Evangeline Butler APRN FNP

Board Certified by the American Academy of Nurse Practitioners

Dear ____________________________

I would like to take this opportunity to welcome you to my family practice and to let you know how I appreciate you for choosing Caring Heart Family Nurse Practitioner as your primary care provider. I work with a dedicated team of Registered Nurses, Physical Therapists, Mental Health Specialists, Technologists, and other allied health care providers whose main goal is to provide you individual care and to focus on your wellness and disease prevention.

By having a team of healthcare providers, we can work efficiently and work collaboratively with your local hospitals and a wide range of physician specialists to coordinate your healthcare needs including impatient hospitalization and specialty consultations as needed.

Before your visit or our home visit, please notify your health insurance company for your new primary care provider Evangeling Butler APRN FNP-BC. Also, please fill out the forms enclosed so we can process your healthcare information and the consent form that allows us to receive a copy of your medical records from your previous healthcare provider.

Once again, I would like to thank you for choosing Caring Heart Family Nurse Practitioner as your primary care provider. I look forward to working with you and your family.

Sincerely, ________________________

Evangeline Diaz Butler APRN FNP-BC
CHFNP Founder

Caring Heart Family Nurse Practitioner - New Patient Form

Patient Name: ______________________________ Age: ________ Sex: ________
Last First Middle

Date of Birth: __________ Language: __________ Race: White Other/Including: Black Hispanic

Social Security # ____ – ____ – ____ Email: ______________________________

Mailing Address: ______________________________
Street & No. Apt. # City State Zip Code

Check if home # is same as mobile # Home Phone: __________ Mobile Number: __________

Employer: ______________________________ Work Phone: __________
Name City State

Marital Status: Single Married Divorced Widowed Minor/Child

Spouse's Name: ______________________________ Mobile Number: __________

Spouse's Employer: ______________________________ Employer Number: __________

MINOR/CHILD ONLY Parent/Responsible Party's Email: ______________________________

Father's Name: ____________________
Address: ____________________
Date of Birth: ____________________
Daytime/Cellphone: ____________________
Employer: ____________________

Mother's Name: ____________________
Address: ____________________
Date of Birth: ____________________
Daytime/Cellphone: ____________________
Employer: ____________________

EMERGENCY CONTACT

Name: ______________________________ Relationship: __________
Last First Middle Initial

Address: ______________________________
Street & No. Apt. # City State Zip Code

Mobile Phone: __________ Alternate Number: __________

INSURANCE

Insurance Name: ____________________ ID# __________ Group # __________

Subscriber's Name: Last First Middle Initial

Subscriber's DOB: __________ Subscriber's Social Security#: ____ – ____ – ____

Subscriber's Employer: ______________________________

Secondary Insurance: ____________________ ID# __________ Group # __________

Subscriber's Name: Last First Middle Initial

Subscriber's DOB: __________ Subscriber's Social Security#: ____ – ____ – ____

Subscriber's Employer: ______________________________

This certifies insurance coverage as listed above and that I have no other health insurance coverage

____
Patient or Parent's Signature, as applicable

FINANCIAL AGREEMENT AND AUTHORIZATION FOR PAYMENT:

I authorize the Caring Heart Family Nurse Practitioner to render medical treatment and emergency medical services, in my absence, to the patient above, and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon receipt thereof.

I authorize the release of any medical information necessary to process the filing of insurance to cover cost of medical treatment. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending stat of claims thereon, and proceeds of insurance are assigned to this office where applicable, but without CHFNP assuming responsibility of the collection thereof. A copy of this assignment is as valid as the original.

Signature: ______________________________ **Date:** __________
Responsible Party

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Patient Name

Date of Birth

Rx (Prescription) History Consent

Patient or Authorized Person's Consent

I authorize the provider **Caring Heart Family Nurse Practitioner** to view my prescription history from other external sources.

With this consent, the **Caring Heart Family Nurse Practitioner** provider(s) may view my prescription history when seen by other providers that have prescribed medications elsewhere to assist the Family Practice provider(s) in carrying out treatment.

