Tanya S. Geraci, APRN
8013 New LaGrange Road
Suite 5
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P: 502-434-7050
F: 844-223-9413
sentinelhealthllc@aol.com
www.sentinelhealthllc.com

## FIRST APPOINTMENT INSTRUCTIONS

- ✓ Complete all forms prior to you appointment.
- ✓ If unable to print forms, please contact the office to have them mailed or emailed to you. Arrive 15 minutes early to complete any unfinished forms.
- ✓ Please bring all of your prescription medications & supplements with you to your appointment.
- ✓ Bring any labs or imaging studies you have available performed within the last six months.
- ✓ If applicable, contact your current provider and have your medical records sent to my office at the above address or fax.
- ✓ Complete your medical forms as thoroughly as possible, even when asking for redundant information. This saves time to devote to your concerns during your appointment.

*Thank you for your cooperation. I look forward to working with you.*

Tanya S Geraci, APRN
Sentinel Health, LLC

# PATIENT DEMOGRAPHIC FORM

| LAST NAME: | FIRST NAME: | M.I. | D.O.B: |
|---|---|---|---|
| SSN: Religion: | GENDER: M F | MARITAL STATUS: M W S D | |
| HOME ADDRESS: | | | |
| CITY: | STATE: | ZIP: | |
| HM PHONE: | CELL PHONE: | EMAIL: | |
| EMPLOYER: | WORK PHONE: | | |

| PREFERRED PHARMACY: | PHONE: | LOCATION: |
|---|---|---|
| MAIL ORDER PHARMACY: | PHONE:<br>FAX: | ADDRESS: |

| PRIMARY CARE PROVIDER | PHONE | HOSPITAL AFFILIATE |
|---|---|---|
| | | |
| LIST SPECIALIST PROVIDERS | PHONE | TYPE OF SPECIALTY |
| | | |
| | | |
| | | |
| | | |
| REFFERAL SOURCE: | | |

| IN CASE OF EMERGENCY: | | |
|---|---|---|
| NAME: | RELATIONSHIP: | CONTACT NUMBER(s): |

**I GIVE PERMISSION FOR MY MEDICAL INFORMATION AND TEST RESULTS TO BE RELEASED TO THE FOLLOWING INDIVIDUALS:**

| NAME: | RELATIONSHIP: |
|---|---|
| | |
| | |
| | |

***MESSAGES REGARDING MY MEDICAL INFORMATION MAY BE LEFT ON MY (ckeck all that apply)***

CELL PHONE ☐ HOME PHONE ☐ WORK PHONE ☐ HOME EMAIL ☐ WORK EMAIL ☐

***I consent to Telehealth or Phone Appointments as may be deemed necessary & understand additional consent forms may be required.*** Initial ________

Printed Name: ______________________________ Date: ________________

Patient Signature: ______________________________

Relationship if guardian: ______________________________

## Health History Form

**Patient Name:** ______________________________ **DOB:** ______________

**Medication List :**

1. ______________________ 6. ______________________
2. ______________________ 7. ______________________
3. ______________________ 8. ______________________
4. ______________________ 9. ______________________
5. ______________________ 10. ______________________

**List any over-the-counter medications, vitamins, supplements used:** ______________________

______________________________________________

**Medication Allergies:** ______________________________________________

**Environmental Allergies** (including latex)**:** ______________ Pregnant or plans to become pregnant in 6 mo.___

**Personal Health History** **(circle any of the following for which you have been treated):**

Acute Bronchitis
Allergic Rhinitis
Alcohol/Drug Addiction
Arthritis (type): ______________
Asthma
Attention deficit disorder
Autoimmune disorder
Cancer (type): ______________
COPD/Emphysema
Liver/Gallbladder Disorder

Chronic pain (where): ______________
Clotting disorder
(type) :______________
Depression/Bipolar disorder
Diabetes, Type 1 Type 2
Diverticulitis
DVT/Pulmonary embolism
Eye disorder
Gastritis/PUD
Glaucoma
Heart Attack/MI

Heart Palpitations
Heart Valve Issue
Hepatitis (type): A,B,C
High Blood Pressure
High Cholesterol
High Triglycerides
HIV/AIDS
Menstrual problems
Kidney disease
Macular Degeneration
Migraine headaches
Pace Maker

Peripheral vascular disease
Pancreatitis
Prostatitis/UTI
Reflux
Seizures
Sinusitis
Skin condition
Sleep Apnea
Stroke/TIA
Thyroid disease
OTHER (specify): ______________
______________

**List any Specialists you are treated by:**

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

**Immunizations History** **(list last date of vaccine or "unknown" or "never" as applicable)**

Influenza (date):
Hepatitis B (date):
Meningitis (date):

