Cheryl Vallie, RN, CFNP

REGISTRATION FORM

(Please Print)

Today's Date:_____________

PATIENT INFORMATION

Male / Female

Name: Last First Middle Sex (Please select one)

Single / Married / Divorced / Separated / Widowed

Social Security No Birth Date Marital Status (Please select one)

Street Address City State Zip Home Phone

Mailing Address City State Zip Alternate Phone

Occupation Employer Work Phone

Chose Clinic Because / Referred to Clinic by

Other Family Members seen here

INSURANCE INFORMATION

Occupation Employer Employer Address Employer Phone

Primary Insurance Group No Policy No Co-Payment

Subscriber's Info: Name Social Security Birth Date Relationship to Insured

Secondary Insurance Policy No Relationship to Insured

IN CASE OF EMERGENCY

Contact Name Relationship to Patient Primary Phone Alt Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Cheryl Vallie or insurance company release any information required to process my claims.

Patient / Guardian Signature

Date

CHERYL VALLIE, RN, CNP

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME: ☐ Male ☐ Female **DOB:**

MARITAL STATUS: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PREVIOUS OR REFERRING DOCTOR:

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

IMMUNIZATIONS AND DATES: ☐ Tetnus ☐ Influenza ☐ Pneumonia ☐ Chickpox

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

CHERYL VALLIE, RN, CNP

MEDICATIONS (Please list ALL prescribed AND over-the-counter drugs, including vitamins and inhalers)		
Name	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS	
Name of Drug	Reaction

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

EXERCISE	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occassional vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
DIET	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
CAFFEINE	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
ALCOHOL	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
TOBACCO	Do you use tobacco?				☐ Yes	☐ No
	# _______ ☐ Cigarettes - pks/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	# of years _______ Or year quit _______					
DRUGS	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
SEX	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for pregnancy, list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness realted to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intraveneous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?					

CHERYL VALLIE, RN, CNP

PERSONAL SAFETY				
	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become maor public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?		

FAMILY HEALTH HISTORY

	AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS
Father				Children	MALE	FEMALE	
Mother					MALE	FEMALE	
Sibling	MALE	FEMALE			MALE	FEMALE	
	MALE	FEMALE			MALE	FEMALE	
	MALE	FEMALE		Grandmother	Maternal		
	MALE	FEMALE		Grandfather			
	MALE	FEMALE		Grandmother	Paternal		
	MALE	FEMALE		Grandfather			
	MALE	FEMALE					

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ______ days.		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Nuber of pregnancies_____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, Hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hotflashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms a	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam? ________________		

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MEN ONLY				
Do you usually get up to urinate during the night?	☐	Yes	☐	No
If yes, # of times _____				
Do you feel pain or burning with urination?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Do you feel burning discharge from penis?	☐	Yes	☐	No
Has the force of your urination decreased?	☐	Yes	☐	No
Have you had any kidney,bladder,or prostate infections in the last 12 months?	☐	Yes	☐	No
Do you have any problems emptying your bladder completely?	☐	Yes	☐	No
Any difficulty with erection or ejaculation?	☐	Yes	☐	No
Any testicle pain or swelling?	☐	Yes	☐	No
Date of last prostate and rectal exam? _______				

OTHER PROBLEMS					
☐	Skin	☐	Chest/Heart	☐	Recent changes in:
☐	Head/Neck	☐	Back	☐	Weight
☐	Ears	☐	Intestinal	☐	Energy level
☐	Nose	☐	Bladder	☐	Ability to sleep
☐	Throat	☐	Bowel	☐	Other pain/discomfort
☐	Lungs	☐	Circulation		

Cheryl Vallie, RN, CFNP

PAYMENT TERMS: Co-payments and / or Deductibles are due immediately at the time of service. There will be a service charge of $35.00 for non-sufficient funds. If it is not taken care of in a timely manner, it will be turned over the District Attorney's office.

INTERACTION AND CORRESPONDENCE TERMS: Threatening and / or abusive treatment of medical staff members will not be tolerated. The right is hereby reserved to terminating service immediately upon verbal or written notification. Cheryl Vallie reserves the right to terminate the patient / healthcare provider relationship for any other reason. If termination takes place, a reasonable time period will be provided in order to allow patient to establish care and alternate healthcare provider.

