Caring Hearts & Minds
concierge healthcare

Lorraine Bonaldi, MSN, MBA, APRN, FNP-BC

Adult Assessment Initial Visit

Date _____
NAME: _____ BD: _____
Title: _____Dr. _____Mr. _____Mrs. _____Ms. _____Prof _____Other _____
Chief Complaint ~ REASON FOR YOUR VISIT: _____
GENDER: male Pronouns: _____he/his _____she/her _____they/them
ADDRESS: _____
City: _____ State: ____ ZIP:_____
Cell Phone: _____ Home phone: _____
Best Phone to call_____
OK To leave a message? Yes _____ No _____Able to receive text messages? Yes ____No _____
Email_____
Social Security Number: _____/_____/_____

Pharmacy: _____
Insurance: _____
(Please provide copy)
Cash Pay: (Zelle)_____
Employer: _____
Occupation: _____
RELATIONSHIP Status: ____Never Married _____Married ____Living with Partner ____Divorced ____ Separated ____Widow/Widower _____ Other ____ Live Alone _____TYPE of housing
Spouse/Partner (if applicable) _____
Are you safe? _____Yes ____ Unsure_____ Want to talk more privately? _____yes _____no
RACIAL/ETHNIC Background: _____
Primary Language Spoken: _____

FAITH Preference: _____
Highest Level of Education: _____
Military: _____ Yes _____No _____ Active

New or Established Patient
Detailed history
Detailed examination
Medical decision making, moderate complexity

How did you hear about Caring Hearts & Minds? _____

Interested in Hormone Replacement Therapy (HRT) via pellets: ____Yes No _____Unsure (tell me more about this)

Medication Allergies: _____

_____

Other Allergies_____
Current Medications

_____

_____

Other meds/over the counter meds:
Sertraline

_____

Medical Information/Medical History:

_____

_____

Surgeries/Surgery History: _____

_____

Family History: _____
Do you have children? _____Yes _____No _____ Ages: _____
Do you have pets? _____
If you are over age 50, have you had a colonoscopy? _____
Females only: When was your last mammogram? _____
When was your last PAP smear? _____
Vaccinations: _____
Are you interested in discussing vaccinations? ___ Yes ____ No TYPE: _____
____ COVID ____ Hepatitis ____TB ____HIV____ STDs_____

Are you in pain today? _____ Where? _____ 0/10 scale _____

Mental Health/Psychiatric History: depression and anxiety

_____
In case of emergency for your safety or the safety of others, whom may I call (Contact must be over age 18)

_____
Who is allowed to have access to your medical records?

_____
_____**(Relationship)**

PFSH: (Past Family/Social History): _____
Pertinent medical history of family:

_____

_____

WOMEN: post-partum anxiety or depression _____

Drug/Alcohol/Caffeine Use: ____Yes _____What How often? _____
Quantity?

_____

Longest period of sobriety _____

_____

Any hospital Rehab? _____

Sleep Concerns? _____

Nightmares? _____

Depression? How long? More sad than happy? What makes it better?

Depressed mood for > 2 weeks

Sleep Loss of interest dec energy concentration guilt/worthlessness appetite change self-esteem

psychomotor slowing irritability (ADHD)

Anxiety how often? How long? Triggers

Excess worry restless easily fatigued irritability muscle tension dec sleep dec concentration

Panic Attacks

Palpitations Sweating Trembling SOB/chest pain Nausea Dizziness Paralysis fear dying fear of "Going crazy"

OCD: _____ what makes it worse? _____

PTSD nightmares experience dreams/flashback avoidance behavior inc vigilance

Past Psych Hx (dx/hospitalizations/meds/violence) SA/cutting_____ SI_____ HI_____

Suicidal Ideations:
- Plan: No
- Intent/A No
- Means: Notes: N/A

Homicidal Ideations:
- Plan: No
- Intent: No
- Means: No
- Notes: No

Aggressive Ideations:
- Plan: No
- Intent: No
- Means: No

Obsessions: denies

Other: denies paranoia; a/v hallucinations

Family Psych Hx: Drugs Mental illness _____ SA/SI _____ Injury to self _____

_____

Social History: _____

DESCRRIBE any of the above _____

_____

Medical Review of Symptoms (as reported by pt.)

