Barbara A. White, MSN, CRNP — Patient Registration Record

PLEASE PRINT CLEARLY

Patient Name: _____
LAST FIRST MIDDLE

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____
month/day/year

Home Phone: _____ Work Phone: _____ Social Sec. #:_____

Responsible Party: _____
LAST FIRST MIDDLE

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Driv. Lic. #: _____

INSURANCE INFORMATION

Insurance Company: _____ ID#: _____ Group #: _____

Subscriber's Name: _____
LAST FIRST MIDDLE

Medicare #: _____ Medicaid #: _____ Med Assistance #: _____

Is this a legal case? ☐ Yes ☐ No Is this a Worker's Comp Case? ☐ Yes ☐ No

Date of Accident/Injury: _____ Employer at Time of Accident/Injury: _____

Auto Insurance Company: _____ Policy #: _____

Insur. Co. Address: _____ Claim #: _____

Attorney Name: _____ Attorney Phone: _____

Attorney Address: _____

NOTE: IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST ANSWER AND SIGN FORM

I, _____, hereby authorize **Barbara A. White, MSN, CRNP**, to apply for benefits on my behalf for services rendered to me (or my minor
(PRINT your name here)
child) and request that payment be made by _____ Insurance Company and that payments be sent directly to **Barbara A. White, MSN, CRNP**.
(print name of Ins. Co. here)
I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me (or my minor child) if my account is turned over to an attorney for collection. I agree to pay all/any reasonable legal fees (25% is deemed reasonable), court costs, and other expenses incurred as a result of said collection. The undersigned agrees that should suit be filed, venue (location of) shall be in Prince George's County, Maryland, venue in any other counties being waived hereby. I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of information relating to any claim for benefits, in order to process any claim for benefits. Furthermore, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

I understand that if I fail to show up for an appointment or cancel an appointment with less than 24 hours' notice, I will be charged $26.00.

_____ _____

SIGNATURE (by patient or responsible party) **DATE**

MEDICAL HISTORY FORM

PLEASE PRINT Date: _____

Patient Name: _____ DOB: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Work Phone: _____ Other Phone: _____
Driver's License Number: _____ Social Security Number: _____
Sex (Circle): Male Female

Do you have allergies to medications, X-Ray dyes, or other substances? ☐ Yes ☐ No
If yes, please list the name of the substance and type of reactions below.

Medication or Substance **Type of Reaction**
_____
_____
_____

Past Medical History & Review of Systems
Please circle if you have had problems with or are currently experiencing any of the following:

1. High Blood Pressure	13. Bronchitis	25. Ulcers	37. Arthritis
2. Diabetes	14. Pneumonia	26. Change in bowel habits.	38. Low Back Problems
3. Cancer	15. Persistent Cough	27. Unexplained weight loss or gain.	39. Skin Diseases
4. Heart Disease	16. T.B.	28. Hemorrhoids	41. Blood Disorders
5. Chest Pain or Tightness	17. Hay Fever	29. Gall Bladder Disease	42. Venereal Diseases
6. Shortness of Breath	18. Abdominal Discomfort	30. Colitis	43. Anxiety
7. Swollen Ankles	19. Indigestion	31. Hepatitis or Jaundice	44. Depression
8. Palpitations	20. Nausea	32. Thyroid Disease	45. Anemia
9. Lightheadedness	21. Vomiting	33. Head or Neck Radiation	46. Alcohol Abuse
10. Frequent Urination	22.Constipation	34. Headache	47. Drug Abuse
11. Rheumatic Fever	23. Diarrhea	35. Kidney Disease	48. Gout
12. Asthma	24. Blood in Stool	36. Kidney Stones	49. Other

Gynecologic and Obstetric History:
Age at onset of period: _____ Frequency: _____ Length of Period: _____
Pregnancies: _____ Births: _____ Miscarriages: _____
Prolonged or abnormal bleeding: ☐ Yes ☐ No If yes, please explain: _____
Leakage of urine: ☐ Yes ☐ No If yes, please explain: _____
Pelvic Pain: ☐ Yes ☐ No If yes, please explain: _____
Abnormal discharge: ☐ Yes ☐ No If yes, please explain: _____

Please List and Supply Dates of:
Surgeries: _____
Hospitalizations other than for surgery: _____

Immunization History:
Hepatitis B ☐ No ☐ Yes When: _____ Pneumovax ☐ No ☐ Yes When: _____
Tetanus ☐ No ☐ Yes When: _____ Flu Vac ☐ No ☐ Yes When: _____
Other: ☐ No ☐ Yes When: _____ Pneumovax ☐ No ☐ Yes When: _____

