

Advanced Practice Primary Care



*Please review and update the information below to the best of your ability. **

Patient Registration

PLEASE WRITE LEGIBLY

Patient Name: _____ DOB: _____
Last Name First Name

What is your preferred first name? (Nickname, Chosen name, etc) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email address: _____

Preferred Contact Phone Number: ☐ Cell ☐ Home ☐

SSN: _____ (For your identity privacy at Advanced Practice Primary Care LLC and is used solely for that purpose)

For the purposes of Insurance only, number will be strictly confidential

The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Please answer all questions.

What was your assigned sex at birth? What gender do you identify as? What pronoun do you use?

- ☐ Male
- ☐ Female
- ☐ He/Him/His/Her

Interpreter needed? ☐ Yes ☐ No Primary Language: _____

- ☐ Hispanic ☐ Non-Hispanic ☐ Asian ☐ Black ☐ White ☐ Alaskan Native ☐ Pacific Islander
- ☐ American Indian

Homeless Status? ☐ Not Homeless ☐ Homeless ☐ At Risk ☐ Transitional Housing ☐ Living in Shelter

Occupation: _____ Employer: _____

Employment Status (Check one): ☐ Full Time ☐ Not Employed ☐ Part Time ☐ Retired

☐ Seasonal ☐ Self-Employed ☐ Student (Full Time) ☐ Student (Part Time) ☐ Seasonal
☐ Migrant ☐ Neither

Are you a US Veteran? ☐ Yes ☐ No

Primary Care Provider (PCP) Information (Please select one of the following):

☐ I wish to establish Primary Care with Advanced Practice Primary Care LLC

☐ I see Advanced Practice Primary Care as Adjunctive/Additional Care only:

My Primary Care Physician (PCP) is: _____

☐ I do not have a Primary Care Physician and do not wish to establish Primary Care with Advanced Practice Primary Care.

Emergency Contact Name: _____ **Relationship:** _____

Address: _____ **City:** _____ **State** _____

Zip: _____ **Phone:** _____ **Legal Guardian?** ☐ Yes ☐ No

Guarantor (Person who is financially responsible for the account):

Name: _____ **Relationship to the patient:** _____

Address (if different from patient): _____ **City:** _____

State: _____ **Zip:** _____ **Social Security Number:** _____ **Gender:** ☐ M ☐ F

DOB: _____ **Guarantor Primary Language:** _____

Advanced Primary Care Department requires that ***all*** insurance coverage be pre-verified (7 business days) before we are able to bill for you. If this process has not been completed ahead

INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

FAVORITE PHARMACY

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

<input type="checkbox"/> Chickenpox	Date: _____	<input type="checkbox"/> Meningococcus	Date: _____
<input type="checkbox"/> Flu Shot	Date: _____	<input type="checkbox"/> MMR (<i>Measles, Mumps, Rubella</i>)	Date: _____
<input type="checkbox"/> Gardasil/HPV	Date: _____	<input type="checkbox"/> Pneumonia	Date: _____
<input type="checkbox"/> Hepatitis A	Date: _____	<input type="checkbox"/> Tdap (<i>Tetanus and pertussis</i>)	Date: _____
<input type="checkbox"/> Hepatitis B	Date: _____	<input type="checkbox"/> Tetanus	Date: _____
		<input type="checkbox"/> Zostavax (<i>Shingles</i>)	Date: _____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear	Date _____	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Bleeding between periods
Last Mammogram	Date _____	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Heavy periods
Age of first menstrual period:	_____		<input type="checkbox"/> Extreme menstrual pain
Date of last menstrual period or age of menopause:	_____		<input type="checkbox"/> Vaginal itching, burning, or discharge
			<input type="checkbox"/> Wake in the night to go to the bathroom

Number of pregnancies: _____ births: _____ ☐ Hot flashes
 miscarriages: _____ abortions: _____ ☐ Breast lump or nipple discharge
☐ Cesarean sections If yes, then number: _____ ☐ Painful intercourse
☐ Sexually active
 Current sexual partner is ☐ Female ☐ Male
 Do you use condoms ☐ Yes ☐ No
 Other Birth control method used: _____
☐ Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

