KRIS SILVERMAN FNP
NURSE PRACTITIONER

New Patient Registration

321 W. Limberlost Drive
Tucson, AZ 85705
Office 520-965-4875 / Fax 520-203-7778

Thank you for choosing Kris Silverman as your primary care provider. We need you to provide the following information to sign up with our medical services.

Please complete the registration form in its entirety so we can quickly process your registration. In addition, we will need a copy of the following documents emailed to kristucsongeriatrics@gmail.com, faxed to 520-203-7778, or delivered to the office. After we receive these documents, we will contact you to schedule your first appointment.

1. Copy of Driver's License and or State ID
2. Copy of Power of Attorney (POA) paperwork including Financial/Durable, Medical and Mental Healthcare.
3. Copy front and back of insurance cards including Medicare cards
4. DNR (Do Not Resuscitate) form if applicable
5. Any pertinent, recent lab results, imaging, doctor visit summaries, or hospital discharge paperwork.
6. List of current medications, and medication & food allergies
7. List of Specialists -- Cardiologist, Nephrologists, Gastroenterologists etc.

Durable/Financial POA: _____

Medical POA: _____

Mental Health POA: _____

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Authorization for Release of Medical and Pharmacy Records

Patient Name: _____

Date of Birth: _____ Phone number: _____

The person listed above consents to the release of my medical information to:

KRIS SILVERMAN FNP, LLC
520-965-4875

321 W. Limberlost Drive
Tucson, AZ 85705

I understand that my records are confidential and cannot be disclosed without written authorization, except when permitted by law. The information released may include pertinent health information, laboratory results, pathology results, medication and prescription history, and entire medical chart.

Potential for Re-Disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of privacy of this information once Kris Silverman FNP, LLC discloses it to another party.

Rights of the Individual: You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

_____

Name of Patient

_____

Signature of Patient or Representative Date

_____

If signing as a Patient Representative, list relationship to Patient

KRIS SILVERMAN, FNP - FINANCIAL POLICY AND INFORMATION

The following is a statement of our financial policy which we ask you to read and sign prior to your first appointment. Additionally, we require you to present your insurance card/s before your first appointment.

MEDICARE
We are Medicare providers, and we do accept assignment.

HMO and PPO
It is your responsibility to know your benefits regarding covered services, deductibles, copays, coinsurance and referrals. You may call the Member Services phone number on your insurance card for assistance.

CONTRACTED INSURANCE CARRIERS
We will submit a claim to your insurance company for medical visits. If payment is not received within 60 days, the balance will become your responsibility. It will be your responsibility to recover the reimbursement from your insurance carrier.

PRIVATE INSURANCE CARRIERS
We will supply you with the necessary paperwork for you to submit the claims to your insurance company for reimbursement. Full payment is required when services are rendered. I have read this policy, and I understand that regardless of insurance, I am financially responsible for payment of services.

_____
Signature & Date

_____
Printed Name

Credit Card Authorization

I authorize Kris Silverman FNP, LLC to charge my credit card for services rendered. This authorization is for co-pays, and any payments not covered by my insurance company for services provided by Kris Silverman FNP, LLC. This authorization remains in effect until cancelled in writing and only if the account is in good standing. I agree to update any information regarding this credit card account.

Patient Name: _____

Card Number: _____

Card Type: _____

Exp.Date: _____ Security Code: _____

Signature: _____

Cardholder Name: _____

Billing Address: _____

_____

Email: _____

Date: _____

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NURSE PRACTITIONER

INSURANCE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Primary Insurance: _____

ID #: _____ Group #: _____

Secondary Insurance: _____

ID #: _____ Group #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefit payments be paid directly to Kris Silverman, FNP. I understand that I am financially responsible for any balance not paid by third party providers. I also authorize Kris Silverman, FNP or her agents to release any information required to process my claims.

_____

Signature Date

If the signature above is someone other than the patient, print the name of signer and the relationship to the patient below.