____ Neuro ____TBI ____SEIZ ____Stroke ____ Kidney ____Liver ____GI ____MSK_____SKIN ____Other

EYE doctor? _____ GYN/OB _____ Neurologist ____ Cardiac/pulmonary _____ GI/GU_____MSK_____

DEPRESSION SCALE

Please fill out

Instructions: Circle the best answer for how you have felt over the past week

1.	Are you basically satisfied with your life?	Yes or No
2.	Have you dropped many of your activities or interests?	Yes or No
3.	Do you feel that your life is empty?	Yes or No
4.	Do you often get bored?	Yes or No
5.	Are you in good spirits most of the time?	Yes or No
6.	Are you afraid that something bad is going to happen to you?	Yes or No
7.	Do you feel happy most of the time?	Yes or No
8.	Do you often feel helpless?	Yes or No
9.	Do you prefer to stay home, rather than going out and doing new things?	Yes or No
10.	Do you feel you have more problems with memory than most?	Yes or No
11.	Do you think it is wonderful to be alive now?	Yes or No
12.	Do you have thoughts you be better off dead or of hurting yourself?	Yes or No
13.	Do you feel worthless the way you are now?	Yes or No
14.	Do you have energy?	Yes or No
15.	Do you have trouble falling or staying asleep, or sleeping too much?	Yes or No
16.	Do you have a poor appetite or overeating?	Yes or No
17.	Do you feel your situation is hopeless?	Yes or No
18.	Do you think most people are better off than you are?	Yes or No

ASSESSMENT/EVALUATION ~ Practitioner
Do not write below this area

Height: _____ Weight: _____ BMI: _____
HR_____BP_____ (sitting, side) _____Temp _____ 02 Sat _____

Neuro/Psych
Affect: worried
Appearance: casually dressed, wearing dark sunglasses for her photophobia
Approach: cooperative
Attention/Concentration: not tested.
Behavior: engaged
Cognition: draw clock
EPS /Tardive Dyskinesia: No involuntary movement noted or reported.
Eye Contact: good
Insight: fair
Judgment: Fair
Language: ____appropriate _____confused _____Other
Memory: not tested
Mood: "mostly happy" _____
Motor Activity: no psychomotor agitation or retardation observed, normal gait
Orientation X4
Speech: Normal rate and rhythm
Thought Content: Thinking is linear.
Delusions: _____none observed _____ other

Cardiac/Pulmonary _____

_____

GI/GU _____

MSK _____

SKIN/HAIR/NAILS _____

OTHER: _____

PLAN OF CARE/MEDICATIONS:
1._____
2._____
3._____
4._____
5._____
6. _____

○ Risk/Benefits/Side Effects/Alternatives to proposed treatment discussed with client and
○ Medication Consent Form signed.

○ Discussed need to present to clinic/urgent care/ER prior to follow-up appointment if symptoms worsen or
side effects appear.
○ Discussed the importance of continued therapy.
○ Provided ____day supply of _____Lot# _____Exp date _____
Provided _____

○ Potential impact of drugs and alcohol use on psychiatric symptoms discussed with client.
○ Labs: Ordered: _____
○ Xrays, studies Ordered: _____
Results discussed with client: _____
○ Referral to: _____
_____
○ Notes: _____
○ Follow-up at medication clinic in one-two months with prescriber _____One Month _____Two Months

_____ **Date**_____
Lorraine Bonaldi, MSN, MBA, APRN, FNP-BC

CPT Code: _____
ICD-10 Code(s):
1._____
2. _____
3. _____
4. _____
5. _____
6.

Rule outs/Differentials:
_____

PATIENT RESPONSIBILITY AGREEMENT
Please Read and Sign

Lorraine Bonaldi, APRN, FNP-BC appreciates the confidence you have shown in choosing me to provide you your medical needs. I am committed to providing you with the highest quality healthcare. Please read and sign this for to acknowledge your understanding of your responsibility as a patient at *Caring Hearts & Minds*.

1. *Preparing for your appointment*: Please plan to arrive at your scheduled time for your appointment if face to face. This will give us ample time to get all patient information entered into your account, collect your co-pay, and have any necessary paperwork completed.
2. *Late arriving patients*: We reserve the right to request you reschedule your appointment if you arrive after your appointment time. Late arriving patients are disruptive to the practice and other patients.
3. *Missed appointments (No Shows):* Our policy is that you will be charged $75.00 for missed visits, whether tele-health or face to face appointments. If not cancelled 24 hours of your scheduled time. Please help us serve you better by keeping your regularly scheduled appointments or provide us the courtesy of canceling or rescheduling well in advance of the appointment. If we are unavailable to answer your call, please leave a detailed message.
4. *Disruptive Behavior:* Caring Hearts & Minds has zero tolerance for patients exhibiting disruptive behavior. Caring Hearts & Minds will not tolerate abusive patient displays of this type of behavior. And you will immediately be asked to leave the premises and reported to the appropriate authorities.
5. *Payment Policy:* All co-payments, co-insurance and deductibles are expected to be paid at the time service or prior service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from the patient can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. You are responsible for services denied by your insurance as not medially necessary or not covered. There are several patient responsibility components which may apply to an insurance payment.
6. *Insurance Charges:* You are responsible for notifying us immediately should your insurance change. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the resulting balance.
7. *Cash Payments:* Cash payments are accepted at an already-discounted rate and payment is due at the time of service
8. *Open Balance:* a $20.00 administrative feel will be added to each month a statement is sent due to an open balance.