MINOR PATIENT TERMS: Patients under 18 years of age are to be accompanied by an adult retaining guardianship or legal aid representation. Non-parental relationships will require legal documentation expressing rights of guardianship of legal aid verification.

SERVICE RESTRICTION TERMS: Patients requiring chronic inpatient nursing home care and / or disability exams will need to seek an alternative healthcare provider. Cheryl Vallie will not participate or testify in insurance or lawsuit cases. No worker's compensation cases will be seen. Patients must be seen in clinic setting for services. Patients who cannot be brought to the clinic for regular check-ups will need to seek an alternative provider. Non-English speaking patients must be accompanied by a translator or be rescheduled. Only one visitor may accompany each patient visit due to limited seating.

INSURANCE AFFILIATIONS: We are currently enrolled in some health insurances as participating providers but we ask that you check with us about your specific insurance. If we are not in-network with them you will have a balance due.

NO-SHOW APPOINTMENTS: We have experienced a high volume of "NO-SHOW" appointments and are now charging a $50.00 No-Show fee. This fee will not be charged if we have at least 24 hour notice of the cancelled appointment.

ACKNOWLEDGEMENT: I have read, understand, and agree to the terms above.

Signature of Patient/Guardian ____ Date ______

CHERYL VALLIE, CFNP Notice of Privacy Practices
(Includes Texas Privacy Law)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

1. Purpose: The professional staff and employees of the office of CHERYL VALLIE, CFNP follow the privacy practices described in this Notice.

The office maintains your personal health information in records that will be maintained in a confidential manner, as required by law. This health information may include photographs obtained by authorized personnel at the office for treatment purposes. The office must use and disclose your health information to the extent necessary to provide you with quality health care. To do this, the office must share your health information as necessary for treatment, payment and health care operations.

2. What Are Treatment, Payment, and Health Care Operations?

Treatment includes sharing information among health care providers involved in your care. For example, your physician may share information about your condition with the pharmacist to discuss appropriate medications or with radiologists or other consultants in order to make a diagnosis. The office may use your health information as required by your insurer to obtain payment for your treatment and hospital stay. We also may use and disclose your health information to improve the quality of care, e.g., for review and training purposes. It is also determined that patient safety activities of patient safety organizations (PSOs) are deemed to be healthcare operations under the Privacy Rule.

3. How will the office use My Health Information?

Your health information may be used for the purposes listed below, unless you ask for restrictions on a specific use or disclosure:

• To share with your healthcare provider(s) and PSOs as needed for follow-up care. This would include Texas Tech University Health Science Center (TTUHSC), the Permian Basin Healthcare Network (PBHN), and other physicians and healthcare providers with staff privileges at MCHS, ORMC or Basin.

• Religious affiliation to a hospital chaplain or member of the clergy.

• Authorized family members who may consent to your treatment or who are involved in the payment for your treatment.

• Workers' Compensation. (Your health information regarding benefits for work-related illnesses may be released as appropriate.)

• To carry out health care treatment, payment, and operations functions through business associates, e.g., to install a new computer system.

• American Red Cross (or a government disaster relief agency) if you are involved in a disaster relief effort.

• Appointment reminders.

• To inform you of treatment alternatives or benefits or services related to your health. (You will have an opportunity to refuse to receive this information.)

• Used (or disclosed to a business associate) for fundraising, but such information will be limited to your name, address, phone number, and the dates you received services at the office. (You will have an opportunity to opt-out from receiving any fundraising communications after the initial notification required by law.)

• Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required by law).

• Health oversight activities, e.g., audits, inspections, investigations, and licensure.

• Lawsuits and disputes. (We will attempt to provide you advance notice of a subpoena before disclosing the information.)

• Law enforcement (e.g., in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred on the Hospital's premises; and in emergency circumstances relating to reporting information about a crime.)

• To coroners and medical examiners.

• Organ and tissue donation.

• Certain research projects approved by an Institutional Review Board.

• To prevent a serious threat to health or safety.

• To military command authorities if you are a member of the armed forces.

• National security and intelligence activities.

• Protection of the President or other authorized persons from foreign heads of state, or to conduct special investigations.

• Inmates. (Medical information about inmates of correctional institutions may be released to the institution.)