_____

Name Relationship

KRIS SILVERMAN, FNP - NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Our intent as an organization is to be fully compliant with the Health Insurance and Portability and Accountability Act (HIPPA) of 1996.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization. This notice will tell you about the ways we may use and share information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

The law requires us to keep your medical information private. The law also requires that we give you this notice describing our legal duties, privacy practices and your rights regarding your medical information. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make the changes to our privacy practices and the new terms of our notice effective for all medical information including information previously created or received prior to the changes. Before we make a change to our practices, we will amend this notice and make the changes available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific medical information use or disclosure may be revoked at any time upon providing us with receipt of your written intent not to disclose any further medical information.

4. TREATMENT

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you.

5. HEALTH CARE OPERATIONS

We may use and disclose your medical information for our healthcare operations.

6. PAYMENT

We may use and disclose your medical information for payment purposes.

7. ADDITIONAL USES AND DISCLOSURES

In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes:

- Notification of family member or personal representative
- Disaster Relief/Law Enforcement
- Research in limited circumstances
- Funeral Director, Coroner or Medical Examiner
- Specialized Government Functions

- Court Orders or Judicial and Administrative Proceedings
- Public Health Activities/Health Oversight Activities
- Victims of Abuse, Neglect or Domestic Violence

8. YOUR INDIVIDUAL RIGHTS

- You have the right to copies of your medical information.
- You must make a request in writing with a medical record release of information.
- If you request copies of your medical record for your personal files, a nominal charge will apply to cover our costs.
- You have the right to receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations.
- You have the right to request that additional restrictions be placed on our use or disclosure of your medical information. (We will attempt to abide, though we are not required, to the restrictions except in the case of an emergency.)
- You have the right to request that we communicate with you about your medical information by different means (written) or to different locations (workplace). This request must be made in writing.
- You have the right to request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons.
- You may respond with a statement of disagreement that will be added to the medical record.

9. RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

10. COMMENTS AND COMPLAINTS

If you have reason to believe that your privacy rights have been violated, you may bring the matter to our attention by sending a letter describing the nature of your concern. You will not be penalized or retaliated against for filing a complaint. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern to: Kris Silverman FNP 321 W. Limberlost Dr, Tucson, AZ 85705

11. ACKNOWLEDGEMENT

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers participation in the Health Information Exchange of Arizona, or I have previously received this information and decline another copy. I have received the Notice of Privacy Practices form and the Notice of Health Information Practices and have had an opportunity to review.

Signature Date

If the signature above is someone other than the patient, print the name of the signer and the relationship to the patient below.

Name of Signer Relationship

KRIS SILVERMAN FNP
NURSE PRACTITIONER

PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Male: _____ Female: _____ Marital Status: _____

Social Security Number: _____ Home Phone: _____ Cell Phone: _____

Mailing Address: _____

May we leave a message regarding medical care and test results? _____Yes _____No

Would you like to participate in Tele Health Visits? _____Yes _____No

Height: _____ Weight: _____ CPR: _____ DNR: _____ Living Will: _____

Preferred Pharmacy: _____ Location: _____

Food Allergies: _____

Medication Allergies: _____

List all Medications you currently take including Over the Counter medications (or provide list):

_____

_____

_____

_____

_____

Social History:

Smoker: _____Yes _____No _____Previously _____Years Smoked _____Packs Per Day?

Alcohol Consumption: _____Daily _____Weekly _____Drinks per Week _____Never Drink

Describe any Marijuana use: _____

Family History: Living or Deceased, Age or Age at Death, Disease/Conditions.

Father: _____

Mother: _____

Siblings: _____

Surgical History: _____

_____

_____

_____

Last Menstrual Period:_____Date Normal_____Abnormal_____

Colonoscopy: _____ Date _____ Normal _____ Abnormal_____

Mammogram: _____ Date _____ Normal _____ Abnormal_____

Bone Density (DEXA): _____Date_____ Chest Xray: _____Date_____

Personal Medical History (Check all that apply):

