JULIE SACHARKO APRN, LLC
PRIMARY CARE

Patient Name____DOB_______________________

FINANCIAL PRACTICES

ASSIGNMENT OF BENEFITS: In consideration for services and treatment rendered, I hereby assign, transfer and set over onto Julie Sacharko, APRN LLC, (AKA "The Practice"), all health insurance, workers compensation, and automobile insurance, all 3rd party payment or any other benefits of any nature whatsoever due to and payable to me including personal injury protection, medical payments, underinsured/uninsured benefits and any other benefits, and any other coverage which becomes available to me. I hereby direct my insurance company to make all payments I may be entitled to directly to "The Practice".

APPLICABLE TO MEDICARE BENEFICIARIES ONLY: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Administration or its intermediaries or carries of any information needed for this or a related medical claim is true and correct.

FINANCIAL RESPONSIBILITY: I understand and agree: I am responsible for my and my dependents fees to The Practice including any fees not paid by medical insurance that is not paid when the account is due. Reasonable collection and court costs will be paid by me at the interest rate of 3% per month and will be charged on an outstanding balance after 90 days. I am responsible for missed appointment fees resulting from no-show appointments and late cancellations (without 24-hour notice) at the discretion of the providers at "The Practice". Fees for services must be paid for at the time of service and I am responsible for filing for insurance reimbursement. (Medical Records will not be released until all outstanding balances are paid in full.)

CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES: I understand that my insurance may not cover 100% of the fees that are charged when accessing healthcare at "The Practice". I also understand that my insurance coverage is a contract between myself and the insurer. The Practice is billing insurance on my behalf for services rendered by the providers employed there. I understand that "The Practice" is not responsible for my insurance benefits. I understand that it is my responsibility to understand my insurance plan. "The Practice" cannot advocate on my behalf with my insurance company, but they may assist with providing billing codes (CPT) and diagnosis codes (ICD-10) codes when submitting bills on my behalf. I understand that I may have personal responsibility for co-pays, co-insurance, and deductibles when they are part of my insurance coverage. I understand that by law I must pay these fees to "The Practice" when required by my coverage. I understand that these fees must be paid prior to a scheduled appointment when the amounts can be verified, this includes co-insurance and deductible amounts.

NO-SHOW FEES: No-show or late cancellation fees will be charged when I "no-call, no-show" for a previously scheduled appointment or provide less than 24 hours' notice that I am unable to make an appointment. No shows fees will be posted in the check-in area. This fee can be waived as the discretion of the Provider or Office Manager. No show fees must be made before additional appointments are scheduled.

EQUIPMENT OR SUPPLIES: Any equipment or supplies provided to me by "The Practice" remains the property of "The Practice" unless otherwise designated by "The Practice". I understand that it is my responsibility to keep the equipment or supplies in proper working order and if any problems occur to notify "The Practice" immediately and return said equipment or supplies to "The Practice" for repair or exchange. I agree that should I fail to care for the equipment or supplies in a reasonable manner, or if I not comply with the parameters necessary to participate or I should electively discontinue participation in the program I must return said equipment or supplies within 30 days or I will be responsible for the cost of the equipment or supplies. Should "The Practice" request return of the equipment or supplies I understand that I have 30 days to return the equipment or supplies or I will be responsible for their cost.

Signed____ Date____________________________

"The Practice"
Representative____

I understand that I can revoke this consent in writing, except to the extent that "The Practice" has already taken action in reliance on it. I understand that if I revoke this consent "The Practice" may refuse to provide me with treatment. I also understand that this consent authorizes "The Practice" to use and disclose all past information documented in my medical record in accordance with the Privacy Notices provided. _______________Initial

JULIE SACHARKO APRN, LLC
PRIMARY CARE

MEDICAL HISTORY

Name____ DOB____________________

Your Past Medical History and Chronic Medical Conditions (check all that apply)

