LaTonya Carroll, DNP, APRN
3702 Perry Ave, Kensington, MD 20894 Phone: (410) 870–HTIP / Fax: (410) 390–8591
1391 W. 5th Ave, #241, Columbus, OH 43212 Phone: (614) 569–8940 / Fax: (614) 375–4130

Patient Demographic and Insurance Intake Form

Last Name: _____ First name: _____ MI: _____

DOB: _____ SS #: _____ Sex: _____ Marital Status _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____@_____ Referred by: _____

Insurance Information

Primary Insurance Co: _____ ID #: _____ Grp #: _____

Secondary Ins Co: _____ ID #: _____ Grp #: _____

Policy Holder name: _____ ID #: _____

Policyholder DOB: _____ Policy holder address: _____

Policyholder SS #: _____ Policyholder Sex: _____ Copay Amount: _____

Patient Authorization

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services rendered.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor) _____ Date: _____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain verification of LaTonya Carroll, DNP, APRN as my primary care provider (PCP). I understand that if I do not have LaTonya Carroll, DNP, APRN on file as my PCP that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non–covered expenses by my insurer.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor) _____ Date: _____

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Medical History

Last Name: _____ First Name: _____

DOB: _____ Date: _____

Have you ever been diagnosed or treated for the following? (if yes, please specify)

Yes or No Heart Disease? _____
Yes or No High blood pressure? _____
Yes or No Lung Cancer? _____
Yes or No Cancer? _____
Yes or No Diabetes? _____
Yes or No Thyroid disease? _____
Yes or No Kidney disease?_____
Yes or No Gastrointestinal disease? (stomach, colon, liver, etc) _ _____
Yes or No Infectious diseases? (hepatitis, T.B., AIDS, Lyme) _____
Yes or No Major Surgery? _____
Yes or No Difficulty with healing of wounds? _____
Yes or No Any keloids, bad scars or excessive bleeding? _____

Do you have a history of:		Is there a family history:
Asthma?	Yes or No	Yes or No
Hives?	Yes or No	Yes or No
Eczema?	Yes or No	Yes or No
Psoriasis?	Yes or No	Yes or No
Skin cancer?	Yes or No	Yes or No

Other skin disorders? _____

Are you allergic to any medications? (if so, please list) _____

Are you taking any medications including vitamins and supplements? (if so, please list) _____

_____

Are you pregnant or nursing? (if applicable) _____

Do you have a need for antibiotics prior to surgery or visiting the dentist? _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature (if applicable): _____ **Date:** _____

Relationship to Patient (if applicable): _____

(Revised 1/19)

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HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organizations Privacy officer to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (printed): _____

Signature: _____ Date: _____

Relationship to Patient (if minor): _____

Consent for Evaluation and/or Treatment

By signing below, I am giving my consent to the practice of Health, Travel, Immunizations, and Physicals for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/or treatments and given the option to accept or decline.

Patient Name (printed): _____

Signature: _____ Date: _____

Relationship to Patient (if minor): _____

(Revised 1/19)

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Contact Information

May we leave a message concerning your test results…….

On your answering machine/voicemail ? **Yes** or **No**

Office/Work Voicemail? **Yes** or **No**

With another Person? **Yes** or **No**

Please list the person(s) with whom we can discuss your protected health information?

_____

_____

_____

_____

Cancellation Policy

In order to serve our patients better, we have instituted a cancellation policy. We require 24 hour notice for all cancellations. As a courtesy, reminder calls are made 2 days before your appointment to allow for you to contact us in the event you need to cancel or reschedule your appointment. We ask that you provide us with the same courtesy. If an appointment is missed, cancelled or rescheduled without 24 hour notice there will be a $25.00 charge billed to the patient. By signed below I am acknowledging that I have been notified of the cancellation policy.

Patient Signature: _____**Date**: _____

Parent/Guardian Sig. (if applicable): _____ **Date**: _____

Relationship to Patient (if applicable): _ _____