- | | | |
|-------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Abuse/Domestic Violence | <input type="checkbox"/> Developmental or Behavioral Disorders | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Acid Reflux (GERD) | <input type="checkbox"/> Diabetes - Insulin | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes - Non-Insulin | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Allergies/Hayfever | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Leg/Foot Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Ear or Hearing Problems | <input type="checkbox"/> Meniere's disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Autism Spectrum Disorder (ASD) | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> MRSA exposure |
| <input type="checkbox"/> Back Injury | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Muscle, Joint, or Bone Problems |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> GI Problems | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Birth Defects or Inherited Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bladder or Kidney Problems | <input type="checkbox"/> Has Pacemaker | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Overactive Thyroid |
| <input type="checkbox"/> Blood Clots (or DVT) | <input type="checkbox"/> Head Trauma/Injury | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> Headaches | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pre-Eclampsia |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Breast Problem | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Reflux or Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hiatal Hernia or Reflux Disease | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Congenital Anomalies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thrombophilias |
| <input type="checkbox"/> Congestive Heart Failure (CHF) | <input type="checkbox"/> Hospital Admission Other Than Birth | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Varicosities |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Vision or Eye Problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Other |

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
1. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE? AGE	SIGNIFICANT HEALTH PROBLEMS
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Grandmother (maternal) Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease
		<input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Grandfather (maternal) Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease
		<input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Grandmother (paternal) Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease
		<input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Grandfather (paternal) Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease
		<input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Father Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease
		<input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Mother Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease
		<input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Brother/Sister Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease
		<input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Brother/Sister Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease
		<input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Other: _____ Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease
		<input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke

SOCIAL HISTORY

Education <input type="checkbox"/> Less than 8th grade <input type="checkbox"/> High school <input type="checkbox"/> 2 year college <input type="checkbox"/> 4 year college <input type="checkbox"/> Post graduate	Caffeine <input type="checkbox"/> None <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy # of cups/cans per day? _____ Alcohol Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how often? <input type="checkbox"/> Occasionally <input type="checkbox"/> < 3 times a week <input type="checkbox"/> > 3 times a week How many drinks per week? _____	If not currently, did you ever use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cigarettes - ____pks./day <input type="checkbox"/> Chew - ____ /day <input type="checkbox"/> Cigars - ____ /day <input type="checkbox"/> # of years _____ Or year quit _____
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic partner	Drugs Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list: _____ _____	
Exercise Level <input type="checkbox"/> None (No exercise) <input type="checkbox"/> Occasional exercise <input type="checkbox"/> Moderate exercise <input type="checkbox"/> High level exercise	Tobacco Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	

REVIEW OF SYSTEMS

Please check all that apply:	Ears/Nose/Mouth/Throat	Genitourinary	Neurological
Allergic/Immunologic	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Frequent Sneezing	<input type="checkbox"/> Difficulty Hearing	<input type="checkbox"/> Difficulty Urinating	<input type="checkbox"/> Fainting
<input type="checkbox"/> Hives	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Incomplete Emptying	<input type="checkbox"/> Headaches
<input type="checkbox"/> Itching	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Increased Urinary Frequency	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Urinary Loss of Control	<input type="checkbox"/> Migraines
	<input type="checkbox"/>		<input type="checkbox"/>

<input type="checkbox"/> Sinus Pressure	<input type="checkbox"/> Frequent Infections	<input type="checkbox"/> Easy Bruising/Bleeding	<input type="checkbox"/> Numbness
Cardiovascular	<input type="checkbox"/> Frequent Nosebleeds	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Restless Legs
<input type="checkbox"/> Arm Pain on Exertion	<input type="checkbox"/> Hoarseness	Integumentary (Skin)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Chest Pain on Exertion	<input type="checkbox"/> Mouth Breathing	<input type="checkbox"/> Changes in Moles	<input type="checkbox"/> Weakness
<input type="checkbox"/> Chest Heaviness/Pressure on Exertion	<input type="checkbox"/> Mouth Ulcers	<input type="checkbox"/> Dry Skin	Psychiatric
<input type="checkbox"/> Irregular Heart Beats (Palpitations)	<input type="checkbox"/> Nose/Sinus Problems	<input type="checkbox"/> Eczema	<input type="checkbox"/> Alcohol Overuse
<input type="checkbox"/> Known Heart Murmur	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Growth/Lesions	<input type="checkbox"/> Anxiety/Stress
<input type="checkbox"/> Light-headed on Standing	Endocrine	<input type="checkbox"/> Itching	<input type="checkbox"/> Depression
<input type="checkbox"/> Shortness of Breath When Lying Down	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Jaundice (Yellow Skin/Eyes)	<input type="checkbox"/> Do Not Feel Safe in Relationship
<input type="checkbox"/> Shortness of Breath When Walking	<input type="checkbox"/> Increased	<input type="checkbox"/> Rash	<input type="checkbox"/> Mania
<input type="checkbox"/> Swelling (edema)	<input type="checkbox"/> Thirst/Hunger/Urination	Musculoskeletal	<input type="checkbox"/> Sleep Problems
Constitutional	Gastrointestinal	<input type="checkbox"/> Back Pain	Respiratory
<input type="checkbox"/> Exercise Intolerance	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Cough
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Black or Tarry Stool	<input type="checkbox"/> Muscle Aches	<input type="checkbox"/> Coughing Up Blood
<input type="checkbox"/> Fever	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Weight Gain (____lbs)	<input type="checkbox"/> Change in Appetite		<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Weight Loss (____lbs)	<input type="checkbox"/> Frequent Indigestion		<input type="checkbox"/> Snoring
Eyes	<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Wheezing
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Trouble Swallowing		
<input type="checkbox"/> Irritation	<input type="checkbox"/> Vomiting		
<input type="checkbox"/> Vision Change	<input type="checkbox"/> Vomiting Blood		
Date of Last Exam:_____			

