Medical History Form

Lynn Rowley, FNP, APRN-BC-----Primary Care Medicine

2204 S. Dobson Rd, suite 101 Mesa, AZ 85202 phone 480-361-8966 fax 480-912-3514

Patient Name_____________________________DOB_______________Todays Date___________

List Medications you are ALLERGIC to and reaction____

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Pharmacy______________________________Phone :_____________________________________

Current Medications: Dose: Frequency:

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Have you had history of: Anemia Asthma Blood Clots CAD CHF COPD Depression, Diarrhea, Emotional Problems, Diabetes, Heart Burn; High Blood Pressure, Perm Pacemaker, Skin Disorders, Sleep Apnea, Stroke, Thyroid problems, Tuberculosis, Ulcers,

Cancer? What type?____

Please list any other Medical History and / or Problems

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Patient Name____

Surgical history: Have you had? (Please circle and give date done)

Angioplasty_______Appendix surgery________Cardiac Bypass ___________ Gastric Bypass__________

Gallbladder surgery_________ Hernia surgery______________ Hysterectomy w/Ovaries_____TURP___

Joint(s) replacement? ____

List any other surgeries____

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Family History: mother___________________________________Father____________________________

Sister__________________________________ Brother____

Heart disease stroke diabetes osteoporosis thyroid disease Cancer-------------------

Date of Last:	**Do You:**
Tetanus/Tdap_____________	Smoke yes no
Pneumonia shot___________	If so how many packs per day____/Yrs__
Shingles shot______________	Do you Drink Alcoholic beverages? Yes/No
Flu Vaccine_______________	If so, how many drinks day____ week___
Mammogram______________	Ever had problem with substance abuse Y/N
Pap Smear________________	How Many Cups Coffee a Day_______
PSA______________________	How Much Exercise Do You Do?
Colonoscopy______________	Daily________ Weekly________
DEXA/Bone Density________	

Married, single, divorced, widowed Do you have Children? Yes No how many______

Advanced Directives Yes No

Assignment of Benefits Form

Lynn Rowley NP

2204 S Dobson Rd   Suite 101

Mesa, AZ   85202

Phone: 480-912-3510   Fax: 480-9123514

Patient: ___________________________

I, ________________________, understand that services rendered to me by Lynn Rowley NP are my financial responsibility and that the provider will bill my insurance company,

________________________ as a courtesy. I authorize my insurance company to pay my benefits directly to Lynn Rowley NP and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by (Insurance Company).

I authorize the provider to release any information necessary to adjudicate the claim, and understand that here may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also understand that should my insurance company send payment to me, I will forward the payment to Lynn Rowley NP within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event that I receive any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to Lynn Rowley NP immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, authorize (Provider) to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated ______________

Signature: _____________________________

Privacy Notice

Lynn Rowley NP
Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Lynn Rowley NP to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Lynn Rowley NP describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lynn Rowley NP Carrington reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lynn Rowley NP 2204 S Dobson Rd Suite 101, Mesa, AZ 85202.

With this consent, Lynn Rowley NP may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent Lynn Rowley NP may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Lynn Rowley NP may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Lynn Rowley NP restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow Lynn Rowley NP to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lynn Rowley NP may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

________________________________ _______________________
Print Patient’s Name Date

____
Print Name of Patient or Legal Guardian, if applicable

LYNN ROWLEY NP

2204 S DOBSON RD SUITE 101

MESA, AZ 85202

TELEPHONE (480) 361-8966 FAX (480) 361-5957

REQUEST FOR MEDICAL RECORDS
FAX (480) 361-5957

DATE: ______________________ FAX # ______________________

DOCTORS NAME ____

FACILITY NAME ____

PHONE/FAX NO: ____

PATIENT NAME: ____

DATE OF BIRTH: ____

INFORMATION REQUESTED:

_______ COMPLETE MEDICAL RECORDS ___________ # YEARS

_______ LABS & X RAY REPORTS

_______ HOSPITAL DISCHARGE SUMMARIES

_______ SURGERY & CONSULTATION

_______ SUMMARY FROM PHYSICIAN

I hereby authorize and request you to release to Lynn Rowley NP, the above noted medical records.

PATIENTS SIGNATURE_______________________________________ **DATE:**____________________

This FAX is personal, confidential and privileged information intended for the named recipient only.

If you received it in error, please destroy it and call us to advise us of same. Thank You