High Blood Pressure		High Cholesterol/Triglycerides		Diabetes Type 1	
Diabetes Type 2		Low Thyroid (hypothyroid)		Overactive Thyroid (hyperthyroid)	
Anxiety		Depression		Bi-Polar Disorder	
ADHD/ADD		Schizophrenia		Migraine Headaches	
Tension Headaches		Low Back Pain		Upper Back Pain	
Neck Pain		Hearing Loss/Hard of Hearing		Glaucoma	
Cataracts		Wears Glasses		Wears Dentures	
Eczema		Psoriasis		Breast Cancer	
Colon Cancer		Lung Cancer		Thyroid Cancer	
Skin Cancer		Brain Tumor		Bladder Cancer	
Brain Aneurysm		Abdominal Aneurysm		Arthritis	
Epilepsy		GERD/Heartburn/Reflux		Atrial Fibrillation (A-fib)	
Heart Attack		Congestive Heart Failure (CHF)		Alzheimer's/Dementia	
Ankle Swelling (Edema)		Varicose Veins		Stroke (CVA)	
Diarrhea		Constipation		Prostate Disease	
Low Blood Pressure		Urine Leakage (Incontinence)		Hemorrhoids	
Liver Disease		Kidney Disease		Erectile Dysfunction	
PMS		Heavy Periods		PCOS	
Seasonal Allergies		TMJ (jaw problems)		HIV/AIDS	
Overweight/Obesity		Fibrocystic Breast Disease		Chronic Fatigue Syndrome	
Fibromyalgia		Other:		Other:	
Other:		Other:		Other:	

Past Surgical History (please indicate year if known)

Tonsillectomy		Adenoidectomy		Gall Bladder Removal	
Thyroid Removed		Heart Bypass		Heart Valve Replacement	
Bowel Surgery		Hysterectomy		Tubal Ligation	
Vasectomy		Wisdom Teeth Removal		Hip Replacement R L	
Cataract Removal		Knee Replacement R L		Spleen Removed	
Face Lift		Tummy Tuck		Eye Lift	
Ear Tubes (Myringotomy)		Carotid Endarterectomy		Hammer Toes	
Foot Surgery		Elbow Surgery		Hand Surgery	
Colonoscopy		EGD Endoscopy		Heart Catheterization	
Knee Laparoscopy		Abdominal Laparoscopy		Bronchoscopy	
Other:		Other:		Other:	
Other:		Other:		Other:	

Reviewed by ____ Date____________________

JULIE SACHARKO APRN, LLC
PRIMARY CARE

Name____DOB_________________________

Family History (please indicate the diseases your relatives have (check all that apply)

High Blood Pressure		High Cholesterol/Triglycerides		Diabetes Type 1	
Diabetes Type 2		Low Thyroid (hypothyroid)		Overactive Thyroid (hyperthyroid)	
Anxiety		Depression		Bi-Polar Disorder	
ADHD/ADD		Schizophrenia		Migraine Headaches	
Tension Headaches		Low Back Pain		Upper Back Pain	
Neck Pain		Hearing Loss/Hard of Hearing		Glaucoma	
Cataracts		Wears Glasses		Wears Dentures	
Eczema		Psoriasis		Breast Cancer	
Colon Cancer		Lung Cancer		Thyroid Cancer	
Skin Cancer		Brain Tumor		Bladder Cancer	
Brain Aneurysm		Abdominal Aneurysm		Arthritis	
Epilepsy		GERD/Heartburn/Reflux		Atrial Fibrillation (A-fib)	
Heart Attack		Congestive Heart Failure (CHF)		Alzheimer's/Dementia	
Ankle Swelling (Edema)		Varicose Veins		Stroke (CVA)	
Diarrhea		Constipation		Prostate Disease	
Low Blood Pressure		Urine Leakage (Incontinence)		Hemorrhoids	
Liver Disease		Kidney Disease		Erectile Dysfunction	
PMS		Heavy Periods		PCOS	
Seasonal Allergies		TMJ (jaw problems)		HIV/AIDS	
Overweight/Obesity		Fibrocystic Breast Disease		Other:	
Other:		Other:		Other:	

Your Medications

Medication Name	Dose	Morning Pill	Lunch Pill	Dinner Pill	Bedtime Pill	Just As Needed

Reviewed by ____Date_________________________

Name____**DOB**____________________

Your Medicine Allergies (check all that apply and indicate reaction)

Medication Name	X	Reaction
Penicillin/Amoxicillin		
Sulfa/Sulfur/Bactrim		
Zithromax/Azythromycin		
Erythromycin		
Clindamycin		
ACE Inhibitors (Lisinopril/Prinivil etc.)		
Statins (Cholesterol medicine)		
Codeine		
Oxycodone/Hydrocodone (Vicodin/Norco/Percocet)		
Morphine		
Sudafed (Pseudoephedrine)		
Other:		
Other:		
Other:		

Your Food Allergies:

Food	X	Reaction
Strawberries		
Milk/Dairy		
Wheat/Gluten		
Peanuts/Peanut Butter		
Other Nuts		
Shrimp/Shellfish		
Fish		
Eggs		
Soy		
Chocolate		
Other:		
Other:		

Environmental Allergies:

Allergen	X	Reaction
Dogs		
Cats		
Pollen		
Dust		
Grass		
Mold		
Other:		
Other:		

Reviewed by____Date____________________

JULIE SACHARKO APRN, LLC
PRIMARY CARE

Name____DOB___________________________

May we share any vaccine information with the state/national immunization registry? □ Yes □ No

Do you have a living will or advanced directives (what you want done if you can't make medical decisions for yourself?