Pneumovax (date):
Shingles (date):
Tetanus (date):

Hepatitis A (date):
CoVID-19 (brand) (date):
OTHER (specify type and date):

**Surgical History** **(including procedures such colonoscopy; give dates and physician's name, if known):**

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

## Social History:

**Who Lives in your Household?** ____________________

**Marital Status:** Single / Married / Widow / Widower / Other: ____________________

**Number of Children** (include sex and ages): ____________________

**Sexually Active?** YES NO If yes: **Monogamous?** YES NO **with:** MEN WOMEN BOTH

**Tobacco:** Do you smoke currently? YES PREVIOUSLY NEVER

If yes: __________ packs per day since age ____________________

If previously: __________ packs per day from age ______________ to ______________

**Alcohol:** How many drinks per day/week/month do you consume? ____________________

Have you or any family member been treated for alcoholism? YES NO If yes, whom: ____________________

**Substance Abuse:** Have you ever or do you currently use any illicit drugs (marijuana, cocaine, etc)? YES NO

If yes, what substance(s): ____________________

Have you or any family member been treated for substance abuse issue? YES NO If yes, whom: ______________

**Religion:** ____________________ **Occupation (job title):** ____________________

**Do you have a Living Will?** YES NO

## Family History (siblings, parents, grandparents, aunts, uncles):

| Relative | Age (if living) | Age of death | State of health (and medical conditions) OR cause of death |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Maternal GM | | | |
| Maternal GF | | | |
| Paternal GM | | | |
| Paternal GF | | | |
| Siblings (B/S) | | | |
| (B/S) | | | |
| (B/S) | | | |
| (B/S) | | | |
| (B/S) | | | |
| Children (M/F) | | | |
| (M/F) | | | |
| (M/F) | | | |
| (M/F) | | | |

(B – Brother; S – Sister; M – Male/Son; F – Female/Daughter)

**Patient Signature:** ____________________ **Date:** ______________

**(If form completed by person other than patient; please list name and relationship)**

**Physician Signature:** ____________________ **Date:** ______________

**FEMALE**

# Screening/Prevention Log

**Patient:** ______________________________ **DOB:** ____________________

| **Screening** | Date | Date | Date | Date | Date | Date | Date | Date | Date |
|---|---|---|---|---|---|---|---|---|---|
| Complete physical exam | | | | | | | | | |
| Pelvic/Pap smear | | | | | | | | | |
| Breast exam | | | | | | | | | |
| Mammogram | | | | | | | | | |
| Bone density | | | | | | | | | |
| Fecal hemoccult | | | | | | | | | |
| Colonoscopy | | | | | | | | | |
| Chest x-ray | | | | | | | | | |
| ECG | | | | | | | | | |
| Ophthalmic exam | | | | | | | | | |
| Dental exam | | | | | | | | | |
| **Laboratory** | Date | Date | Date | Date | Date | Date | Date | Date | Date |
| Lipids | | | | | | | | | |
| Fasting glucose | | | | | | | | | |
| Urinalysis | | | | | | | | | |
| BUN/creatinine | | | | | | | | | |
| Hg $A_1C$ | | | | | | | | | |
| Urine microalbumin | | | | | | | | | |
| Vitamin D | | | | | | | | | |
| Vitamin $B_{12}$/folic acid | | | | | | | | | |
| CBC (with differential) | | | | | | | | | |
| CMP | | | | | | | | | |
| TSH, T4, T3, rT3, TPO | | | | | | | | | |
| HCV antib | | | | | | | | | |
| PT/INR | | | | | | | | | |
| | | | | | | | | | |
| **Immunizations** | Date | Date | Date | Date | Date | Date | Date | Date | Date |
| COVID-19/type | | | | | | | | | |
| Influenza/type | | | | | | | | | |
| <7dTaP/Tdap>7 | | | | | | | | | |
| TB/PPD | | | | | | | | | |
| Pneumovax 23 | | | | | | | | | |
| Prevnar 13 | | | | | | | | | |
| Zostavax (50yrs)/Shingrix | | | | | | | | | |
| HPV (3) type | | | | | | | | | |
| Hepatitis B (3) | | | | | | | | | |
| Hepatitis A (2) | | | | | | | | | |
| MMR | | | | | | | | | |
| BLOOD TYPE | | | | | | | | | |

## Medication and Allergy Log

**Patient:** ______________________________ **DOB:** ______________

**Allergies:**

Pharmacy ______________ Address ______________________ Ph ______________

| Medication | Dosage | Directions & quantity | Diagnosis | Date started | Date stopped |
|---|---|---|---|---|---|
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# PATIENT FINANCIAL RESPONSIBILITY POLICY