We reserve the right to dismiss patients from the practice who do to adhere to these patient responsibilities. Thank-you for your understanding the importance of keeping your appointment.

Patient or Responsible Party Signature: _____
Print Name: _____ Date _____

CANCELLATION & NO-SHOW FEE
Policy that is required by ALL patients

Missed or late cancelled appointments without a 24-hour notice will result in a ***$75.00*** no-show fee. This fee is separate charge which will not be covered by your insurance plan. You will need to pay this fee in full before you reschedule any future appointments.

Caring Hearts & Minds requires a debit/credit card or health savings account and signature on file as a method of payment. The card you provide us will be run if there is a balance due on your account. Balance dues include no-shows, cancellations without a 24-hour notice, deductibles, co-insurance, co-pays and charges not covered by insurance. A receipt can be sente to address upon request. I agree not to dispute the payment with my credit card company, so long as the transaction corresponds to the terms of *Caring Hearts & Minds*.

Patient Name (please print): _____

Signature: _____

AMEX/MC/VISA/DISCOVER Card # _____

Expiration Date: _____ Security Code _____ Zip Code _____

This notice/Signature serves as your consent to charge the balance due on account. We do not call-in advance. Under no circumstances other than the conditions mentioned above, will *Caring Hearts & Minds* charge your credit card. In conjunction with HIPAA regulations, all credit information will be kept confidential.

WHY WE CHARGE A NO-SHOW FEE: A patient who does not show up for their appointment and who had not cancelled their appointment with at least 24-hour's notice affects the care we provide our other patients and the cost of care. Each no-show represents a missed opportunity for another *Caring Hearts & Minds* patient to see the provider.

I have read and understand Caring Hearts & Minds has a ***$75.00*** fee for any no-show and late cancellation. I agree to pay Caring Hearts & Minds no-show fees as stated above if I no-show or have not called Caring Hearts & Minds office at least 24 hours in advance to cancel my appointment.

Patient Name (please print): _____

Signature: _____Date: _____

FINANCIAL CONTRACT/AGREEMENT

1. I understand that if I do not pay my account with *Caring Hearts & Minds* in full that my account may be assigned to a collection agency for collection.
2. I understand that if my account is assigned to a collection agency that the collection agency will charge a commission or fee that may be as much as 40% of the amount I owe to *Caring Hearts & Minds*. I agree if my account is assigned to a collection agency's commission or fee to the amount I woe to Caring Hearts & Minds and I agree to pay that additional amount.
3. I understand that the addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially more than the amount owed under my agreement. I understand, for example, that if the unpaid balance that I owe to *Caring Hearts & Minds* may add up to $400 to my account and I agree to pay the sum $1,400 in such event.
4. I understand and agree that in the event of legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees.
5. I understand that without an authorization or refund from my HMP/PPO and/or primary care provider, I will be financially responsible for the charges I owe.

Signature: _____Date: _____

MEDICARE (ONLY SIGN IF YOU HAVE MEDICARE)

We accept Medicare. We will submit your claim to Medicare, but you will be responsible for any deductibles, co-insurance or ANY charges NOT covered by Medicare and/or your secondary insurance should you have one.
Secondary Insurance: this office will NOT file your secondary insurance. If your secondary insurance has not paid within 90 days pf the date of service, payment for services becomes the patient's responsibility.

Signature: _____ Date: _____

HIPAA RELEASE FORM- RELEASE OF INFORMATION

I authorize the release of information including examination, diagnosis, and related records/information rendered to me and claims information. _____ Yes _____ No

The information may be released to: _____

This release will remain in effect until terminated by me in writing: (initial) _____

Messages:
Please call (check all that apply):
( ) my home ( ) my work
( ) my cell phone

If unable to reach me (check all that apply):
( ) you may leave a detailed message
( ) please leave a message asking me to Return your call

HIPPA (please check box)
( ) A notice of Privacy Practices has been offered to me or made available should I choose to take one.

Signature: _____ Date: _____

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/provider/person/facility/entity listed below.

Patient Name: _____DOB: _____

Signature: _____Date:_____

The information you may release subject to this signed release form is as follows:

( ) ***Complete Records***
( ) Care plan
( ) Pathology reports
( ) Hospital reports
( ) Office notes
( ) History and Physical
( ) Lab reports
( ) Treatment records
( ) Medication records
( ) Progress notes
( ) Radiology reports
( ) Operative reports

( ) Other _____

Release my protected health information to the following facility:
Name: Caring Hearts & Minds, Lorraine Bonaldi, APRN, FNP-BC
Address: 1001 Pyramid Hwy Suite 206, Sparks, NV 89431

Patient Signature: _____Date: _____