

**PATIENT INFORMATION**

Patient's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_ Sex:  Male  Female Social Security #: \_\_\_ - \_\_\_ - \_\_\_

Patient's Home Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: (\_\_\_\_\_) \_\_\_\_\_ Secondary Phone: (\_\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

**PARENT / GUARDIAN INFORMATION**

*If you are providing the information above for a patient under the age of 18 yrs old, please complete the section below:*

Parent/Guardian Name: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_

Address (if different from above): \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_

Address (if different from above): \_\_\_\_\_

**INSURANCE HOLDER INFORMATION**

*If the patient is not the employed insurance holder, please complete the section below:*

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT**

*In the event that a parent or guardian is unavailable, an emergency contact may be needed.*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Alternate Phone: (\_\_\_\_\_) \_\_\_\_\_

**BILLING WAIVER**

Please initial in all areas below in the event that your current insurance situation should change within the year.

I. Assignment of Benefits: I hereby authorize direct payment for Medicare/other insurance company benefits (if applicable) to Northern Lights Clinic for services rendered by the corporation and its employees (Physicians, Audiologists, Physical Therapists, DME). I understand that I may be financially responsible for any balance not covered by my insurance company (i.e. co-pays and/or deductibles). Benefits that are received by myself, unassigned from the insurance company, will be considered the legal property of Northern Lights Clinic and must be reassigned to Northern Lights Clinic without delay.

Initial: \_\_\_\_\_

II. Medicare/Medicaid: I certify that the information given by me in applying for payment is correct. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. A photocopy of these assignments shall be valid as the original.

Initial: \_\_\_\_\_

III. Legal Fees: Any legal and court fees incurred by Northern Lights Clinic in the collection of fees owed to Northern Lights Clinic will be the financial responsibility of the involved patient party.

Initial: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES (HIPAA)**

I have received a copy of Northern Lights Clinic's Privacy Practices.

No, thank you. I choose to waive receipt of Northern Lights Clinic's Privacy Practices.

Acknowledgement of Privacy Practices was unable to be obtained because \_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE**

*Please read the following statement carefully.*

The following are individuals to whom I agree to permit Northern Lights Clinic to disclose my protected health information. The nature of the disclosures includes, but is not limited to, medical or billing information. I understand that Northern Lights Clinic is not obligated to determine the legitimacy of a disclosure request made by a representative to whom I have granted consent.

This authorization excludes those entities that do not require written consent; including, but not limited to, commercial insurance carriers, workers compensation carriers, and treatment activities between one healthcare provider and another.

I hereby authorize Northern Lights Clinic to provide the named individual(s) with all medical data and information they may request, as indicated, concerning my illness or injury with the exception of the restrictions noted on your written notice of privacy practices.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  Medical Information  Billing Information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  Medical Information  Billing Information

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Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  Medical Information  Billing Information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  Medical Information  Billing Information

Yes  No I would like to receive communication from Northern Lights Clinic regarding information that may benefit me in making current and/or future healthcare decisions. This information will not be sold to third parties and will be used under the sole discretion of Northern Lights Clinic S.C.

**Right to Revoke:** You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent is effective on the date the revocation is received by us.

I have had a full opportunity to read and consider the contents of this two (2)-page form. I certify that the above information is current and accurate. I understand that, by signing this form, I am giving my consent to Northern Lights Clinic to disclose my protected health information to the representatives identified above. This consent is valid for one year from the signature date unless amended or revoked.

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Family Doctor \_\_\_\_\_ Patient# \_\_\_\_\_

**Medical History** (check if applicable):

- \_\_\_ Diabetes
- \_\_\_ Sleep Apnea
- \_\_\_ Stroke
- \_\_\_ Glaucoma
- \_\_\_ Acid Reflux
- \_\_\_ Heart Disease
- \_\_\_ COPD / Asthma
- \_\_\_ Bleeding Disorders
- \_\_\_ High Blood Pressure
- \_\_\_ Cancer (please specify): \_\_\_\_\_

Other Medical Problems:

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**Surgical History** (list previous surgeries and dates): \_\_\_\_\_

**Family History** (medical problems that run in your family): \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Social History:** Smoking  No  Yes (how much \_\_\_\_\_)  Quit (when \_\_\_\_\_) # of alcoholic drinks per week \_\_\_\_\_

**Review of Systems** (please circle yes or no):

- General: fatigue Y/N
- Eyes: dry eyes Y/N
- Joints: neck pain Y/N
- Lungs: cough Y/N
- Heart: chest pain Y/N
- Psych: depression Y/N
- GU: incontinence Y/N
- Neuro: weakness Y/N
- Stomach: pain Y/N
- Immune: allergies Y/N
- Skin: rashes/itching Y/N

**ENT:**

- hearing loss Y/N
- ringing in ears Y/N
- ear pain or drainage Y/N
- dizziness Y/N
- imbalance Y/N
- reflux/heartburn Y/N
- hoarseness Y/N
- sinus infections Y/N
- nasal obstruction Y/N
- nasal drainage Y/N
- sleep problems Y/N
- snoring Y/N

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

MD/NP reviewed \_\_\_\_\_  
(date / initial) \_\_\_\_\_

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Nurse: \_\_\_\_\_ Appt. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Consulting Practitioner: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

HPI: \_\_\_\_\_

Alleviating Factors: \_\_\_\_\_ Aggravating Factors: \_\_\_\_\_

Severity & Timing of Discomfort: \_\_\_\_\_

Previous Allergy Testing: ( ) Yes ( ) No Date: \_\_\_\_\_ Location: \_\_\_\_\_

Previous Studies (lab/CT) / Old Records: \_\_\_\_\_

Vitals: BP \_\_\_\_\_ Height \_\_\_\_\_ Epworth Score \_\_\_\_\_  
 T \_\_\_\_\_ Weight \_\_\_\_\_  
 P \_\_\_\_\_ Neck \_\_\_\_\_  
 R \_\_\_\_\_ BMI \_\_\_\_\_

Dictation Complete

