Jillian Russell APRN LLC

Patient Registration Form

Legal Name: (Last)_____ (First) _____ (MI)_____
Preferred Name (if different from above): _____
Legal sex: ☐ female ☐ male
SSN: _____ **Mother's maiden name:** _____

Address: _____
City: _____ **State:** _____ **Zip:** _____
Home phone: _____ **Cell phone:** _____

☐ Consent for phone calls ☐ Consent for text messages

Email address: _____ **Date of Birth:** _____

Contact preference: ☐ Home phone ☐ Work phone ☐ Mobile phone ☐ Mail ☐ portal

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black ☐ Hispanic

☐ White/Caucasian ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other

Marital status: ☐ Single ☐ Married ☐ Divorced

Sexual orientation: ☐ Lesbian, gay or homosexual ☐ Heterosexual ☐ Bisexual ☐ Chose not to disclose ☐ Other _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender male/female to male ☐ Transgender female/male to female ☐ Gender non-conforming (neither exclusively male or female) ☐ Chose not to disclose

☐ Other (not listed) _____

Pronouns: ☐ He/him ☐ She/her ☐ they/them

CONACT INFORMATION

Name: _____ Relationship: _____
Home phone: _____ Mobile phone: _____

NEXT OF KIN

Name: _____ Relationship: _____
Home phone: _____ Mobile phone: _____

EMPLOYMENT

Employer name: _____

Employer phone: _____

Usual occupation: _____

GUARDIAN

Name: _____ ☐ Relationship to patient: _____

DOB: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ N/A

INSURANCE / RESPONSIBLE PARTY INFORMTION

Responsible party: ☐ Self ☐ Spouse ☐ Parent ☐ Guarantor ☐ Other: _____

Responsible party information:

Legal Name: (Last)_____ (First) _____ (MI)_____

DOB: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ Check if address is same as patient's address

SSN: _____ **Sex:** ☐ Female ☐ Male

GENERAL CONSENT FOR TREATMENT

I hereby consent to and authorize the administration of medical treatment and procedures by Jillian Russell, APRN, and/or designated representatives at Jillian Russell APRN LLC.

I understand that the treatment may include, but is not limited to, medical examinations, diagnostic procedures, therapeutic interventions, and the administration of medications. The purpose, risks, benefits, and alternatives to the proposed treatment will be explained to me, and I will have had the opportunity to ask questions.

the event of an emergency where I am unable to provide consent, I authorize the healthcare professionals involved in my care to undertake any necessary and appropriate treatment.

understand that I am financially responsible for the costs associated with the treatment, and I am aware of any applicable insurance coverage.

This consent for treatment is effective for the duration of my treatment unless otherwise specified in writing.

Patient/Representative Signature: _____ **Date:** _____

Jillian Russell APRN LLC

Medical History Form

Patient Name: _____ DOB: _____

Allergies (please list any allergies to drugs, latex, etc):

Allergy	Reaction

Medications (please list all medications, herbal supplements and/or vitamins you take on a regular basis):

Medication	Dose	Frequency

Family history

	Father	Mother	Child	Sibling	Grandparent		Father	Mother	Child	Sibling	Grandparent
Alcoholism	☐	☐	☐	☐	☐	High cholesterol	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	Kidney disease	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	Mental illness	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	Migraines	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	Thyroid disease	☐	☐	☐	☐	☐
High BP	☐	☐	☐	☐	☐	Other	☐	☐	☐	☐	☐

Social History

☐ Yes ☐ No Do you use tobacco products? If yes, what one? _____ How long? _____
☐ Yes ☐ No Do you drink alcohol? How much? _____ Type ☐ Liquor: _____ ☐ Beer: _____
☐ Yes ☐ No Do you use recreational drugs? What type? _____
☐ Yes ☐ No How much caffeine do you consume? _____
☐ Yes ☐ No Do you exercise regularly? If so, how often and for how long? _____

Have you ever been diagnosed with any of the following?

