The Lady with the Lamp

Visiting Nurse Practitioner

Office: (281) 706.9232
Fax: (844) 899.4223
www.TheVisitingNP.com
2323 Riverway Oak Drive
Kingwood, TX 77345

Nurse Practitioners

Tiffany Cutbirth, APRN NP-C
Amy Hardy-Covey, APRN FNP-BC
Sonia Bassett, APRN AGNP-C
Kami Wasilewski, APRN FNP-C

Supervising Physicians

Dr. Srikanth Raayasa
Dr. Mohan Rathi

New patient information packets must be completed and sent to our office before any patient can be scheduled for a visit. Completed information packets can be faxed to 844.899.4223 or emailed to OfficeAdmin@TheVisitingNP.com

*** PLEASE ATTACH COPIES OF ALL INSURANCE CARDS ***

Introduction

Thank you for considering the services of **The Lady with the Lamp**. We are a visiting nurse practitioner practice that brings healthcare services to home-bound geriatric patients in their place of residence, including personal homes, independent-living, assisted-living, skilled-nursing facilities, and personal care homes. We provide meaningful care and coordination with the goal of increasing quality of life and preventing unnecessary hospitalizations.

Our nurse practitioners and staff are well-versed in the chronic conditions facing the geriatric population. We leverage this expertise to manage the comprehensive care needs of our patients through proactive communication with all parties involved, including the patient, their families, and their entire care team; including facility owners, facility staff, home-health and hospice agencies.

Our staff is comprised of individuals who desire autonomy, thrive in an environment in which they become deeply knowledgeable of the patient, their lives, and their support system, embrace the role of educating patients and families of their choices and challenges, see the advantages of being responsible for the overall coordination and execution of the patient's care plan, and are rewarded by being a critical member of our patient's overall well-being.

We take on the role of Primary Care Provider (PCP) for our patients. We can fit in and work with existing specialists while becoming the primary point of contact for the patient's overall care plan. In addition to designing and implementing a plan of care, we work closely with home health and hospice companies to provide comprehensive care throughout all phases of the aging process and are here to help educate our patient and their families on all of their options. We have no business relationships with nor receive any compensation from home health or hospice agencies but are committed to helping you understand your options and identifying the agencies that best fit the needs of our patients. It is important to remember that the patient always has the right to choose their providers, including services such as home health and hospice, and nothing in this document binds the patient to anything other than giving us permission to become your PCP and begin overseeing the patient's care.

To become a patient of The Lady with the Lamp, we must have the patient or their responsible party complete and sign this patient packet, and then fax or email it to our office. Once received, we will contact you to arrange for our initial visit.

Communication Guidelines

To best serve our patients, their families, and the facilities in which they live, we ask that everyone operate under the following communication guidelines.

All calls to our Providers and staff should be made to our main office number, 281.706.9232. This will ensure that all calls are handled effectively and efficiently and also allow our teams to focus on the patients they are seeing. It is our goal that all calls will be handled within 24 hours of receipt.

If you feel the patient is experiencing an emergency situation, please call 911.

Our office hours are from 8:30 to 5:00 Monday through Friday. Calls made to our office outside of these hours will be forwarded to the on-call Provider's voice mail. They will review these calls and handle them accordingly.

Any prescription refill requests can be faxed to 844.899.4223 or called into our main office number. When requesting a prescription refill, always provide the patient's name, DOB, current medication, dosage, and instructions.

Signature: _____

PATIENT PROFILE

PATIENT INFORMATION

First name _____MI_____

Last name _____SSN_____

Gender Male | Female

Birthdate _____ Age _____

Ethnicity/Race

☐ American Indian/Alaska Native ☐ Hispanic or Latino

☐ Native Hawaiian or Pacific Islander ☐ Asian

☐ White ☐ Black or African American

☐ Did not ask ☐ Not provided by patient

CONTACT INFORMATION

PATIENT

Phone _____ Primary language_____

Address_____

City _____ State _____Zip_____

PRIMARY CONTACT/NEXT OF KIN

Name _____ Phone _____

Address_____

City _____ State _____Zip_____

Relationship _____

Person(s) with whom we may share your medical info

Name _____ Phone _____

Address _____

City _____ State _____Zip_____

Relationship _____

ADVANCED DIRECTIVES

☐ Full code - Date _____

☐ Out of hospital DNR - Date _____

☐ Other _____ Date _____

☐ Medical Power of Attorney (provide contact info below)

