

**Patient Information**

Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_  
First MI Last

Male  Female Date of Birth: \_\_\_/\_\_\_/\_\_\_ Marital Status  Single  Married  Divorced  Widowed

Address: \_\_\_\_\_  
Street Address City State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell/Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Occupation: \_\_\_\_\_  
Required for Worker's Compensation

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Name Relationship to patient

**Physician Information**

Referring Physician: \_\_\_\_\_ Date of next MD Appt: \_\_\_/\_\_\_/\_\_\_

Primary Care Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Friend or Patient \_\_\_\_\_

**Appointment Policy**

I understand that my practitioner is treating me as a patient and will need my consistent attendance to be effective. I understand that if I am late for my appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three consecutive appointments, I will be discharged for being non-compliant with my physician's orders and plan of care.

I understand and agree that Carol Pelletier APRN,DNP requires a 24-hour advance notice of cancellation. I also understand I will be charged \$25.00 for each missed appointment if not cancelled 24 hours in advance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under 18 years of age)  Mother  Father  Legal Guardian

**Authorization For Treatment**

I hereby consent to and authorize all therapy treatments/services, which may be considered necessary for the diagnosis and/or treatment of the patient named above at Carol A Pelletier APRN,DNP.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under 18 years of age)  Mother  Father  Legal Guardian

**Financial Policy and Insurance Information:**

I understand and agree that all insurance claims will be directly submitted to my PRIMARY insurance company on a weekly basis as a matter of convenience, and that I am ultimately responsible for the balance in full. Carol Pelletier APRN,DNP is not responsible for deductibles or copayments. I also understand I am responsible to pay my patient balance, as well as any charges denied by my insurance company on a WEEKLY BASIS.

I understand I will receive a statement of activity each month and payment is expected upon demand. If payments are not received within 30 days from the last date of service patient will than charged at late fee of \$ 25.00 for each thirty day late payment is.

If your injury is a result of a motor vehicle accident we will send claims to your health insurance or your personal motor vehicle insurance company, however if you choose to use your health insurance you will be responsible to pay all co-pays, deductibles and coinsurances at the time of treatment. Carol Pelletier APRN,DNP will not wait for payment of services contingent upon a settlement.

If your injury is a result of a workers compensation claim, we will verify that the claim is open. If the claim is in process or pending, you must provide us with other payment options, such as your health insurance. If a claim is denied, we will bill your health insurance and you are responsible for all co-pays, deductibles and coinsurances.

I agree to the financial policy outlined above, and authorize the release of medical information pertaining to my treatment to the payer or health practitioner involved in my care. I also authorize payment of insurance benefits to be paid directly to Carol Pelletier APRN,DNP for services rendered.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under 18 years of age) Mother Father Legal Guardian

**Primary Insurance:**

Name of Subscriber: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber's relationship to patient: Self Spouse Parent Other

Address of subscriber: \_\_\_\_\_  
If subscriber address is different than patient

Subscriber Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Patient ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

**Secondary Insurance:**

Name of Subscriber: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber's relationship to patient: Self Spouse Parent Other

Address of subscriber: \_\_\_\_\_  
If subscriber address is different than patient

Subscriber Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Patient ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

## Medical History

Allergies	Y	N	Depression	Y	N	Multiple Sclerosis	Y	N
Anemia	Y	N	Diabetes	Y	N	Osteoporosis	Y	N
Anxiety	Y	N	Dizzy Spells	Y	N	Parkinson's	Y	N
Arthritis	Y	N	Emphysema/Bronchitis	Y	N	Rheumatoid Arthritis	Y	N
Asthma	Y	N	Fractures	Y	N	Seizures	Y	N
Cancer	Y	N	Gallbladder Problems	Y	N	Speech Problems	Y	N
Cardiac Condition	Y	N	Hepatitis	Y	N	Stroke	Y	N
Cardiac Pacemaker	Y	N	High Blood Pressure	Y	N	Thyroid Disease	Y	N
Chemical Dependency	Y	N	Incontinence	Y	N	Tuberculosis	Y	N
Circulation Problems	Y	N	Kidney Problems	Y	N	Vision Problem	Y	N
Currently Pregnant	Y	N	Metal Implants	Y	N	Allergic to Latex	Y	N

Do you smoke? Y/N                      Are you on blood thinners? Y/N

Please describe or explain any other conditions or precautions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### History of Falls

Have you been injured as a result of a fall in the last year? Y/N      Date of fall: \_\_\_\_\_

Have you had two or more falls in the last year? Y/N                      Dates of falls: \_\_\_\_\_

### Current Medications

Please list all current medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Surgical History

Please list all past surgical procedures and the date of surgery: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices:**

Carol Pelletier APRN,DNP . reserves the right to modify the privacy practices outlined in the notice.

I, \_\_\_\_\_ have received a copy of the Notice of Privacy Practices for Carol Pelletier APRN,DNP

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: (If patient is under 18 years of age)  Mother  Father  Legal Guardian  
Carol Pelletier APRN,DNP . reserves the right to modify the privacy practices outlined in the notice.

**Authorization For Release of Information**

I authorize the release of information during the course of my treatment at Carol Pelletier APRN,DNP . reserves the right to modify the privacy practices outlined in the notice. I \_\_\_\_\_ have received a copy of the Notice of Privacy Practices for Carol Pelletier APRN,DNP

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under 18 years of age)  Mother  Father  Legal Guardian , Inc.  
including but not limited to medical records, verbal and written communications to my insurance company, doctors and third party payers.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under 18 years of age)  Mother  Father  Legal Guardian