__ADHD	__Anxiety	__Alcoholism	__High Cholesterol
__COPF	__Bipolar	__Dementia	__Allergies/Seasonal
__HIV	__Depression	__Ulcers	__Irritable Bowel
__Lupus	__Psoriasis	__Hepatitis	__Diabetes
__Anemia	__Eczema	__Diverticulitis	__Pulmonary Embolism
__Asthma	__Emphysema	__Gallstones	__Peripheral Vascular Disease
__Sciatica	__Headaches	__Migraines	__Bladder Problems
__Nosebleeds	__Glaucoma	__Colitis	__Macular Degeneration
__Stroke	__Liver Disease	__Heart Attack	__GERD/Acid Reflux
__Neuropathy	__Sleep Apnea	__Hiatal Hernia	__Osteoporosis/penia
__Thyroid	__Kidney Stones	__Prostate CA	__Rheumatoid Arthritis
__Bleeding	__ Cancer	__ BPH	__Parkinsons Disease
__Crohns	__Celiac Disease	__Arthritis	

Specialty Physicians or other Providers who participate in your HealthCare: (Please List all)

Cardiologist: _____ Oncologists: _____

Neurologist: _____ Endocrinologists (Diabetes): _____

Pulmonologist: _____ Orthopedic: _____

Nephrologist: _____ Ophthalmologists: _____

Dentist: _____ Podiatrist: _____

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Office 520-965-4875 / Fax 520-203-7778

Authorization/Consent for Treatment, Release of Information, Photograph, & Assignment of Benefits

I, _____, hereby voluntarily consent and authorize outpatient care encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (blood, urine, etc.), radiology examinations (X-rays, MRIs, etc.), prescribing medications, referring to specialists, and minor surgical procedures, performed by Kris Silverman FNP, LLC (the Nurse Practitioner) and her staff.

Additionally, I authorize Kris Silverman FNP, LLC to request and release my personal medical information, bill my insurance, and take my photo for identification in our Electronic Medical Record system.

I understand that I am free to withdraw my consent and to discontinue participation with Kris Silverman FNP. However, this consent will remain in effect until such time that I notify Kris Silverman FNP in writing of termination of said consent.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents and agree to be bound by these terms and conditions.

_____

Patient's Name (Print)

_____

Patient's or Medical POA Signature Date

_____

If POA Signature, Name of POA (Print)

Functional Assessment of Activities of Daily Living

(These questions help us understand how you are functioning with everyday tasks)

Mobility:

Wheelchair use: _____ Walker use: _____

Can you stand from seated position without assistance: _____

If need assistance to transfer or stand, how many people are needed to assist: _____

Transportation:

Do you have any concerns about your driving? _____

Do you use Uber/Lyft /or a medical transport? _____

Social Stimulation/Hobbies:

Please list your activities and hobbies: _____

_____

Diet and meals:

Can you feed yourself _____ Cook meals _____ Shop for groceries _____ Drink easily _____

How much of your meals do you eat on a regular basis: _____

Dressing:

Can you pick out your clothes and dress yourself without assistance? Yes or No (circle)

Can you put your shoes & socks on? Yes or No Can you button your shirt? Yes or No

Can you do your own laundry? Yes or No

Communication:

Any Problems with: _____Speech _____Hearing _____Dental/Teeth _____Eyes/Vision

Do you wear dentures or have a bridge? _____

Do you wear Hearing Aides? _____ Should you wear hearing aids? _____

Toileting/Showering:

Can you get out of bed and go to the toilet by yourself? Yes or No (circle)

Do you need assistance with the following? _____Shaving _____Washing _____Showering safely

Medications:

Do you manage your own medications? Yes or No (circle)

What Pharmacy do you use? _____

Do you have any concerns about medications you are currently taking (list)? _____

_____

_____

Life Skills:

Can you use a cell phone? Yes or No (circle) TV remote? Yes or No Computer? Yes or No

Do you manage your finances and pay your bills? Yes or No

Are you handling your appointments with doctors, banks, insurance etc.? Yes or No

Can you leave your home for a medical appointment without assistance? Yes or No

History of Falls:

Are you afraid of Falling? Yes or No (circle) Do you have a history of Falls? Yes or No

Provide any history or list injuries from falling: _____

Who routinely helps you with any tasks you cannot manage? _____

_____

Immunizations:

COVID: List or vaccines and dates if applicable: _____

_____

Influenza/Flu: Do you get an annual flu shot? Yes or No When was your last flu shot? _____

Tetanus DtP: _____ TB screening: _____

Pneumonia: _____ Shingles Vaccine: _____

Please share anything else about your medical or health history that you want or feel is important:

_____

_____

_____

_____

_____

_____

_____