White Plains Primary Care LLC
Consent to Treat Form

1. I _____ (patient name) give permission for **White Plains Primary Care LLC** to give me medical treatment.

2. I allow **White Plains Primary Care LLC** to file for insurance benefits to pay for the care I receive.

I understand that:

- **White Plains Primary Care LLC** will have to send my medical record information to my insurance company..
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay, or I do not have insurance.

3. **I understand:**

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient's Signature Date

_____ _____

Patient or Guardian Signature Date
(for children under 18)

White Plains Primary Care

Patient Name:_____ **Date of Birth:** ___/___/_____

Address:_____

City:_____ State:_____ Zip Code:_____ Sex: _____

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

Email Address:_____

Preferred Method of Contact: ___Phone ___Email Employment:_____

Marital Status: _____ Social Security No.:_____

Race: __American Indian or Alaskan Native __ Asian __ Black or African American __ White

__Native Hawaiian or other Pacific Islander

Ethnicity: __Hispanic or Latino __ No Hispanic or Latino

Preferred Language: _____

How were you referred to us?_____

Pharmacy Name:_____ City:_____ Zip Code: _____

Insurance Information

Primary Insured Name:_____ DOB: ___/___/_____

Relationship to Patient's Policy Holder:_____

Insurance Company:_____ ID:_____

Group ID:_____

Secondary Insurance Company:_____ ID:_____

Emergency Contact:_____ Phone Number:_____

Relationship to Patient:_____

Private Insurance Assignment of Benefits

I, the undersigned, authorize payment of medical benefits to White Plains Primary Care for any services furnished to me. I understand that I am financially responsible for any amount not covered by insurance. I also authorize you to release my information concerning health care, advice, treatment, or supplies provided to me to my insurance company or their agent. This information will be used for Purposes of evaluation and administrating claims and benefits.

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by White Plains Primary Care. I agree that if this account is turned over for collections, all costs (including reasonable collections fees and court costs) will be added to the outstanding balance. I have read and fully understand the above consent for treatment and financial responsibility.

Patient Signature:_____ Date:__/__/_____

Social History:

Drug Use __Y__N:Drug of Choice_____ Caffeine Use__Y__N:Servings Per Day_____

Exercise Habits:(How Many Times Per Week)_____

Alcohol Use: __Non-Drinker __Social Drinker __Heave Alcohol Consumption

__Recovering Alcoholic

Diet Salt Intake: (Amount Used) __Small __Medium __Large

Early Morning Awakening: __Y__N

Do you have a living Will:__Y__N

Advanced Directives:_____

Women Only:

LMP: ___/___/_____ Pregnant:__Y__N Planning Pregnancy: __Y__N, if yes when_____

No. of Pregnancies: _____ No. of Miscarriages:____ No. of Abortions:____

No. of C-Sections:_____ No. of Living Births:____ No. of Ectopic Pregnancies: ____

Last PAP Smear: ___/___/_____ Was last PAP normal:___Y___N

Family History:

Bleeding Disorder:	M F S B C	Heart Disease:	M F S B C
Cancer:_____:	M F S B C	Kidney Disease:	M F S B C
Diabetes:	M F S B C	Mental Illness:	M F S B C
Epilepsy:	M F S B C	Osteoporosis:	M F S B C
Glaucoma:	M F S B C	Stroke:	M F S B C
High Blood Pressure:	M F S B C	Thyroid Disease:	M F S B C

Other:_____

Health History **Name:**_____ **Date of Birth:**__/__/____

Chief Complaint:_____

Current Medictions:_____

_____

_____

Allergies:_____

Past Medical History

Last Colonoscopy:_____ **Last Mammogram (Women Only):**_____

Last EKG:_____ **Last Eye Exam:**_____

Last Foot Exam:_____ **Last A1c (Pre-Diabetics, Diabetics):**_____

Y	N	Alcoholism	Y	N	Depression	Y	N	Hepatitis	Y	N	Pneumonia
Y	N	Allergies	Y	N	Diabetes Type 1	Y	N	Heart Murmur	Y	N	Rheumatic Fever
Y	N	Anemia	Y	N	Diabetes Type 2	Y	N	Heart Palpitations	Y	N	Sexual Dysfunction
Y	N	Arthritis	Y	N	Prediabetes	Y	N	High Cholesterol	Y	N	STD
Y	N	Asthma	Y	N	Difficulty Breathing	Y	N	Headache	Y	N	Stroke
Y	N	Bleeding Disorder	Y	N	Dizziness/Fainting	Y	N	High Blood Pressure	Y	N	Thyroid Disease
Y	N	Bronchitis	Y	N	Epilepsy	Y	N	Incontinence	Y	N	Ulcer
Y	N	Cancer_____	Y	N	Glaucoma	Y	N	Lactose Intolerance	Other:_____		
Y	N	Chest Pain	Y	N	Gout	Y	N	Migraines			
Y	N	COPD	Y	N	Heart Disease	Y	N	Osteoporosis			

Previous Surgeries/Hospitalizations:_____

_____

_____

Smoking Status:

Tobacco User: __Yes __No Have you had Second Hand smoke exposure?__Y__N

__Current Everyday Smoker __Current Some Day Smoker __Heavy Tobacco Smoker

__Light Tobacco Smoker __Never a Smoker __Former Smoker

No. of Years_____ Pack per day_____ Quit Date_____

HIPPA Compliant Authorization for Release of Medical Information Pursuant to CFR 164.508

Patient:_____ **Date of Birth:**__/__/_____

Address:_____

City:_____ **State:**_____ **Zip Code:** _____

Release From:_____

Phone:_____ **Fax:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Release To: [] **Jennifer McManus, DNP, CRNP, FNP-BC, CARN-PA**

50 Post Office Rd, Suite 304

Waldorf, MD 20602

Office (240) 349-2448

Please Fax Records to (240) 349-2243

	Progress Notes		**Laboratory Results**
	Radiology		**Hospital**
	All Records		**Office Visit**

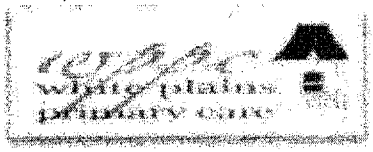
Dates of Records Requested:_____

I hereby authorize the release of the above requested records. This request will expire one year from the date signed.

Signature: _____

Printed Name:_____

Date:__/__/_____



Authorization for Release of Health Information

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with Maryland State law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I understand that:

1. **White Plains Primary Care** uses SureScripts as a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these information will be utilized to **White Plains Primary Care.**

2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts to **White Plains Primary Care.**

3. I have the right to revoke this authorization at any time in writing and send it to **White Plains Primary Care.** I understand that I may revoke this authorization except to the extent that the action has already been taken based on this authorization.

4. Signing this authorization is voluntary. My treatment payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by State and Federal Law.

6. This authorization does not authorize **White Plains Primary Care** to discuss my health information or medical care with anyone other than those permitted under applicable law.

Patient's Printed Name: _____

Patient's Signature: _____ **Date:** ___/___/___
(Signature of patient or representative authorized by law)

Relationship to Patient: _____

Witness Signature: _____ **Date:** ___/___/___

50 Post Office Road, Suite 304, Waldorf, MD 20602
240-349-2448 240-349-2243 Fax
Dr. Jennifer McManus, DNP, CRNP, FNP-BC
Family Nurse Practitioner
WhitePlainsPrimaryCare.com

Medical Information Release Form

(HIPPA Release Form)

Name: _____ **Date of Birth:** _____

Release of Information

____ I authorize the release of information including the diagnosis, records, examination rendered to me and claim information. This information may be released to:

Spouse: _____

Children: _____

_____

Other: _____

____ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call ____ My home ____ My work ____ My Cell Phone _____

If unable to reach me:

____ You may leave a detailed message.

____ Please leave a message asking me to return your call.

____ Other _____

The best time to reach me is (day) _____ between (time) _____

Signature: _____ **Date:** _____

White Plains Primary Care

50 Post Office Road, Suite 304
Waldorf, MD 20602

No Show Fee Policy

I understand that any cancellation of an appointment will result in either a $25.00-dollar fee for a General Visit, to include but not being limited to Telehealth, Follow-Up, Office Visit, Medication Refill, MAT Appointment or $70.00-dollar fee for a Physical Exam (Wellness) to include but not being limited to Pre-Operative Visit, if not cancelled 48-hours in advance (business day) of the time of my appointment.

I understand the doctor's staff has no responsibility to notify me subsequent to my having made my appointment.

Print Name: _____

Signature: _____

Date: _____

Collections Policy for Non-Payment

I understand that services may not be covered by my insurance and I agree to pay for these services or supplies rendered, to include but not being limited to Deductibles, Co-Pays, Co-Insurances. I understand that in the event these services are not paid in full, in a timely manner that they will be sent to a collection agency and I will be responsible for affiliated fees over and above my unpaid balance, to include but not being limited to a 30% Collection Fee.

Print Name: _____

Signature: _____

Date: _____

White Plains Primary Care (Jennifer L. McManus, C.R.N.P.) strives to provide exceptional care to all patients without prejudice and discrimination, if for any reason, payment cannot be made in full, contact the office 240-349-2448 to make payment arrangements. Weekly, Bi-Weekly and Monthly payment plans are available on a case by case basis.

Referrals and Refills

NAME:_____ DATE:_____

Dear Patients:

We strive to have an efficient and organized office. Patient care is of the utmost importance. Please read the following changes to our administrative and medication refill procedures. If you should have any questions and/or suggestions, please feel free to talk to any of our staff. Please initial after each procedure.

1. Please allow 48 hours for prescription refill request. _____
2. Please allow 48 hours for referrals. Please be aware of the protocol related to your particular insurance with regards to referrals. _____
3. All messages are checked at the beginning of each business day. We do our best to have all calls returned before closing, but there are times that the calls may be returned the next business day. _____
4. There will be a $30.00 charge for any administrative forms. This includes Employment and Disability forms. _____

Please Note: Dr. McManus WILL NOT be in the office on Fridays. It is an administrative day and patients are not seen.

Thank you for your time and cooperation.