Please add any other information about your health that you would like your provider to know here:

Parent, Guardian, or Caregiver Signature

Date

Advanced Practice Primary Care



HIPAA Privacy and Release of Information Authorization

Patient Name:

Patient DOB:

I, _____ hereby authorize Advanced Practice Primary Care and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Patient Printed Name

Date

Patient Signature

775-683-8239



Pauline.stoltzner@APprimarycare.com



APprimarycare.com



6630 S. McCarran Blvd #A12, Reno NV 89509



of your appointment time, we will provide documentation of your visit to submit to your insurance company. You will be given any applicable discount for your office visit.

Please provide your insurance information below:

Insurance Company: _____

Claims Address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Member ID # _____ Group # _____ Subscriber ID # _____

****Please be prepared to present your insurance card at check-in at each visit****

I authorize the following individual(s) to arrange appointments at Advanced Practice Primary Care LLC

Name: _____ DOB: _____ Relationship to Patient: _____

Name: _____ DOB: _____ Relationship to Patient: _____

To the best of my knowledge the above information is complete and accurate.

Signed _____ **Date:** _____

****Please sign and date each item below****

ACKNOWLEDGEMENT AND AUTHORIZATION:

☐ **I have read and understand the HIPAA/Privacy Policy for Advanced Practice Primary Care LLC**

Signed _____ **Date:** _____

☐ **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

☐ **I authorize Advanced Practice Primary Care LLC to release medical information required to process my claim**

Signed_____ **Date:**_____

☐ **I have read and understand the Financial Policy for Advanced Practice Primary Care LLC**

Signed_____ **Date:**_____

☐ **I authorize Advanced Practice Primary Care LLC to obtain/have access to my medication history**

Signed_____ **Date:**_____

☐ **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____

Advanced Practice Primary Care



Financial Policy Patient Financial Agreement

Advanced Practice Primary Care LLC is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card. Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit.

As a courtesy, Advanced Practice Primary Care LLC will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you. For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you aren't sure, please talk to your insurance member services or one of our staff before scheduling.

For Medicare patients: Medicare Patient's Signature – I authorize payment to be made on my behalf to Summit Medical Clinic for any services provided to me by my provider. I authorize my provider to release to the Health Care Financing Administration and its agents any information needed to determine my benefits. I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

Patient Name: (Print) _____

Patient Signature _____

I have read and I understand Advanced Practice Primary Care financial policies and I accept responsibility for the payment of any fees associated with my care.

This is a legally binding contract between Advanced Practice Primary Care LLC and you. The words, I, me, my, you and your all refer to the patient.

_____ (initial) I agree to be financially responsible for payment of Advanced Practice Primary Care LLC. Cash, check or credit cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. Advanced Practice Primary Care LLC is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ (initial) I agree to give Advanced Practice Primary Care LLC my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Advanced Practice Primary Care LLC the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

_____ (initial) I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 24 hour notice was not given. There will be a fee of \$30.00 for any missed office visits and \$50.00 for any missed office procedures.

_____ (initial) I understand there will be a \$25.00 fee for all returned Checks

_____ (initial) I understand that all services provided to me by Advanced Practice Primary Care LLC are considered medically necessary, if I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.

_____ (initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been

approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) Advanced Practice Primary Care LLC has a contract with my insurance company. Advanced Practice Primary Care LLC will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

_____ (initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Advanced Practice Primary Care LLC my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Advanced Practice Primary Care LLC pursuing any collection means possible.

_____ (initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

_____ (initial) If the reason for my appointment is related to a work injury or auto accident, I agree to give Advanced Practice Primary Care LLC the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that Advanced Practice Primary Care LLC can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit. I have read and I understand Advanced Practice Primary Care LLC financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature

Date

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Advanced Practice Primary Care LLC.

This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document. I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured, I am responsible for the charges of all services provided to me. I authorize Advanced Practice Primary Care LLC to deposit checks received on my account when made out in my name. I have read and I understand Summit Medical Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature

Date