*Thank you for choosing Sentinel Health, LLC to serve your health care needs. We are pleased to participate in your health and wellness and look forward to establishing a lasting relationship as your health care provider. As part of this relationship, we have outlined expectations for your financial responsibility in the Patient Financial Responsibility Policy.* ***Please read this document thoroughly.*** *You may receive a copy of this policy at your request.*

**Demographic & Insurance Changes**

*It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

**Payment for Services**

- *Sentinel Health, LLC* is a fee for service practice and is not affiliated with any insurance company or third party payer.
- Full payment for all services rendered is expected at the time of your appointment.
- In *rare* cases, *prior* to your appointment, arrangements may be made for partial payment.
  - This applies only to current, established patients who have maintained regular scheduled care and who do not have any existing balances.
  - Partial payments must meet or exceed 60% of charges incurred.
  - Partial payment does not apply to any tests sent out for analysis and/or supplements. Balances for these services must be paid in full at time of receipt.
- If you choose to self-file, itemized statements may be issued at patient's request to assist with insurance reimbursement
- Generally, FSA & HSA accounts may be used for payment of your visit and services. Please confirm this with your individual plan.
- If you have a debit card associated with your FSA or HSA, you may use this for payment.
  - We are not responsible for non-payment through your HSA or FSA plan and you will be liable for full payment should payment be rejected by your issuing plan.
  - Payment in full is expected at time of service. Itemized statements may be issued at patient's request if needed for filing purposes.
- We accept cash, check and Master Card & Visa Only.

**Billing**

- If you and your provider have agreed on partial payment and you owe additional money after your visit, you can expect to receive a statement.
  - Statements are emailed unless you do not have an email or you request it be mailed.
  - As with slow mail, emails get lost. It is your responsibility to fulfill unpaid balances regardless of receipt of statement as this is the agreement entered into should Sentinel Health, LLC agree to accept partial payment prior to your appointment.
- Payment is expected within **10 days** of receipt of your statement or not later than 14 days following the date of services received.
- Unpaid balances, beyond 30 days, will accrue interest at 10% for each 30 days delinquent.

**Failure to Pay & Non-Emergency Appointments**

- Outstanding balances or failure to pay unpaid balances may result in physicals and other routine or screening appointments being rescheduled.
- Past due accounts may hinder your ability to have appointments scheduled.
- Patients who ignore collection notices and fail to pay their balance risk dismissal from the practice.

**Fees**

- **IT–Admin** fee. The fee is added to medical office, phone, & tele-health visits and will be assessed at **15%** of the visit rate. i.e office visit $105— IT-Admin fee $15.75.
- Returned checks are subject to a **$30 fee** and your account may be placed on a "cash-only basis." We will accept payments only by cash or credit card until the balance is cleared.

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- **Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment may result in a charge of $30.** Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. If you must cancel an appointment, *Sentinel Health, LLC* requires a minimum of 24 hours notice.
- There may be additional charges applied to your account if we are asked to copy medical records per patient request or participate in a Deposition or Phone Consultation on your behalf.

**Guarantor**

Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.

**Insurance**

- ***Sentinel Health, LLC* does not contract with any insurance company.**
- Your health insurance policy is a contract between you and your Health Insurance Company or employer. **Please Note** it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our provider participates.
- ***You must keep a current insurance card on file***. This information will be used for insurance filing when ordering out of office diagnostic or laboratory testing. If your current insurance information is not up to date with our office, this may impede coverage for laboratory or diagnostic testing and it will be your responsibility to provide current insurance information and resolve disputed claims that might occur.
- If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.

**Medicare Patients**

Medicare does not cover out of network providers and may not cover services that your provider recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

**Minors and Dependents**

- Parent and guardians are responsible for payments for their dependents at the time services are rendered.
- The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, it is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent.

**Referrals and Authorizations**

Please be aware if authorization for referrals or diagnostic studies is required by your insurance company. If you do not clarify this requirement before care is provided, you may be responsible for the cost of the care. When in doubt contact your plan directly for clarification.

**Worker's Compensation/Personal Injury**

*Sentinel Health, LLC* does not participate in Workman's Compensation or Personal Injury care. Should you choose to have individualized care through *Sentinel Health, LLC*, it is under direct cost to you.

