Patient Information

First Name	Last Name	MI	Date of Birth

Address

City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Email Address

Gender	Marital Status	Race	Preferred Contact
☐ M	☐ Married	☐ American Indian	☐ Mail
☐ F	☐ Single	☐ Asian	☐ Home Phone
	☐ Divorced	☐ Black	☐ Work Phone
	☐ Separated	☐ White	☐ Cell Phone
	☐ Widowed	☐ Other	☐ E-Mail
	☐ Life Partner		☐ Patient Portal

Responsible Party

First Name	Last Name	MI	Date of Birth

Address

City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Emergency Contact

First Name	Last Name	MI	Date of Birth

Address

City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Pharmacy Information

Preferred Pharmacy

Name

Address

City	State	Zip Code

Phone	

Insurance Information

Policy Holder (If not patient)

First Name	Last Name	MI	Date of Birth

Primary Insurance Carrier

Address

City	State	Zip Code

Phone	Policy No.	Group No.

Secondary Insurance Carrier

Address

City	State	Zip Code

Phone	Policy No.	Group No.

Health Information

Current Medications (Include amount, how often, prescription and non-prescription)

Social History

	Currently	In the past	Never	
Drink Alcohol:	☐	☐	☐	How much and how often? _____
Use tobacco products:	☐	☐	☐	How much? _____
Substance abuse:	☐	☐	☐	What substance? _____

Family History

	Mother	Father	Sibling	Maternal G'mother	Maternal G'father	Paternal G'mother	Paternal G'father	N/A
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Thryoid	☐	☐	☐	☐	☐	☐	☐	☐

Surgeries/Hospitializations (including the year)

☐ No surgeries or hospitalizations

Current Symptoms									
General	☐	Fever	☐	Night Sweats	☐	Unexplained Weith Loss of Gain			
	☐	Fatigue							
Skin	☐	Rashes	☐	Cancers	☐	Change in Hair, Skin or Nails			
Eyes	☐	Glasses	☐	Contact Lenses	☐	Pain	☐	Changing Vision	☐ Discharge
Ear Nose	☐	Ear Pain	☐	Hearing Change	☐	Persistent Runny Nose			
Throat	☐	Sore Throat	☐	Change in Voice	☐	Sinus Trouble			
Heart	☐	Chest Pain	☐	Ankle Swelling	☐	Palpatations			
Lung	☐	Cough	☐	Short of Breath	☐	Wheeze			
Gastro-	☐	Nausea	☐	Blood in Stool	☐	Change in Bowel Movements			
Intestinal	☐	Ulcers	☐	Heartburn					
Genito-	☐	Bood in Urine	☐	Painful of Frequent Urination		☐ Incontinence			
Urinary			☐	Sexually Transmitted Disease					
	Women:		☐	Vaginal Discharge	☐	Change in Menstrual Cycle or Sexual Function			
	Men:		☐	Testicular Pain	☐	Decreased Urinary Stream			
			☐	Penile Discharge	☐	Change in Sexual Function			
Orthopedic	☐	Painful Joints	☐	Muscle Weakness					
Nero/Psych	☐	Seizures	☐	Tremor	☐	Paralysis	☐	Frequent Headaches	
			☐	Anxiety					
Allergy	☐	Hives	☐	Hay Fever					
Circulation	☐	Leg Swelling	☐	Blood Clots					

Allergies		No known allergies
1. Medication:	_____	Reaction: _____
2. Medication:	_____	Reaction: _____

Notice of Privacy Practices: Concierge Care, NP

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

Patient Health Information (PHI)

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

How we use your patient health information

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services. In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights

You have certain rights with regard to your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

Our Legal Duty

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area and on our website at www.DoctorsCare.com. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer listed below.You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Concierge Care, NP
Attn: Privacy Office
P.O. Box 183
Eaton, NH 03832

Office of Operations Support
NH Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

Email: privacyoffice@conciergecarenp.com

Authorization for Release of Information

Patient Name: _____ DOB: _____

Concierge Care, NP is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released** Check each that can be given to person/ entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other:
☐ Spouse (provide name & phone number)	☐ Financial ☐ Medical
☐ Parent (provide name & phone number)	☐ Financial ☐ Medical
☐ Email communication (provide email address)*	☐ Financial ☐ Medical ☐ Breach Notification

*In order for email communication to occur, please accept the disclosure below:

_____ I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.
Initial

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

X _____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation)

Financial Policy and Disclosure

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all serviced provided by Concierge Care, NP.