Mona Davis, MSN, FNP
RiverPlace Counseling & Wellness, PLLC, Lewiston, ID

PATIENT INFORMATION

Date Completed:	Date of Birth: Age:
Patient First Name:	Patient Last Name:
Address: City:	State Zip
Phone:	Referral from:
Primary Care Physician:	Physician Phone:

MEDICAL REVIEW OF SYSTEMS

Current Medications (RX and over the counter)

Medication Name	Total Daily Dosage	Estimated Start Date

Drug Allergies ___

Environmental Allergies ___

Chronic Medical Conditions ___

Surgeries ___

History of Serious Medical Illness ___

Do you have or have you had problem with: (please explain any problem)

___ Unexplained weight loss ___

___ Appetite ___

___ Night Sweats ___

___ Fatigue ___

___ Insomnia ___

___ Fever ___

Medical Review of Systems continued:

CLIENT NAME: ______________________________ **DOB:** ____________________

<u>Have you experienced</u> (check all that apply)

Skin
- ___ Itching
- ___ Rashes
- ___ Nodules
- ___ Eczema

Eyes
- ___ Visual change
- ___ Eye Pain / Itching

Ears
- ___ Pain / Itching
- ___ Decreased hearing
- ___ Ringing / Popping

Nose and Throat
- ___ Sore throat
- ___ Runny Nose
- ___ Frequent nose bleeds
- ___ Sinus infections

Respiratory
- ___ Cough
- ___ Sputum
- ___ Wheeze
- ___ Shortness of breath
- ___ Exercise intolerance

Cardiovascular
- ___ Chest pain
- ___ Palpations
- ___ High Blood Pressure

Gastro Intestinal
- ___ Abdominal pain
- ___ Indigestion
- ___ Nausea and vomiting
- ___ Diarrhea / Constipation

Genitourinary
- ___ Pain with urination
- ___ Urination frequency
- ___ Incontinence
- ___ Female
  - ___ vaginal discharge
  - ___ pain
  - ___ irregular periods

Musculoskeletal
- ___ Pain
- ___ Stiffness
- ___ Decreased range of motion

Neurological
- ___ Changes in smell / taste
- ___ Seizures
- ___ Headache
- ___ Weakness
- ___ Poor balance
- ___ Numbness
- ___ Tingling

Psychiatric
- ___ Depression
- ___ Anxiety
- ___ Difficulty concentrating
- ___ Paranoia
- ___ Episodes of mania

Additional Comments:

____

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____

____

CONSENT FOR TREATMENT

I, ______________________________ fully understand what I have just read and
(print name)

offer my consent for treatment free from any pressure to do so.

____

(Patient Signature) (Date)

____

(Parent/Guardian Signature for minor child)

____

(Parent/Guardian Signature for minor child)

ASSIGNMENT AND RELEASE

For your convenience we will submit claims to your insurance provider. It is important to understand the insurance company is responsible to the patient, and the patient is responsible to our office for any balances not paid by the insurance carrier. Please make your payment arrangements with our financial coordinator when necessary. We can not bill Medicare or Medicaid. Phone consults will be charged at the rate of $2.00 per minute and can not be billed to insurance.

<u>COURT ACTION/LEGAL FEES</u>

Patients are discouraged from having their provider subpoenaed. Even though you are responsible for the testimony fee, it does not mean that my testimony will be solely in your favor. I can only testify to the facts of the case and to my professional opinion. These services typically cannot be billed to insurance and are the responsibility of the patient. The following fees are in effect:

1. Preparation time (including submission of records): $175 per hour
2. Time required in giving testimony: $225 per hour
3. Depositions: $225 per hour
4. Phone calls related to court case: $175 per hour
5. Mileage: 55 cents per mile
6. All attorney fees and costs incurred by the patient as a result of the legal action.
7. Filing a document with the court: $100
8. Minimum charge for a court appearance: $1200

A retainer of $1200 is due in advance. If a subpoena or notice to meet an attorney is received without a minimum of 48 business hours' notice, there is an additional $250 express charge. Also, if the case is reset with less than 72 business hours' notice, then the client will be charged $500 (in addition to the retainer of $1200).

NOTE: A 15% finance charge will be applied to balances showing 90 days past due. Accounts showing no payment activity for 90 days will be considered delinquent and referred to AUTOMATED ACCOUNTS, INC. Please understand that you will be charged $40 for each missed appointment. We request a 24 hour notice be given when cancelling appointments.

I hereby authorize my insurance benefits be paid directly to River Place Counseling & Wellness, PLLC. *I am financially responsible for non-covered services.*

I authorize the provider to release any information required.

I agree to these terms.

X____ Date ________________________

Patient signature

RiverPlace Counseling & Wellness, PLLC
312 Miller Street
Lewiston, ID 83501
(208) 750-1802

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. For efficiency in care, your records may be faxed or transmitted electronically, provided there is a Release of Information on file.

We use an automated voice reminder system to remind our clients of their appointment. You have the choice to opt out of receiving these reminders.

Phone #: (______) ________ - ____________________

______ I do not wish to receive automated appointment reminder calls

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER
(check all that apply):

Cell/Home Telephone # ________________________________

- **____O.K. to leave message with detailed information**
- **____Leave message with call back number only**

Work Telephone # ________________________________

- **____O.K. to leave message with detailed information**
- **____Leave message with call back number only**

Written Communication

- **____O.K. to mail to my home address** __________________________
- **____O.K. to mail to my office/work** ___________________________
- **____O.K. to fax to this number** _____________________________

Email Address ____

Please note: Email correspondence is not considered to be a confidential medium of communication

HIPAA PRIVACY POLICIES

____ I have been informed of the notice of privacy practice. The full HIPPA Policy is available to view in the waiting area. I will review it as needed.

____ I wish to receive a paper copy of the HIPPA Guidelines.

____________________________	________________________	________________
Client signature (or parent/guardian signature for minor child)	**Print name**	**Date**