Jamee Baltzell, APRN, NP-C Jamie Niemerg, APRN, CPNP
202 West Center Street, Dieterich, IL 62424
Phone: (217) 500-1388 | Fax: (833) 944-2035

NEW PATIENT REGISTRATION

New Patient Information Today's Date: ______________________

Full Name: ____ Date of Birth: ______________________

Race: ____ Gender: ☐M ☐ F

Address/City/State: ____________________________________ Home Number: ______________________

Email Address: _______________________________________ Mobile Number: _____________________

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): ____

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.

Fees

Membership fees and product sales require payment at the time of service.

Appointments

We strive to provide the best possible service and availability to all of our patients. Please help us serve you better by keeping your scheduled appointments or by calling as early as possible to cancel.

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

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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.

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

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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

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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	