Affinity Family Health Wellness

Jamee Baltzell, APRN, NP-C  Jamie Niemerg, APRN, CPNP

1108 N East Street, Olney, IL 62450

Phone: (618) 429-9470 | Fax: (833) 944-2035

# NEW PATIENT REGISTRATION

**New Patient Information**

Today's Date: _____

Full Name: _____ Date of Birth: _____

SSN: _____ Race: _____ Gender: ☐M ☐ F

Address/City/State: _____ Home Number: _____

Email Address: _____ Mobile Number: _____

Employer Name: _____

**Emergency Contact Information**

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

**If you are registering a minor (17 years or younger) complete below**

Name of guardian: _____

Relationship to child: _____ Phone Number: _____

Address (if different than above): _____

**Insurance information**

Primary Insurance: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Policy Number: _____ Group Number: _____

**I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical or surgical benefits to include all major medical benefits to which I am entitled to Affinity Family Health & Wellness, PLLC photocopy is considered valid. I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges.**

_____ _____

Signature of Patient or Patient Representative  Date

Affinity Family Health Wellness
Jamee Baltzell, APRN, NP-C Jamie Niemerg, APRN, CPNP
1108 N East Street, Olney, IL 62450
Phone: (618) 429-9470 | Fax: (833) 944-2035

Thank you for choosing Affinity Family Health & Wellness located at 1108 N. East Street, Olney IL 62450. To assure we have all the necessary information to assess your health care needs, and secure your appointment, we ask patients to complete the following items PRIOR to being scheduled for a new patient appointment with our office.

- All paperwork must be completed, signed and returned to our office.
- Signed authorization to release medical records from previous PCP/Specialists/Hospitals
- Photo ID/Driver's license (required at every visit)
- Insurance card or current Illinois Medicaid card (required at each visit)
- Power of Attorney, Living Will, Guardianship documentation (if applicable)
- Complete the Patient Portal form (if you have an email address)
- List of specialists you currently see

The following items are required on the day of your appointment:

- ❏ Insurance card(s) and photo ID
- ❏ All current medications in their original bottles
  - ❏ Please note: No refills will be given for medications that are not presented at appointment
  - ❏ ***Please allow 48 business hours for all medication refills***
- ❏ All co-pays are expected at the time of visit

We appreciate your business and respectfully ask:

- Cell phones be silenced while patients are being seen by our providers
- No smoking or firearms are allowed on the property
- Showing up late for a scheduled appointment may result in cancellation of that appointment. (Please see No show/Cancellation policy on page 3)
- ***Two no-call/no-show appointments will result in discontinuation of my treatment relationship with the Provider and Group.***
- Patients should be advised it is not the practice of our providers to prescribe long-term narcotics or benzodiazepines. The need for use of these types of medications will be determined on a case-by-case basis. If these medications are prescribed, you will be asked to sign a controlled substance agreement.

I have read and agreed to the above requirements for my new patient appointment.

_____ _____

Signature of Patient or Patient Representative Date

Affinity Family Health Wellness
Jamee Baltzell, APRN, NP-C Jamie Niemerg, APRN, CPNP
1108 N East Street, Olney, IL 62450
Phone: (618) 429-9470 | Fax: (833) 944-2035

# FINANCIAL POLICY

Thank you for choosing Affinity Family Health & Wellness, PLLC as your healthcare provider. In an effort to provide affordable, quality healthcare and avoid confusion/misunderstanding, we have adopted the following Financial Policy and require you to read and sign it prior to the commencement of any treatment.

**Insurance – all patients**

We cannot bill your insurance company unless you give us current and valid insurance information. As a courtesy to you, we will file claims for those plans with which we have an agreement. Please be advised that you are ultimately financially responsible for payment of medical services rendered by this clinic. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. Affinity Family Health & Wellness, PLLC does not bill any third-party insurers. If you received services that are payable by a third-party insurer, you will be charged the appropriate amount from our standard fee schedule, and are responsible for payment at the time of service.

**Non-insured patients**

If you have insurance coverage with a plan with which we do not participate or you have no health insurance plan, our charges for your care and treatment are due at the time of service. We offer a competitive cash fee schedule for our patients with no insurance.