□ Yes (please provide us with a copy)

□ No Would you like information about this □ Yes □ No

Do you have a healthcare proxy (someone to make medical decisions for you if you are unable to do so?

□ Yes (please provide us with a copy) Name____

□ No Would you like information about this ⍰ Yes ⍰ NDo

you struggle to pay your bills? □ Yes □ No

Do you have food insecurity (trouble getting enough to eat for you and your family)? □ Yes □ No

Do you have transportation insecurity (trouble getting rides to where you need to go)? □ Yes □ No

Is your housing stable (are you at risk of being homeless)? □ Yes □ No

Is your home safe (enough heat, running water, proper lights, no broken steps or railings etc.) □ Yes □ No

Are you at risk for domestic abuse/violence? □ Yes □ No If yes, Would you like help? □ Yes □ No

Are there any other issues you would like to discuss with us? □ Yes □ No If yes, what?________________________________

____

____

We are required by the federal government to collect certain non-medical information. Please be aware that this information is optional for you to provide. This information may help us care for you better. When our practice provides this information to agencies requesting it, the format does not provide your name or personally identifiable information.

Race: □ American Indian or Alaskan Native □ Black or African American □ Asian □ Pacific Islander/Hawaiian □ White

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino

Primary Language: □ English □ Spanish □ Other____

Sexual Orientation: □ Lesbian/Gay/Homosexual □ Heterosexual/Straight □ Bisexual □ Other □ Decline to Disclose

Gender Identity: □ Female □ Male □ Transgender-Female to Male □ Transgender-Male to Female □ Gender Queer

□ Gender Fluid □ Other □ Decline to Disclose

Reviewed by____Date_________________________

JULIE SACHARKO APRN, LLC
PRIMARY CARE

Name____DOB__________________________

PRIVACY NOTICES

NOTICE OF PRIVACY PRACTICES: This notice provides information on how Julie Sacharko, APRN LLC, ("The Practice"), will use and disclose your Protected Health Information (PHI). This notice also explains important rights you have regarding your PHI. "The Practice" reserves the right to change this Privacy Notice at any time.

USE AND DISCLOSURE OF INFORMATION: We will use and disclose your PHI for a variety of treatment, payment, and healthcare operations purposes. Such disclosure of your PHI may be made via mail, telephone, facsimile (fax), modem, email, and/or internet as may be necessary for "The Practice" to conduct business for these purposes. If your PHI contains any privileged or additionally protected information under State of Federal Law (such as HIV testing/status, mental health records, or sexually transmitted infection (STI) etc.) you will be asked to sign a specific authorization for the release of this additionally protected information. All PHI at "The Practices" will be handled in accordance with the Health Information Portability and Accountability Act of 1996.

Specifics of the HIPAA of 1996 can be found on the CDC website at https://www.cdc.gov/phlp/publications/topic/hipaa.html#:~:text=The%20Health%20Insurance%20Portability%20and,the%20patient's%20consent%20or%20knowledge.

RELEASE OF INFORMATION TO SPECIFIED PARTIES: I understand that I have can consent to the release of my PHI to specified parties. I have indicated below my preference in the release of my PHI to specified parties.

□ I DO NOT give permission to "The Practice" to release my medical information to anyone – with the exception of the release of my PHI in order to facilitate emergency or urgent medical care and restrict the release of that information to that which is necessary for the treatment of said emergency.

□ I give permission to "The Practice" to speak with and release to my PHI to the following individuals:

Name____Relationship_____________Phone______________________

Name____Relationship_____________Phone______________________

Name____Relationship_____________Phone______________________

RESTRICTIONS ON USE AND DISCLOSURES: You have the right to request how "The Practice" uses and discloses your health information for the purposes of treatment, payment, and healthcare operations and disclosures to family and friends. You also have the right to ask us to send communications including your PHI to an address, phone number (text), or e-mail of your choice. You also have the right to advise us on how to leave communications (ie. messages on a voicemail or answering machine, with a person who answers the phone). These instruction should be outlined on the communications document included in this packet.

Signature____ Date___________________________

Practice Representative____

I understand that I can revoke this consent in writing, except to the extent that "The Practice" has already taken action in reliance on it. I understand that if I revoke this consent "The Practice" may refuse to provide me with treatment. I also understand that this consent authorizes "The Practice" to use and disclose all past information documented in my medical record in accordance with the Privacy Notices provided. _____________Initials

JULIE SACHARKO APRN, LLC
PRIMARY CARE

Office Contact Details

Authorization to disclose medical information

Patient Name: ____DOB______________________
Patient Address: ____
City: ________________________State: ____________Zip: ________________________________

Unless otherwise specified below all medical records for the last 2 years are to be included excluding protected information as outlined below.