Name _____ Phone _____

Address _____

City_____ State _____Zip_____

Relationship_____

INSURANCE INFORMATION

****PLEASE PROVIDE FRONT AND BACK COPIES OF INSURANCE CARDS****

RESPONSIBLE PARTY

Name_____ Birthdate_____

SSN_____Relation to patient _____

PRIMARY INSURANCE

Company name _____

ID/Group_____

SECONDARY INSURANCE

Company name_____

ID/Group_____

I certify that I have insurance coverage with the insurance companies listed above and assign directly to The Lady with the Lamp, PLLC. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The Lady with the Lamp, PLLC may use my health care information and may disclose such information to the insurance companies listed above and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATIONS

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to The Lady with the Lamp, PLLC. for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____

Signature of beneficiary, guardian, or personal representative

_____

Printed name of beneficiary, guardian, or personal representative

Date _____

Relationship_____

PHARMACY INFO

Pharmacy Name	Phone	Address

PAST MEDICAL HISTORY

SURGICAL HISTORY (circle and provide year, if known)

Appendectomy	Breast biopsy	Lumpectomy	**Male**	**Female**
Bone marrow biopsy	Colostomy	Lymph node biopsy	Orchiectomy	D and C
Bone marrow transplant	Craniotomy	Lymph node dissection	Prostate biopsy	Hysterectomy
CABG	Cystectomy	Needle Aspiration	Prostatectomy	Mastectomy
Cataract extraction	Gastric volvulus	Nephrectomy	Radical prostatectomy	Oophorectomy
Cholecystectomy	Hemicolectomy	Omentectomy	TURP	Ovarian cystectomy
Colectomy	Hip surgery	Pneumonectomy		TAH
Brachytherapy	Knee surgery	Radical neck dissection		TAH/DSO
Other_____	Other_____	Other_____	Other_____	TVH

CANCER HISTORY

Type of Cancer	Year Diagnosed	Chemo/Radiation/Other

IMMUNIZATIONS AND PREVENTATIVE SCREENINGS (provide dates where applicable)

Female	Male
Mammogram _____Colonoscopy _____	Colonoscopy _____PSA _____
Pap smear_____Bone density _____	Prostate _____

Shingles_____ MMR_____ Pneumonia_____ Influenza_____ Tetanus_____

MEDICAL PROBLEMS (circle all that apply)

AID/HIV	Asthma	Coronary artery disease	Hepatitis C	Kidney disease	Renal disease
Allergies	Atrial fib	Depression	Hyperlipidemia	Migraine headaches	Seizure disorder
Anemia	Blood clots	Diabetes	Hypertension	Obesity	Stroke
Angina	Cancer	GERD	Irritable bowel disease	Osteoarthritis	Thyroid disease
Arthritis/Gout	COPD	Hepatitis B	Liver disease	Peptic ulcer disease	Other_____

RECENT DIAGNOSTIC TESTS (provide dates where applicable)

Special Type of Study	CAT Scans or X-Rays	PET / Bone Scans	Ultrasound	MRI	Medical Facility

FAMILY HISTORY

Family Member	Living Status	Medical Problem / Present Health / Cause of Death
Mother	☐ Living ☐ Deceased	
Father	☐ Living ☐ Deceased	
Children	☐ Living ☐ Deceased	
Siblings	☐ Living ☐ Deceased	

ALLERGIES

Drug/Food/Environmental	Reaction	Onset	**Severity** (circle one)
		Child/Adult/Unknown	Very Mild/Mild/Moderate/Severe
		Child/Adult/Unknown	Very Mild/Mild/Moderate/Severe
		Child/Adult/Unknown	Very Mild/Mild/Moderate/Severe
		Child/Adult/Unknown	Very Mild/Mild/Moderate/Severe
		Child/Adult/Unknown	Very Mild/Mild/Moderate/Severe
		Child/Adult/Unknown	Very Mild/Mild/Moderate/Severe