When was your last:
Pap Smear: _____ Breast Exam: _____ Stool Check (for Blood): _____
Mammogram: _____ Cholesterol Check: _____ Prostate Exam: _____

PLEASE PRINT

Patient Name: _____ DOB: _____

Family History: Please indicate if any member of your family (including parents, grandparents, and siblings) ever had any of the following:

Illness	Which family members?	Approx. Age When Diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Stroke		
Mental Illness (depression, anxiety)		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Diseases		
Other:		

Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dosage	Drug Name	Dosage

Prevention and Other Information:

Do you wear seatbelts?	☐ Yes ☐ No	If no, why not?
Do you wear a bike helmet?	☐ Yes ☐ No	☐ Not Applicable
Do you smoke?	☐ Yes ☐ No	If yes, how many packs per day?
Do you drink alcoholic beverages?	☐ Yes ☐ No	If yes, how much per week?
Do you drink coffee?	☐ Yes ☐ No	If yes, how many cups per day?
Do you drink tea?	☐ Yes ☐ No	If yes, how many cups per day?
If there is a gun in your home, is it out of children's reach and unloaded?	☐ Yes ☐ No	☐ Not Applicable
Do you use drugs? (pot, cocaine, etc.)	☐ Yes ☐ No	If yes, explain:
Have you ever engaged in any activity that has put you at risk of getting AIDS?	☐ Yes ☐ No	☐ I'm not sure. If yes, please explain:
Do you wish to be tested for AIDS?	☐ Yes ☐ No	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	☐ Yes ☐ No	☐ I'm not sure. If yes, please explain:
Are you in a relationship in which you have been physically hurt (slapped, kicked, punched, bruised, forced to have sex) by your partner?	☐ Yes ☐ No	
Do you ever feel afraid of your partner?	☐ Yes ☐ No	
Do you have a living will?	☐ Yes ☐ No	
Do you have an organ donor card?	☐ Yes ☐ No	

Barbara A. White, MSN, CRNP **Medication Sheet**

NAME:	**ALLERGIES**
DOB:	
HOME #:	**PHARMACY #:**
WORK #:	

MEDICAL DIAGNOSIS	START	MEDICATIONS	STOP
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

FAMILY HISTORY	
HTN	
DM	
CANCER	
HEART DISEASE	
STROKE	
ASTHMA	
GLAUCOMA	
MENTAL	
OTHER	

SCREENING	07	08	09	10
MAMMOGRAM				
PAP SMEAR				
HEMOCCULT				
PSA				
SIG/COLONOSCOPY				
EKG				

DIAGNOSTIC	Date	Date	Date	Date
CXR				
UGI				
SONO				
CT SCAN				
MRI				

IMMUNIZATIONS	07	08	09	10
TETANUS				
FLU SHOT				
PNEUMOVAX				
HEPATITIS B				
VARICELLA				

COMMENTS	No	Yes
TOBACCO		
COFFEE		
ETOH		
DRUGS		

✓ = Normal ✕ = Abnormal

Barbara A. White, MSN, CRNP

CONSENT TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION (PHI)

USE AND DISCLOSURE OF YOUR PHI:
Your protected health information (PHI) will be used only by **Barbara A. White, MSN, CRNP,** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR PHI:
You may request a restriction on the use or disclosure of your PHI. If **Barbara A. White, MSN, CRNP,** agrees to your request, the restriction will be binding to the practice. Use of disclosure of PHI in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT:
You may revoke this consent to the use and disclosure of your PHI. You **must** revoke this consent **in writing**. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

NOTICE OF PRIVACY PRACTICES:
You have received the Notice of Privacy Practices with a complete description of how your PHI may be used or disclosed.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES:
Barbara A. White, MSN, CRNP, reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices and have reviewed this consent form and give my permission to Barbara A. White, MSN, CRNP, to use and disclose my health information in accordance with it.

Name of Patient: _____

Signature of Patient: _____

Date: _____ Social Security #: _____

Name of Patient's Representative: _____

Signature of Patient's Representative: _____

Relationship of Representative to Patient: _____

13 C Street, Suite G, Laurel, MD 20707
www.barbarawhitecrnp.com
barbcrnp1@yahoo.com
Phone: 301-617-2767
Fax: 301-617-3971
Pager: 301-441-0925

Barbara A. White, MSN, CRNP

LATE CANCELLATION & REFERRAL POLICIES

LATE CANCELLATION POLICY:
We understand that an emergency may occur and may result in you missing your appointment or having to cancel an appointment. If such an emergency happens, we will be glad to reschedule your appointment within the same business week (when it's possible to do so). However, if you fail to arrive for a scheduled appointment or if you cancel an appointment with less than 24 hours' notice **and do not reschedule and keep the rescheduled appointment** within the same business week, you will be charged a $26.00 cancellation fee.

