11321 Iowa Avenue, Suite 2, Los Angeles, CA 90025 310-844-3440 www.pcnusingca.com

Patient Initial Intake Form

Name: _____
Last First MI

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____Relation: _____

Phone #: (H) _____ (W) _____

Preferred Pharmacy: Name:_____ Phone #: _____

FINANCIAL/INSURANCE RESPONSIBILITY FORM

PLEASE READ THIS DOCUMENT CAREFULLY. BY EXECUTING THIS CONTRACT, YOU AGREE TO ALL RIGHTS, DUTIES, AND RESPONSIBILITIES STATED HEREIN.

1. **Cash Patient.** All payments are to be paid at the time of services. Professional Concierge Nursing does not accept primary insurance or assignment for secondary insurance carriers, but will be happy to provide you with an invoice to submit to your insurance carrier.

_____

Patient Signature Date

_____ _____

Signature of Responsible Party or Guardian Date

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Health History

PRESENTING PROBLEM: _____

_____

_____

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Anemia	❑Arthritis	❑ Blood Disease	❑ Cancer
❑ Cataracts	❑ Colds(frequent)	❑ Diabetes	❑ Digestive Problems	❑ Eczema
❑ Epilepsy	❑ Headaches	❑Hepatitis	❑ Herniated Disc	❑ Herpes
❑ Hypertension	❑ High Cholesterol	❑ Kidney Disease	❑ Liver Disease	❑ Lyme
❑ Miscarriage	❑ Pneumonia	❑ Prostate Problems	❑ Rheumatoid Arthritis	❑Stroke
❑ Tumors/Growth	❑ Tuberculosis	❑ Ulcers	❑ Urinary Tract Infections	❑Venereal Disease

Please list any medications you are currently taking (**Be sure to include dosage/frequency**)_____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

_____

Please list any allergies (medication/food/insects,ect): _____

_____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

What is your daily/weekly intake of the following:
Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes/Chew_____packs/day

Diet: ❑Junk Food (fast food & snacks) ❑ Processed (frozen or canned meals) ❑ Standard American (meats, potatoes, fats, desserts)
❑ Wholesome ❑ Vegetarian ❑ Raw Food ❑Other_____

Women's Health: Last menstrual cycle:_____

Number of Pregnancies:_____ Number of Children: _____ Number of Miscarriages: _____

Any sexual difficulties?_____

Men's Health: Last Prostate Exam: _____

Any sexual difficulties? _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

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Review of Systems

Please mark if you have experienced any of these symptoms within the last month:

Y	N	**Neurological**
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	**Skin**
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of _____.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Professional Concierge Nursing to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

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PATIENT CONSENT FORM

Patient's Name _____

Date of Birth _____/_____/_____

A patient coming to **Professional Concierge Nursing** to see a provider gives his/her permission and authority for care by them in accordance with appropriate test, diagnosis, and analysis. The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I hereby consent to the provision of diagnosis, care, and/or treatment by **Professional Concierge Nursing** and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing. I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

_____ _____

Signature of Patient or Person Authorized to Consent*

Date

_____

Relationship (if not Patient)

Privacy Policy

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you on how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact J. Rapha Management, Incorporated dba Professional Concierge Nursing at 11321 Iowa Avenue, Suite 2, Los Angeles, CA 90025, 310-844-3440, regina@jraphamanagement.com at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

Treatment: We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.

For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside of our office such as the pharmacy when a prescription is called in.

Payment: Your protected health information may also be used to obtain payment from an insurance company or another third part. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed.

Health Care Operations: We may use or disclose your protected health information in order to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you be telephone, email, or text to remind you of your appointments.

If we have to share your protected health information to third party “business associates” such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may also use and disclose your protected health information for marketing activities. For example, we might send you a thank you card in the mail with a coupon for specialized services or products. We may also send you information about products or services that might be of interest to you. You can contact us at any point to stop receiving this information.

We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written Authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.

Appointment reminders: We may contact you as a reminder that you have an appointment for your initial visit, follow up visit, or lab work via text, phone or email.

Others Involved in Your Health Care: We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need.

Research: We will not use or disclose your health information for research purposes unless you give us authorization to do so.

Organ Donation: If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation if it is necessary to facilitate this process.

Public Health Risks: We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.

Health Oversight Activities: We may disclose protected health information to health oversight agencies for audits, investigations, inspections or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.

Required by Law: We will disclose protected health information about you when required to do so by federal, state and/or local law.

Workman's compensation: We may disclose your protected health information to workman's comp or similar programs.

Lawsuits: We may disclose your protected health information in response to a court action, administrative action or a subpoena.

Law Enforcement: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to medical records: You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.

Amendment: If you believe the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information You will need to submit a written request on why you feel the health information should be amended. We may deny your request to amend if you did not send a written request or give a reason on why it should be amended. If we deny your request, we will provide you a written explanation. We may deny your request if we believe the protected health information is accurate and complete.

Accounting of Disclosures: You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this "accounting of disclosures" to the individual listed at the bottom of this policy. After your request has been approved, we will provide you the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. This information may not be longer than (STATUTE OF LIMITATIONS) years ago prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.

Restriction Requests: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this be a written request submitted to the individual at the end of this policy.

Confidential Communication: You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.

Paper copy of this notice: You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Name of Contact Person:

Regina Speights, regina@jraphamanagement.com, 310-844-3440
11321 Iowa Avenue, Suite 2, Los Angeles, CA 90025

Please sign and date indicating you have read and understand your Patient Rights.

Name_____Date_____

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that I am voluntarily engaging in a telemedicine consultation done by a "store and forward" route with J. Rapha Management, Incorporated dba Professional Concierge Nursing. I understand that I am submitting a health questionnaire that will contain my basic medical history, current symptoms (if any), and goals for treatment that will be reviewed by a licensed medical provider. The medical provider will then approve the desired medical interventions and/or prescriptions being requested after reviewing your submitted information. Your request will be approved pending any contraindications to therapy and you will be notified by email within 12-24 hours. If the medical provider does not approve the interventions and/or prescriptions being requested, you will be notified by email and will be refunded, in full, the purchase price of the skin care prescriptions.

2. I understand that the health questionnaire I fill out on this website that will be submitted to the medical provider will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that this is a convenience and a courtesy provided by J. Rapha Management, Incorporated dba Professional Concierge Nursing

3. I understand that a telehealth consultation has potential benefits including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the video conferencing connections are not adequate for the situation.

5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that if there is another individual present during the telehealth consultation (if done via video or phone) that I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

6. I understand that the alternative to a telemedicine consultation is to forgo evaluation and treatment with J. Rapha Management, Incorporated dba Professional Concierge Nursing

and to seek out an in-person evaluation elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation via a “store and forward” route.

7. I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through J. Rapha Management, Incorporated dba Professional Concierge Nursing will be limited or not done at all. I understand that I am submitting a health questionnaire that will contain my basic medical history, current symptoms (if any), and goals for treatment.

8. Telemedicine services offered through J. Rapha Management, Incorporated dba Professional Concierge Nursing are not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care.

By signing this form, I certify:

That I have read or had this form explained/read to me and I understand its contents including the risks and benefits of telemedicine.

- That I have had the opportunity to ask questions, if desired by J. Rapha Management, Incorporated dba Professional Concierge Nursing through the contact us section, and have had them answered to my satisfaction before submitting the requested information