**Deductibles/Co-pays**

Our insurance contracts require us to collect deductibles and co-pays at the time of service.

**Appointments**

We strive to provide the best possible service and availability to all of our patients***. Our policy is to charge $25 for missed appointments unless canceled at least 24 hours in advance. Two no-call/no-show appointments or two late cancellations (any cancellation of appointment after the time it was scheduled) will be considered a violation of this contract and result in discontinuation of my treatment relationship with the provider and group.*** Please help us serve you better by keeping your scheduled appointments or by calling as early as possible to cancel.

**Paperwork Services**

Any paperwork filled out by our providers (ex: Short-term disability or FMLA) are subject to a $25 charge.

**Medical Record Copies**

Copies of medical records for personal use or for parties other than your insurance company or other physicians involved with your care are subject to a $25 charge.

**Returned Checks**

All checks returned from the bank for non-payment are subject to a $25 charge.

**This financial policy supersedes all prior written financial policies, contracts, or verbal agreements.

_____ _____

Signature of Patient or Patient Representative Date

Assignment of Benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE TO AFFINITY FAMILY HEALTH & WELLNESS, PLLC FOR ANY SERVICES PROVIDED BY THE PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

_____ _____

Signature of Patient or Patient Representative Date

Affinity Family Health Wellness
Jamee Baltzell, APRN, NP-C Jamie Niemerg, APRN, CPNP
1108 N East Street, Olney, IL 62450
Phone: (618) 429-9470 | Fax: (833) 944-2035

# CONSENT TO TREAT

Patient Name: _____ Date of Birth: _____

Address/City/State: _____ Contact Number: _____

**Consent to Treatment:**

I authorize and request that Affinity Family Health & Wellness, PLLC provide medical services determined to be clinically appropriate for myself, the patient. By signing below, I certify that I have read and understand the terms stated in the Treatment Consent Form and Release and Authorization Form. I fully understand the scope of services, fees, cancellation/no-show policies, payment policy, insurance reimbursement and I agree to abide by the terms stated throughout the course of our therapeutic relationship.

**Consent to Treatment of Minors:**

I authorize and request that Affinity Family Health & Wellness, PLLC provide medical services determined to be clinically appropriate for my child. I hereby represent that I have the legal authority to obtain medical treatment for the minor child for whom I am requesting treatment. I am a biological parent or the legal guardian. If group home or foster family settings, I am designated to authorize treatment. If divorced, I am the primary custodial parent and can secure treatment without the authorization of the other parent.

**Limits of Relationship and Liability:**

I understand that communications between a client and the clinician are confidential and protected by law. I also understand that expectations include when a client is a danger to themselves or others, or when there is a reasonable suspicion of sexual or physical abuse, child or elder abuse, then, by the Illinois State Law, Affinity Family Health & Wellness, PLLC, is obligated to report the information to the Illinois Department of Child and Family Services. Other exceptions include when a court of law orders the information or when information is shared with your insurance company to process your claims.

_____ _____

Signature of Patient or Patient Representative Date

Relationship to patient (if patient not signing):

Reason patient did not sign: ☐Patient is a Minor (Under 17) ☐Other (specify)

Affinity Family Health Wellness
Jamee Baltzell, APRN, NP-C Jamie Niemerg, APRN, CPNP
1108 N East Street, Olney, IL 62450
Phone: (618) 429-9470 | Fax: (833) 944-2035

# ACKNOWLEDGMENT OF PRIVACY PRACTICES, HIPAA AND PERMISSION TO LEAVE MESSAGES

Patient Name: _____ Date of Birth: _____

**I acknowledge that I have received and/or reviewed a copy of Affinity Family Health & Wellness, PLLC Notice of Privacy Practices and HIPAA.**

**I, _____, direct my health care and medical services providers and payers affiliated with Affinity Family Health & Wellness to disclose and release my protected health information described below to:**

You may leave a message at this number _____

You may leave a message at this email address _____

You may leave a message with my spouse, _____ at this number _____

You may leave a message with another person, _____ at this number _____

Health information to be disclosed upon the request of the person named above:

☐Complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment and billing for all conditions)

**OR Disclose only the following selected portions of my health record to the above listed person(s):**

☐Appointment date/time/provider

☐Labs, x-rays, and other test results

☐Prescriptions

☐Billing or insurance matters

☐Other (please list): _____

This authorization shall be effective for one year from the date listed below unless I revoke it. (NOTE: You may revoke this authorization at any time by notifying your healthcare provider.)

