Carol A. Pelletier
APRN, DNP, PLLC

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Phone:603-577-1613 • Fax: 603-809-4934
www.carolpelletier.com

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 of Current Injury:_____

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

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL

Authorization For Treatment

I hereby consent to and authorize all treatments/services, which may be considered necessary for the diagnosis and/or treatment of the patient named above at 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

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 they are subject to a penalty of 1.5% a month or a collection fee.

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 co-insurances 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: _____

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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: _____

_____

_____

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Acknowledgement of Receipt of Notice of Privacy Practices

Carol A. Pelletier, APRN, DNP, LLC 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 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

Authorization For Release of Information

I authorize the release of information during the course of my treatment at Carol A. Pelletier, APRN, DNP, LLC 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