Printed Name ____________________________ Signature _____________________________ Date ______________

## ***MISSED APPOINTMENT POLICY*** rev'd 1/2021

Please Read Thoroughly

Sentinel Health, LLC
8013 New LaGrange Rd, Suite 5
Louisville KY 40222
502.434.7050

Sentinel Health, LLC makes every attempt to provide quality individualized care in a timely manner. These policies have been established to provide for optimal care for all patients. I thank you in advance for your understanding and cooperation.

I personally balance appointments and allot time so each patient receives individualized attention at a reasonable rate. In order to maintain affordable fees and access to care, I ask you please be diligent in arriving to your appointment as scheduled or provide a minimum 24 hour notice of cancellation.

### New Patient Forms

*Please complete any necessary forms as thoroughly as possible prior to arrival so time is not taken from visit to complete forms. If you have not completed your appointment forms, please arrive 15 minutes early. Starting later than the allotted appointment time may limit time available to devote to your care and concerns during your visit.*

### Procedure For Scheduling, Changing or Cancelling Your Appointment

*It is preferred you call to schedule, change, or cancel an appointment. You may email request for changes or cancellations within 24 hrs of your scheduled appointment.*

### Late Cancellations & Missed Appointment

*No-shows, late arrivals and late cancellations inconvenience those individuals who need access to medical care. Missed appointments also extend wait times for appointments and may impair safe delivery of care for yourself and others. Patients often wait for an extended period of time for an appointment and there is a waiting list for those wishing to obtain an earlier appointment. Please be respectful of the medical needs of other patients, and call the office promptly if you must cancel an appointment*

- We require a minimum of **24 hours** advance notice of cancellation in order to not incur a missed appointment fee.
- A $30 fee is assessed for each appointment missed without 24 hours notification.
- Missed appointment fees must be paid prior to rescheduling.
- If 3 consecutive appointments are missed *or* repeated events, patients may be discharged from care as this compromises delivery safe and effective care.

Consideration is taken for special circumstances and emergencies.

**Please initial highlighted areas and sign below.**

- I understand that payment is required at the time of the appointment for service rendered. ______
- I understand that late arrivals, beyond 15 minutes of scheduled time may be asked to reschedule. ______
- I agree to give a full 24 hrs notice of cancellation prior to my appointment or agree to pay missed appointment fee of $30. ______
- I understand any scheduled appointments with 3 consecutive cancellations, missed appointments, or late arrivals will require full payment of missed appointment fees, as indicated above, prior to rescheduling and may be discharged from care. ______
- I agree to regular follow-up appointments, laboratory or diagnostic testing as recommended by my provider to ensure comprehensive safe care. ______

Printed Name: ______________________________

Signature: ______________________________ Date: ______________

## Conditions and Consent

### CONSENT TO DIAGNOSTIC TESTS, PROCEDURES, AND MEDICAL TREATMENT:

*I voluntarily consent to care involving routine diagnostic tests, procedures and medical treatment as ordered by the Sentinel Health medical provider, including his/her assistants or designees. I consent to Allied Health students observing and participating in my care under the supervision of a qualified professional. This consent also includes testing for communicable and blood-borne infectious diseases, such as hepatitis, tuberculosis, and the human immunodeficiency virus (HIV), if a physician orders testing for diagnostic purposes or if there has been an exposure to healthcare personnel. No guarantee has been given to me as to the results that may be obtained from my care.*

### CONSENT TO USE AND DISCLOSURE OF INFORMATION:

*I authorize Sentinel Health medical provider and/or staff to use and disclose information about me to carry out treatment, payment, and healthcare operations. Examples of such uses and disclosures include, but are not limited to, providing information to: (a) any person, company, or entity (such as HMOs, insurance companies, employer sponsored health plans, and review organizations, and any other payor or its review organization or third party administrator) that is or may be liable for paying any claim for benefits arising out of services provided to me; (b) any independent practitioner providing services for me; (c) any providers who may be providing follow-up care to me; (d) any licensing or accrediting organizations necessary for Sentinel Health to obtain or maintain licensure or accreditation; (e) any other persons or entities described in* ***Sentinel Health Notice of Privacy Practices.*** *This consent includes the release of medical records and billing information related to drug-related conditions, alcoholism, psychological and psychiatric conditions, and/or communicable or blood-borne infectious diseases, such as hepatitis, tuberculosis, and the human immunodeficiency virus (HIV). I also consent to any third party payor or its review organization paying for my care to discuss my plan of treatment for utilization review purposes.*

### SENTINEL HEALTH IS NOT RESPONSIBLE FOR LOSS OF PERSONAL ARTICLES:

I understand the Sentinel Health is not liable for the loss of or damage to money, jewelry, glasses, dentures, documents, clothing, or other items of personal property.