_____ _____

Signature of Patient or Patient Representative Date

Affinity Family Health Wellness

Jamee Baltzell, APRN, NP-C  Jamie Niemerg, APRN, CPNP

1108 N East Street, Olney, IL 62450

Phone: (618) 429-9470 | Fax: (833) 944-2035

# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

*All questions contained in this questionnaire will become part of your medical record.*

Patient Name: _____ Date of Birth: _____

**Please check any medical problems you have had in the past:**

- ☐Anemia
- ☐Anxiety
- ☐Arthritis
- ☐Asthma
- ☐Atrial fibrillation
- ☐Autoimmune disease
- ☐Blood transfusion
- ☐Cancer, type:
- ☐Cataracts
- ☐Chronic lung disease/COPD
- ☐Chronic pain
- ☐Colon polyps
- ☐Congestive heart failure
- ☐DVT/Blood Clots
- ☐Dementia
- ☐Depression
- ☐Diabetes mellitus
- ☐Skin disorder; Type:
- ☐Fibromyalgia
- ☐GERD (heartburn)
- ☐GI bleed
- ☐Glaucoma
- ☐Heart attack
- ☐Heart disease or pacemaker
- ☐High cholesterol
- ☐High blood pressure
- ☐Inflammatory bowel disease
- ☐Irritable bowel syndrome
- ☐Insomnia
- ☐Kidney disease/stones
- ☐Liver disease
- ☐Migraine headaches
- ☐Neuropathy
- ☐Osteoporosis/Osteopenia
- ☐Parkinson's disease
- ☐Pulmonary embolism
- ☐Rheumatic fever
- ☐Seasonal allergies
- ☐Shingles
- ☐Sleep apnes
- ☐Stroke or TIA
- ☐Thyroid disease
- ☐Ulcers, Type:
- ☐Other, (specify):

**Please check any surgeries you have had:**

- ☐Appendectomy
- ☐Bariatric surgery
- ☐Breast surgery
- ☐Colonoscopy
- ☐Cosmetic surgery
- ☐C-section
- ☐Eye surgery; Type:
- ☐Gall bladder removal
- ☐Heart surgery, type:
- ☐Hernia repair, type:
- ☐Hysterectomy
- ☐Orthopedic surgery, type:
- ☐Pacemaker
- ☐Spine Surgery; Type:
- ☐Tubal Ligation
- ☐Vasectomy
- ☐Other (specify):

**Family Health History**

| | Age | Sex | Significant Health Problems | | Age | Sex | Significant Health Problems |
|---|---|---|---|---|---|---|---|
| Father | | | | Children | | M F | |
| Mother | | | | | | M F | |
| Siblings | | M F | | | | M F | |
| | | M F | | Grandma Maternal | | | |
| | | M F | | Grandpa Maternal | | | |
| | | M F | | Grandma Paternal | | | |
| | | M F | | Grandpa Paternal | | | |

Affinity Family Health Wellness
Jamee Baltzell, APRN, NP-C Jamie Niemerg, APRN, CPNP
1108 N East Street, Olney, IL 62450
Phone: (618) 429-9470 | Fax: (833) 944-2035

Patient Name: _____ Date of Birth: _____

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:**

| Name of Drug | Dose/Type | Frequency/Method Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Aspirin Daily? Yes No | Medical Marijuana Yes No | |
| Opioids Chronic? Yes No | Contraception Yes No | |

**Allergies to Medications**:

| Name of the Drug | Reaction You Had | Age when occurred |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Health Habits and Personal Safety**

| | | |
|---|---|---|
| Caffeine | None Coffee Tea Other | How much? _____ |
| Alcohol | Do you drink alcohol? | Yes No |
| | What type | |
| | How many drinks per week? | |
| Tobacco | Do you use tobacco or nicotine products? | Yes No |
| | Cigarettes – #/day E-cig - #/day Chew - #/day | |
| | # of years used _____ | Yes No |
| Gynecological History | # of pregnancies:_____ # of live births: _____ Menopause Yes No | |