Signature: _____

Date: _____

Review of Systems: Please circle yes or no for all the of the following symptoms

General

Yes No Fever
Yes No Weight Loss
Yes No Weight Gain

HEENT

Yes No Headaches
Yes No Recurrent Nose Bleeds
Yes No Ear Pain
Yes No Persistent Hoarseness
Yes No Nasal Congestion/ Drainage

Cardiac

Yes No Palpitations
Yes No Fast Heart Rate
Yes No Chest Pain
Yes No Swelling
Yes No Shortness of breath laying flat
Yes No Rheumatic Fever

Muscle Skeletal

Yes No Painful Joints or Muscles
Yes No Swollen Joints
Yes No Muscle Weakness

Hem/ Lymphatic

Yes No Swollen Glands
Where: _____

Gastrointestinal

Yes No Poor Appetite
Yes No Problems Swallowing
Yes No Frequent Heartburn
Yes No Diarrhea
Yes No Constipation

Kidney/ Bladder

Yes No Decrease in Force of Urination
Yes No Painful Urination
Yes No Frequent Urination

Respiratory

Yes No Shortness of Air
Yes No Cough

Endocrine

Yes No Excessive Thirst
Yes No Always Too Cold
Yes No Always Too Warm

Neuro/ Psych

Yes No Fainting Spells
Yes No Dizziness
Yes No Anxiety/ Depression

Skin

Yes No Rash

Medicine Allergies:

_____

_____

Medications: (Please list all medications, dosages & frequency)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Provider:_____ **Date:**_____

Patient History Form

Name: _____

Date of Birth: _____

Please fill out this form answering all the questions, even if you have filled this form out previously. This information is important to update your history prior to your appointment.

Past Medical History: (Please circle yes or no- Do not leave blank.)

Heart Disease	Yes or No	Lung Condition	Yes or No
Stroke	Yes or No	Thyroid Condition	Yes or No
Heart Attack	Yes or No	Diabetes	Yes or No
Angioplasty/ Stent	Yes or No	Kidney/ Bladder Illness	Yes or No
Open Heart Surgery	Yes or No	Stomach/ Colon Illness	Yes or No
Heart Palpitations	Yes or No	Cancer	Yes or No
Heart Valve Disease	Yes or No		
High Blood Pressure	Yes or No		
High Cholesterol	Yes or No		
If female, have you completed menopause?		Yes or No	

Please list any surgeries you have had:

_____

_____

_____

Family Medical History:

Heart Disease	Yes or No	Father	Mother	Brother	Sister
Diabetes	Yes or No	Father	Mother	Brother	Sister
Stroke	Yes or No	Father	Mother	Brother	Sister
High Blood Pressure	Yes or No	Father	Mother	Brother	Sister

Is your father still living? Yes or No age/ cause of death_____

Is your mother still living? Yes or No age/ cause of death_____

Number of brothers or sisters still living _____

Number of brothers or sisters deceased _____

Social History:

Smoking Yes or No

Past Smoker Yes or No Packs per day_____ Date quit smoking_____

Alcohol Use Yes or No How often_____

In accordance with the HIPPA Guidelines, I hereby authorize Your Family and Heart Care Center with Personalized Prevention to discuss my medical information with the following:

Name	Relationship	Phone
1.		
2.		
3.		

I hereby authorize Your Family and Heart Care Center with Personalized Prevention to leave a detailed message on my answering machine.

Yes_____ Phone Number _____ No_____

Your Family and Heart Care Center with Personalized Prevention is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:

Your Family and Heart Care Center with Personalized Prevention

Name of Patient (Please Print): _____

Patient Signature or Authorized Representative: _____

Date: _____

Primary Insurance

Insurance Company: _____

Policy/ ID Number: _____ Group: _____

Carrier of Insurance: _____

If carrier of insurance is different than patient, please fill out below:

Name: _____

Date of Birth:_____ Social Security Number :_____

Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____

Policy/ ID Number: _____ Group: _____

Carrier of Insurance: _____

If carrier of insurance is different than patient, please fill out below.

Name: _____

Date of Birth: _____ Social Security Number:_____

Relationship to Patient: _____

I hereby assign, transfer, and set over to Your Family and Heart Care Center with Personalized Prevention, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby consent to routine diagnostic procedures and medical treatment provided through Your Family and Heart Care Center with Personalized Prevention and I understand procedures and medical treatment provided through Your Family and Heart Care Center with Personalized Prevention and I understand that no guarantee of results has been made. Patients who fail to present for a scheduled appointment, without contacting the office 24 hours prior to their appointment, will be considered a "no show". A fee of $25.00 will be charged directly to the patient, not the insurance. Patients who are assessed a "no show" fee MUST pay this fee before their next appointment is scheduled.

Patient Signature: _____ Date: _____

Personalized Prevention

Your Family & Heart Care

Rhonda Hettinger DNP,NP-C

Patient Information

Name (First M. Last): _____

Address: _____

City/ State/ Zip: _____

Date of Birth: _____

Social: _____

Sex (Circle One): Male Female

Marital Status (Circle One): Single Married Widowed Divorced

Spouse's Name: _____

Home Telephone: _____

Cell Telephone: _____

Work Telephone: _____

Employer: _____

Email: _____

(Email if you would like us to send you email reminders of appointment)

Emergency Contact Information (Name, Phone Number, Relation and Address):

_____

_____

_____