REFERRAL POLICIES:
If you require a referral to see a specialist, we require 48 hours' notice to complete the referral (except for life-threatening emergencies).

I have received a copy of the Late Cancellation and Referral Policies and I understand that if I fail to show up for an appointment or cancel an appointment with less than 24 hours' notice, I will be charged $26.00 (unless the appointment is rescheduled and kept within the same business week). I also understand that Barbara A. White, MSN, CRNP, reserves the right to modify the policies outlined in this notice.

Name of Patient: (Please Print) _____

Signature of Patient: _____

Date: _____

Copy Provided by: (staff initials) _____

OR

Name of Patient's Representative: (Please Print) _____

Signature of Patient's Representative: _____

Relationship of Representative to Patient: _____

Date: _____

3/5/08

13 C Street, Suite G, Laurel, MD 20707
www.barbarawhitecrnp.com
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Phone: 301-617-2767
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Barbara A. White, MSN, CRNP

Notice of Privacy Practices

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

1. OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION (PHI)

The privacy of your PHI is important to us. We understand that your PHI is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share your PHI. We also describe your rights and certain duties we have regarding the use and disclosure of PHI.

2. OUR LEGAL DUTY

The law requires us: to keep your PHI private; to give you this notice describing our legal duties, privacy practices, and your rights regarding your PHI; to follow the terms of the notice that is now in effect. We have the right: to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law; to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we keep, including information previously created or received before the changes. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR PHI

The following section describes different ways that we use and disclose PHI. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose PHI. We will not use or disclose your PHI for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

We may use your PHI: to provide you with medical treatment or services – We may disclose your PHI to doctors, nurses, technicians, medical students, and health care providers to assist them in treating you; for payment purposes; for Health Care Operations (such as improving quality of our services, conducting training programs, evaluating the performance of employees); for appointment reminders; and for providing information about treatment options or health-related benefits or services. We may also release your PHI to a friend or family member that is involved in your care. We may also disclose your PHI to a family member or friend as directed by you. Finally, our office will disclose your PHI when required to do so by federal, state, or local law (as in the case of information about the abuse of a child or dependent adult).

SPECIAL CIRCUMSTANCES

We may use or disclose your PHI when public health risks may be involved. This may include (but are not limited to) reports to prevent or control disease, reports regarding reactions to medications or problems with products, and notification(s) to individuals who may have been exposed to a disease, reports to Worker's Compensation programs, and reports for Health Oversight Activities (for example, audits, investigations, inspections).

Other special circumstances may include:

Lawsuits: If you are involved in a lawsuit, our office may release your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protesting the information requested.

Deceased Patients: We may release your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation: We may release your PHI to organization that handles organ or tissue transplantation as necessary to facilitate the donation if you are an organ donor.

Military Members and Veterans: If you are a member of the armed forces, we may release your PHI as required by military command authorities.

Inmates: We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care services to you, to provide for the safety and security of the institution, or to protect your health and safety or the health and safety of other individuals.

OTHER USES OF PHI

Our office will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. Please note: We are required by law to retain records of your care.

YOUR RIGHTS CONCERNING YOUR PHI

You have a right:

1. To inspect and obtain a copy of your medical records from my office for as long as the information is obtained. This request must be in writing. You may get the form to request access by using the contact information listed at the end of this notice or by sending a letter to the contact person listed at the end of this notice. If you request copies, we reserve the right to charge a nominal fee for each page as well as for postage (if you want the copies mailed).
2. To receive an account of any disclosures we have made regarding your PHI for purposes other than treatment, payment, health care operations, and other specified exceptions.
3. To request restrictions on certain uses and disclosures of your PHI. I have the option to agree or disagree with these restrictions.
4. To request and receive confidential communication and information from me by alternative means and/or at an alternative address. This request must be made in writing to the contact person listed at the end of this form.
5. To request an amendment of your PHI (deleted, modified, or added). I may deny this request if I determine that the information is complete and accurate.
6. To have any complaints you make about my policies or procedures recorded in your PHI.

QUESTIONS OR CONCERNS

Feel free to address any questions or concerns regarding your PHI without fear of prejudice or reprisal. You have the right to file a complaint with the Maryland Board of Nursing and with the Secretary of the U.S. Department of Health and Human Services.

If you have questions regarding this notice, please contact:
Barbara A. White, MSN, CRNP, 13 C Street, Suite G, Laurel, MD 20707; 301-617-2767.