Specific Records Requested____

Sensitive Information

Please circle all additional information to be transferred:

Mental Health	Depression/Anxiety	Alcohol/Substance Abuse
HIV	Genetic Testing	Sexual Transmitted Infection (STI)
Abortion	Domestic Violence	Sexual Assault

Release Information

I hereby authorize Julie Sacharko, APRN LLC, ("The Practice"), to: ____Obtain my records from __________________________________Release my records to:
Provider/Facility ____
Address____City________________________
State__________ Zip Code________________ Phone_________________ Fax________________
Reason for Request:
Transfer In (New Patient)_____ Transfer Out_____ Other_____
Personal ______ Specialist Referral_____

I understand that I have the right to revoke this authorization at any time by providing a written statement to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand, unless otherwise revoked or specified, this authorization.
Please specify an expiration date: _______________. If no date is specified this release will expire in 180 days.

I understand the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

Signature:
Patient/Legal Guardian ____
If signed by guardian, relationship to the patient ___________________Date:________
Witness____

JULIE SACHARKO APRN, LLC
PRIMARY CARE

Demographic Information

Legal Name____

Preferred Name____________________________ Date of Birth__________________________________

Address____

City/State/Zip____

Home Phone:_______________________________Cell Phone: ___________________________________

Email Address______________________________________@_______________________.__________

Cell Phone Carrier (needed for text messaging)____

Preferred Method of Contact: □ Home Phone □ Cell Phone Call □ Text □ E-mail (check all that apply)

Circle One: Gender Assigned at Birth: □Male □Female Gender Identity: □ Male □ Female □ Other_____________

Marital Status: □ Single □ Married □ Separated □ Widowed □ Divorced □ Domestic Partner □ Other (check one)

EMPLOYMENT

Employment Status: □ Employed FT □ Employed PT □ Retired □ Unemployed □ Disabled □ US Military

If employed: Employer____Occupation__________________

Business Address____

City/State/Zip____

Business Phone____ May We Contact You at Work □ Yes □ No

INSURANCE **□ No Insurance Coverage**

Health Insurance Coverage: ____

ID#____ Group #________________________________

Effective Date______________________ Insurance Subscriber: □ Self □ Spouse/Parent □ Other____________

PREFERRED LOCAL PHARMACY ____

MAIL ORDER PHARMACY____

OTHER PHARMACY____

EMERGENCY CONTACT(Please indicate which of your contacts is your next of kin – check the box □)

□ Name ____Phone__________________________

□ Name____Phone__________________________

JULIE SACHARKO APRN, LLC
PRIMARY CARE

Name____DOB__________________________

CONSENT TO USE NON-SECURE TEXTING AND/OR EMAIL FOR COMMUNICATION

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").1 The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" (PHI) by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. Julie Sacharko, APRN LLC, ("The Practice") is a covered entity under the act. A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing.

Standard text messaging and e-mail is not considered HIPAA compliant and may be subject to unintended loss of PHI through hacking or other failure. Whereas, "The Practice" is subject to the provisions of HIPAA and is responsible for protecting the PHI contained in my records and in all communications with me about my health, for ease of communication,

I give consent for "The Practice" to communicate with me via (check all that apply)

□ Standard Text Messaging *please provide phone number for texts*____

□ Standard E-mail *please provide email address*____

I understand that by signing this document I am releasing "The Practice" from liability regarding the loss of my PHI through communication via text or email to the number or email address listed above.

I understand that I can access my PHI and communicate with my providers at "The Practice" through a secure portal provided by ASP.MD the electronic health record used by "The Practice."

"The Practice" will take every precaution to assure that communication sent to the above designated number or email is directed appropriately but under no circumstances takes responsibility for any unintentional errors of loss of PHI that might occur during communication.

Patient Signature____Date___________________________

Signature of Representative of "The Practice"____

I understand that I can revoke this consent in writing, except to the extent that "The Practice" has already taken action in reliance on it. _______________Initials

Consent to Treat

1. I, ______________________________, give permission for Julie Sacharko, APRN LLC to give me medical treatment.
2. I allow Julie Sacharko, APRN LLC to file for insurance benefits to pay for the care I receive and understand that:
    - Julie Sacharko, APRN 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 Signature **Date**

______________________________ ______________________________

POA or Guardian Signature **Date**