PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Provider initials _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?_____

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

Provider initials _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y / N At what age?
Do you have regular periods? Y / N

Provider initials _____

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, hashish, hash oil					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine—speed, ice, crank					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes □ No □
HEROIN					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes □ No □
OTHER: specify)_____ _____ _____					Yes □ No □

Provider initials _____

HIPAA Compliance /NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.
As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations. **Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

**Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

**Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we already have taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Offer.

**The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any person identifiable by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

**The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

**The right to inspect and copy your protected health information.
**The right to amend your protected health information.
**The right to receive an accounting of disclosures of protected health information.
**The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 1, 2003 and we are required to abide by the terms of this Notice of Privacy Practice currently in effect.

Provider initials _____

We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The US Dept of Health and Human Services Office of Civil Rights 200 Independence Ave. SW Washington, DC 20201 202-619-0257 or 1-800-696-6775

I have reviewed and received a copy a of the HIPAA Compliance /NOTICE OF PRIVACY PRACTICES

Date & Signature:_____

You may print or copy this form for your records

Provider initials _____

HIPAA Privacy Authorization to Release Medical Records

Effective Period

This authorization for release of information covers the period of healthcare from today's date: _____to or all past, present, and future periods.

Extent of Authorization

I authorize the release of my complete health record (including records, symptoms relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
OR
I authorize the release of my complete health record with the exception of the following information:
Mental health records
Communicable diseases (including HIV and AIDS)
Alcohol/drug abuse treatment
Other (please specify)

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign 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.

Signature of patient or personal representative: _____

Date: _____

Provider initials _____

Telemedicine Consult / Treatment Consent

I understand that my health care provider wishes me to engage in a telemedicine consultation /treatment and understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Maurice D. Graham, FNP-BC (Family Nurse Practitioner), providing healthcare services to me via telemedicine.

I attest I am a Maryland or Washington, D.C. resident seeking telemedicine services with

NP-VIP Concierge Svc, LLC.

My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

I understand that I will be responsible for any fees, copayments or coinsurances that apply to my telemedicine visit.

I have had a direct conversation with my health provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

As long as this consent is in force (has not been revoked) Maurice D. Graham FNP- BC (Family Nurse Practitioner) may provide health care services to me via telemedicine without the need for me to sign another consent for treatment and I may revoke my consent orally or in writing at any time by contacting NP-VIP Concierge Svc, LLC, at mauricegraham@np-vipconierge.com and may have a copy of this consent form

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me and I fully understand its contents including the risks and benefits, and that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Provider initials _____

Date :_____

Signature: _____

Provider initials _____

Consent for Treatment:

By signing this form, I authorize NP-VIP Concierge Svc, LLC, practitioners and staff to evaluate and treat urgent, primary care and telemedicine medical conditions.

Financial Obligations: Payment is due in full at the time service is provided by NP-VIP Concierge Svc, LLC. We accept cash, debit and credit cards. We will bill certain insurance carriers with the insurance information you provide. NP-VIP Concierge Svc, LLC does not accept all insurance plans and any payment due for services is the patient's responsibility. Any co-payments or office fees are due at the time of service. We are contracted only with a few insurance carries, and it is the patient's responsibility to ensure we are covered with the patient's insurance plan. If we do not carry your insurance plan you may be able to submit your receipts to your insurance company, however you will need to contact your insurance plan. Once your claim has been processed, any outstanding balance will be your responsibility. For uninsured patient's payments will be due in full at the time of service or pre-approved payment arrangements can be made.

Referrals: Proper insurance documentation and any required referrals and pre-authorizations is the responsibility of the patient. In the absence of appropriate referrals or pre-authorization, you agree to accept full responsibility for any charges related to the services performed by NP-VIP Concierge Svc, LLC. Additionally, if services are rendered which are outside the scope of your referral or authorization, you accept full responsibility for these charges.

Laboratory Fees: You may be referred to an outside laboratory for tests. These fees will be billed to your insurance (if we are contracted with your insurance) or to you by the laboratory. It is the patient's responsibility to use a laboratory contracted by your insurance provide (if we are contracted with your insurance) If a tissue sample needs to be read by a dermatopathology's, you may be charged and be responsible for those additional services.

Authorization for Release of Medical Records: I authorize the release of medical records and information necessary to process insurance claims for medical and surgical benefits.

Minor Patients: The accompanying parent/legal guardian of the minor child will be responsible for payment at the time of service, and for the minor's account balance.

Delinquent Accounts and Collections: If a patient has not made payments on their account for 90 days, that account is considered delinquent and the patient will not be scheduled for any future appointments until the account is current. Delinquent accounts may be turned over to a collections agency, and you understand that you will be charged for, and herby agree to pay, all costs and expenses incurred in collecting any past due fees.

Missed Appointments: If you need to cancel your scheduled appointment we require 24-hour notification (one business day). Patients may be charged $50.00 for a missed appointment. If a missed appointment fee is applied, future appointments will not be scheduled until the missed appointment fee is paid in full. If you miss two appointments within a 12-month period and/or do not comply with the appropriate cancelation notification procedures as listed above, we may not continue to see you as a patient.

Taking of Photographs: I consent to the taking of a series of photographs along with pertinent information pertaining to these pictures for my practitioner's use for: documenting your medical records; educational lecturing; or submit to appropriate sources for research purposes.

Consent to Contact via Email: I acknowledge NP-VIP, Concierge Svc, LLC will contact me via unencrypted email with the email address I listed for the following reasons: appointments, patient portal access, products and services. Lab results or medical information will not be sent in an email,

Provider initials _____

and it is highly encouraged you call the office with any concerns and DO NOT submit medical questions or concerns via email.

With your signature, you verify that you have read, understand, and agree to comply with the above consents and policies. I have had adequate opportunity to discuss any procedures with my provider and have read and accept the risks/benefits.

Signature & Date: _____

Provider initials _____