SOCIAL HISTORY

MARITAL STATUS

☐ Married ☐ Widowed ☐ Separated

☐ Divorced ☐ Single ☐ Partnered for ___years

PATIENT LIVING WITH

☐ Alone ☐ Spouse ☐ Children

☐ Parents ☐ Friend ☐ _____

WORK HISTORY

Employment/Occupation_____ Retired: ☐ No ☐ Yes

TOBACCO USE

☐ Current ☐ Former ☐ Never ☐ Unknown

Type_____ Units per day_____ Years used_____

Tried to quit? ☐ No ☐ Yes Date quit _____ Longest duration tobacco free_____

Passive smoke exposure ☐ No ☐ Yes

☐ Current every day smoker ☐ Smoker, current status unknown ☐ Former smoker

☐ Current some day smoker ☐ Never smoker ☐ Unknown if smoked

ALCOHOL USE

☐ No ☐ Yes ☐ Formerly (Year Quit) _____

Type_____ Frequency_____ Amount_____ Date of last use_____

FEMALE REPRODUCTIVE

Number of pregnancies _____ Number of children _____

Age at menopause _____ Age at last period _____ Hormone use? ☐ No ☐ Yes

DEVELOPMENTAL HISTORY

FUNCTIONALITY

☐ Fully active ☐ Restricted in physical activity ☐ Ambulatory, capable of self-care ☐ Limited self-care ☐ Disabled

Other notes_____

_____

GENERAL ASSESSMENT

Reason for visit _____

SYMPTOMS (circle all that apply)

Abdominal Pain	Painful/difficult urination	Insomnia	Poor fluid intake	Chest pain	Headache	Nausea
Cough	Problem coping	Constipation	Hives	Night Sweats	Rash	Increased thirst
Pallor/pale color	Petechiae/spotting	Weight loss	Weight gain	Dizziness	Infections	Other _____

Primary care physician_____ Consulting/Referring physician_____

REVIEW OF SYSTEMS

GENERAL
- ❑ Recent weight gain; ?___
- ❑ Recent weight loss: ?___
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes - hands or feet

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

_____

_____

PAIN HISTORY

Do you experience pain? ☐ No ☐ Yes Location_____ How is your pain relieved?_____

Current pain level – (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

MEDICATION HISTORY ☐ See Attachment for Medications

Medication (Name, Rx or OTC)	Strength of Drug	Daily Dosage / How Taken

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

YOUR RIGHTS You have the right to:	**YOUR CHOICES** You have some choices in the way that we use and share information as we:	**OUR USES AND DISCLOSURES** We may use and share your information as we:
• Get a copy of your paper or electronic medical record • Correct your paper or electronic medical record • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated	• Tell family and friends about your condition • Provide disaster relief • Include you in a hospital directory • Provide mental health care • Market our services and sell your information • Raise funds	• Treat you • Run our organization • Bill for your services • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests • Work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

OTHER INFORMATION

- Effective Date of this Notice is February 20, 2018
- Privacy official: Rick George, OfficeAdmin@thevisitingnp.com 281.706.9232
- We never market or sell personal information.

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my healthcare provider if I, or the person for whom this information was provided, ever have a change in health.

_____	_____
Signature of patient, parent, guardian, or personal representative	Date
_____	_____
Printed Name of patient, parent, guardian, or personal representative	Relationship to patient
_____	_____
Reviewed by	Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

PATIENT NAME _____

DATE OF BIRTH _____

PHONE _____

TO WHOM RECORDS WILL BE SENT

The Lady with the Lamp, PLLC.

2323 Riverway Oak Drive

Kingwood, TX 77345

Fax: (844) 899.4223

Office: (281) 706.9232
Email: OfficeAdmin@TheVisitingNP.com

FROM WHOM RECORDS WILL BE RELEASED

(Office Use Only – Leave Blank)

PLEASE RELEASE THE FOLLOWING

☐ Problem list	☐ History & Physical	☐ X-Ray reports	☐ EKG reports
☐ Labs	☐ Consultation notes	☐ Progress rotes	☐ Immunizations
☐ Radiology reports	☐ Hospital records	☐ Emergency records	☐ Other _____

INCLUDING INFORMATION (IF APPLICABLE) PERTAINING TO

☐ Mental health	☐ Drug/Alcohol	☐ HIV/AIDS	☐ Other _____

THIS INFORMATION IS BEING RELEASED FOR THE FOLLOWING PURPOSE(S)

☐ Continued patient care	☐ Personal use	☐ Attorney / Legal
☐ Insurance claim	☐ Disability determination	☐ Other _____
☐ Radiology reports	☐ Hospital records	☐ Emergency records

I understand that the information is for the specific purposes stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance of it.

SIGNATURES

To the best of my knowledge, the above information is complete and correct and I authorize the release of medical records to the party listed above.

_____	_____
Signature of patient, parent, guardian, or personal representative	Date
_____	_____
Printed Name of patient, parent, guardian, or personal representative	Relationship to patient
_____	_____
Reviewed by	Date