### PRIVACY NOTICE AND RIGHTS:

I acknowledge that I have received the HIPAA Notice of Privacy Practices (the "**Notice**") from Sentinel Health, LLC ("**Sentinel Health**") and that I have been provided an opportunity to review it.
I understand that:

- Sentinel Health can change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.
- Sentinel Health can and will use my information for purposes of my treatment, payment for treatment, and healthcare operations.
- The Notice explains in more detail how Sentinel Health may use and share my protected health information for other purposes.
- I have the rights regarding my protected health information listed in the Notice.
- Sentinel health can change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.

*I authorize Sentinel Health to contact me regarding my Protected Health Information (**PHI**), such as but not limited to, appointment reminders, lab results, referrals, return phone calls.., via the following methods.*
I Opt-In _____ I Opt-out _____

a) I acknowledge receiving a copy of Sentinel Health Notice of Privacy Practices. _____

**OR**

b) I did not receive a copy of the Notice today but was given the opportunity to read the notice and declined a copy._____

The undersigned agrees that a copy of the consent, release and assignment of benefits may be used in place of the original copy.

Patient Name (print): ________________________________ Date: ________________________

Signature: ________________________________ Relationship if not signed by patient: ______________

Print Name: ________________________________ Relationship to patient: ______________

**SENTINEL HEALTH**, LLC
Louisville, Kentucky

**Notice of Privacy Practices**

*This notice describes how health information about you maybe used and disclosed and how you may get access to this information. Please read completely and if you have questions or concerns please feel free to discuss them.*

**This office has always safeguarded your health information and we will continue to treat each patient with the utmost respect.**

We reserve the right to change this notice of privacy practices and terms of this notice at anytime as permitted by law. We reserve the right to apply the new terms in our privacy practices to all health information that we maintain including health information we created or received before the changes.

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**Use and disclosures of health information:**
We use and disclose health information about you for treatment, payment, and healthcare operations. *For example: should we need to disclose your health information in order to make a referral for specialty services, labs, diagnostic exams, or in order to secure health insurance payment.*
*Terms defined:*
**Treatment:** We may use or disclosure information to a physician or other healthcare provider currently providing treatment to you.

**Payment:** We may use and disclose health information to obtain payment for services provided to you.

**Healthcare operations:** We may use and disclose healthcare information in connection with healthcare operations that may include; assessment and quality improvement activities, reviewing the competence or qualifications of our healthcare professionals, evaluation of practitioners and providers conducting training programs, accreditation, certification, licensing, or other credentialing activities. In the event this office is ever sold, information may be shared to this provider or administrator of care, or if you are referred to another provider for treatment, information maybe shared with this provider. All those working under the auspices of Sentinel Health, LLC are required to sign an agreement of confidentiality.

**To your family and friends:** We may only disclose your health information to you. With your written consent to release health information, we may disclose your health information to a family member, friend, or other designated persons to the extent necessary to help with your healthcare or for payment of your healthcare.

**Persons involved with your care:** In the event of your incapacity or emergency circumstances, we may make the determination, based on our professional judgment, to disclose your health information. We will only disclose the most pertinent information's to be persons most directly involved. In case of emergency, we may disclose or use health information to notify or assist in the notification of a family member, your personal representative, or another person responsible for your care to provide notice of your location, your general condition, or death.

If you have a family member is in the room with you they will here your healthcare information. Please do not ask a family member to come back with you if you do not want them to know your healthcare information.
Your permission will be required for any persons to pick up supplements, supplies, x-rays, or other similar forms of health information.

**Marketing:** Your information will not be used for marketing communications without your previous written consent.

**Required by law:** We will use or disclose your health information when we are required to do so by law.

**Abuse or neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health and safety or the health and safety of others.

**National security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

**Appointment reminders:** we may use or disclosure health information to provide you with appointment reminders such as voice mail, text message, or a phone call to your residents answered by a family member, postcard, or letter. **If you do not wish such messages to be left in such a manner please notify our office.**

**YOUR RIGHT**

**Access:** You have the right to a copy of your treatment records provided you make a written request. These records will be photocopies of your existing records. We reserve the right to charge for repeated request for copies.
**Disclosing accounts:** you have the right to receive a list of instances in which we disclose health information for purposes other than treatment, payment, health care operations, or certain other activities during the last six years. If you request this information more than once in one year there will be a reasonable fee.
**Restrictions:** You have the right to have additional restrictions on the use or disclosure of your health information. This request must be in writing. We are not required to agree to these restrictions, but if we do, we must abide by them.
**Amendments:** You have the right to request in writing that your healthcare information be amended. Your request should clearly state your reason for request. Your request maybe denied