_____ Yes, I give my consent to view my prescription history.

Patient or Authorized Person

Date

_____ No, I do not give my consent to view my prescription history

Patient or Authorized Person

Date

PRESCRIPTION REFILL POLICY

To our patient,

Please follow the procedures outlined below when calling the office to request a refill.

Prescriptions are written and/or called into the pharmacy at the end of the business day; Refill requests left on the voice mail after hours, on holidays or weekends, will be processed on the next regular business day. ***Please do not wait until you run completely out of a medication to request a refill.***

HIPAA NOTICE OF PRIVACY PRACTICE
PATIENT CONSENT/ACKNOWLEDGE FORM

I hereby acknowledge receipt of the Notice of Privacy Practice.

With this consent, Caring Heart Family Nurse Practitioner may call and leave a message on voice mail or in person, mail, email to my home or other alternative location. Any items that assist the practice in carrying out Treatment, Payment, Healthcare Operations (TPO), pertaining to my clinical care, including laboratory test results, or such as appointment reminder cards and patient statements.

I have the right to request that **Caring Heart Family Nurse Practitioner** restrict how it uses or discloses my Patient Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations (TPO). The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Restrictions: ____________________

By signing this form, I am consenting to allow Caring Heart Family Nurse Practitioner to use and disclose my Patient Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations (TPO).

Disclose my Patient Health Information (PHI) to: ____________________

Caring Heart Family Nurse Practitioner will leave a message: ______ **Yes** ______ **No**

Phone #: ____________________

Phone #: ____________________

____
Signature of Patient/Guardian

____
Print Name of Patient

____
Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: (source)

Physician/Facility

Mailing Address

City, State, Zip

Fax:

Phone:

To Release Medical Information of:

Patient Name

Social Security Number

Date of Birth

TO BE RELEASED TO: **Caring Heart Family Nurse Practitioner Fax # 386-232-5152**

Information to be released:
I hereby authorize the above-named source to release or disclose: all medical records or other information regarding my treatment, hospitalization, and/or outpatient care, including, but not limited to, psychological or psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, AIDS (Acquired Immune Deficiency Syndrome), symptomatic HIV infection, and HIV antibody testing.

Reason for release:

- Moving - New Address
- Changing Treating Doctors
- Other

Please release information ☐ via: ☐ Mail Pick up, phone/cell No.

"Medical Records" means information recorded in any form or medium that identifies the patient and relates to the patient's history, diagnosis, treatment or prognosis. Note: Law authorized the release of health care information without patient authorization in a number of situations, including disclosures to a third-party payer such as insurance companies if the disclosure is to reimburse the health care provider, or the patient, for medical services and supplies. This authorization is valid for 90 days from the date of signature, unless I specify otherwise or revoke it.

Signature of Patient or Authorized Agent

Date

Signature of Patient or Authorized Agent

Caring Heart
FAMILY NURSE PRACTITIONER

Medical History

Drug Allergies: ______________________________

____

Height: ______________

Weight: ______________

Year / Medical Diagnose

Year / Surgical History

Date / Immunization

Social History

Smoking Y ☐ N ☐ Never ☐

How many packs a day? ______________

Year you quit smoking? ______________

Are you planning to quit smoking? Y ☐ N ☐

Do you drink alcohol? Y ☐ N ☐

How many ounces, bottles, etc.? How often?

____

Do you use illicit drugs? Y ☐ N ☐

Pharmacy: ______________________________

____

Previous PCP: ______________________________

Specialist(s): ______________________________

____

Allergies: ______________________

____

Caring Heart
FAMILY NURSE PRACTITIONER

Medication Record

Patient: ______________________ Date of Birth: ______________

Date	Medication and Strength	Quantity	Instructions	Refills	Pharmacy	Side Effect

This page is for the provider and staff

New Orders:

Lab/IPS

Xray

Screening

Referalls