• Alcohol and drug abuse information has special privacy protections. The office will not disclose any information identifying an individual as being a patient or provide any medical information relating to the patient's substance abuse treatment unless:

(i) the patient consents in writing;
(ii) a court order requires disclosure of the information;
(iii) medical personnel need the information to meet a medical emergency;
(iv) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; or
(v) it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.

Certain types of information will be subject to additional restrictions on disclosure, such as AIDS test results and psychotherapy notes.

4. Your Authorization Is Required for Other Disclosures.

Except as described above, we will not use or disclose your health information unless you authorize (permit) the office in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

5. You Have Rights Regarding Your Medical Information.

You have the following rights regarding your health information, provided that you make a written request to invoke the right on the form provided by the office:

• Right to request restriction. You may request limitations on your health information we use or disclose for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular surgery), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. However, you may request to restrict certain disclosures of your health information if the services were paid in full and out of pocket has been met, at which time we will comply with your request.

• Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.

• Right to inspect and copy. You have the right to inspect and request copies of your health information regarding decisions about your care. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by the office. The office will comply with the outcome of the review.

• Right to request amendment. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by the office, which requires certain specific information. The office is not required to accept the amendment.

• Right to accounting of disclosures. You may request a list of the disclosures of your health information that have been made to persons or entities other than for health care treatment payment or operations in the past six (6) years. After the first request, there may be a charge.

• Right to a copy of this Notice. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our web site at www.FanousMD.com.

• Right of notification of breach. The office will notify you in the event a breach of your protected health information has occurred and you were affected.

• Right of notification of genetic information. You may prohibit the office from using or disclosing your genetic health information for underwriting.

6. Requirements Regarding This Notice.

The office is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. The office may change this Notice and these changes will be effective for health information we have about you as well as any information we receive in the future. The office will prominently post any revision made to this Notice at our web site listed herein.

Contact our Privacy Officer at 432-699-6271 if:

- you have a complaint;
- you have any questions about this Notice;
- you wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- you wish to obtain a form to exercise your individual rights described in paragraph 5.

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Officer, or, you may file a complaint with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services.

There will be no retaliation for filing a complaint with either the practice's Privacy Officer or with the Office for Civil Rights.

To file a complaint with the OCR, you may:

(1) Mail it to:

Secretary of the U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Washington, D.C. 20201;

(2) Call (202) 619-0257 (or toll free (877) 696-6775);

(3) Or visit the OCR website, www.hhs.gov/ocr/hipaa/, for more information on the options listed above, or for electronic filing options.

Revised 7.16.14

Cheryl Vallie, RN, CFNP

Release of Information Form:

I ______________________________________ am giving CHERYL VALLIE, RN, CFNP FAMILY PRACTICE and her staff my permission to discuss my care, lab reports, x-rays, and any medical information including scheduling with the following person(s).

NAME	PHONE	RELATIONSHIP

I do also hereby give my permission to leave a message concerning my medical care at any one of the following phone numbers:

Home:		
Mobile:		
Work:		
Alternate:		

Signature of Patient/Guardian ____ Date ____________________

MEDICATION FLOWSHEET

PATIENT NAME:			ALLERGIES:		
DATE		**MEDICATION**	**REFILLS**		
Start	Stop	Dosage/Direction/Amount	Date	Amount	Initials

Cheryl Vallie, RN, CFNP

Private Patient Payment Agreement:

I ____________________________________ understand that CHERYL VALLIE, RN, CFNP FAMILY PRACTICE is accepting me as a private pay patient.

We are committed to providing you with the best possible medical care; if you have special needs we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Our office participates in a variety of insurance plans. It is YOUR responsibility to:

- The total patient balance due is required to be paid at the time the services are provided.
- For your convenience we accept **cash, check, Visa, MasterCard, and Discover.**
- It is **your responsibility** to inform us **BEFORE** your visit when payment cannot, otherwise payment is expected at the time of service.
- If you fail to make payment in full for services that are rendered to you, your outstanding balance will be sent to a collections agency. If you consistently refuse to pay for services rendered, the office Cheryl Vallie may choose to cease providing services to you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements, past due, and current balances should be addressed BEFORE services are provided and to the Office Manager.

Signature of Patient/or Responsible Party ____ Date _______