☐ Allergies	☐ Diabetes	☐ High blood pressure	☐ Peripheral vascular disease
☐ Anemia	☐ Diverticulosis/diverticulitis	☐ High cholesterol	☐ Pneumonia, recurrent
☐ Anxiety or depression	☐ Erectile dysfunction	☐ HIV	☐ Prostate, cancer
☐ Arthritis or RA	☐ Epilepsy/seizures	☐ Kidney stones	☐ Prostate, enlarged
☐ Asthma	☐ Fibromyalgia	☐ Kidney disease	☐ Psoriasis or Eczema
☐ Afib	☐ Gallbladder disease	☐ Liver cirrhosis	☐ STDs
☐ Chronic back pain	☐ Heart disease	☐ Liver steatosis (fatty liver)	☐ Stroke
☐ COPD/chronic bronchitis	☐ Heart murmur	☐ Multiple sclerosis	☐ TB
☐ Cancer	☐ Herpes	☐ Osteopenia	☐ Ulcers, stomach or intestine
☐ Constipaton or diarrhea	☐ Hepatitis	☐ Osteoporosis	☐ Other:

Hospitalizations, surgeries or serious accidents:

Date	Reason

Additional information:

Jillian Russell APRN LLC

Patient Portal User Agreement and Consent

Patient Portal Agreement and Consent Form

Introduction: This Patient Portal Agreement and Consent Form ("Agreement") is entered into between Jillian Russell APRN ("Provider") and the undersigned patient ("Patient"). This Agreement governs the use of the Patient Portal, an online platform provided by the Provider for accessing and managing health information.

Terms and Conditions:

1. **Access to the Patient Portal:** 1.1 The Patient will be provided with a secure username and password to access the Patient Portal. 1.2 The Patient agrees to keep their login credentials confidential and not share them with unauthorized individuals.
2. **Use of Patient Portal:** 2.1 The Patient agrees to use the Patient Portal for the sole purpose of managing their health information. 2.2 The Patient acknowledges that any unauthorized use of the Patient Portal is strictly prohibited.
3. **Security:** 3.1 The Patient understands that the Patient Portal utilizes security measures to protect the confidentiality of health information. 3.2 The Patient agrees to promptly report any suspected unauthorized access to their Patient Portal account.
4. **Responsibility for Information Accuracy:** 4.1 The Patient is responsible for ensuring the accuracy of the information provided through the Patient Portal. 4.2 The Provider is not liable for any inaccuracies resulting from information entered by the Patient.
5. **Communication:** 5.1 The Patient agrees to receive communication from the Provider through the Patient Portal, including appointment reminders and test results. 5.2 The Patient has the option to opt out of certain non-essential communications.

Consent: I, the undersigned Patient, hereby consent to the terms and conditions outlined in this Patient Portal Agreement. I understand that the Patient Portal is a tool for managing my health information, and I agree to use it responsibly.

Authorization: I authorize the Provider to disclose my health information through the Patient Portal and understand that this information may include, but is not limited to, laboratory results, appointment scheduling, and communication with healthcare providers.

Termination of Access: I understand that the Provider reserves the right to terminate my access to the Patient Portal at any time for violations of this Agreement or any other reason deemed appropriate by the Provider.

Amendments: The Provider reserves the right to amend this Agreement, and any changes will be communicated to the Patient through the Patient Portal or other appropriate means.

Acknowledgment:

Patient: _____ Date: _____

Provider/Representative: _____ Title: _____ Date: _____

Jillian Russell APRN LLC

HIPAA Privacy Policy

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you on how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact Jillian Russell APRN LLC at 352-537-5865 at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

Treatment: We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.

For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside of our office such as the pharmacy when a prescription is called in.

Payment: Your protected health information may also be used to obtain payment from an insurance company or another third part. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed. If covered

by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or it's intermediaries or carriers for payment of aa Medicare or Medicaid claim.

Health Care Operations: We may use or disclose your protected health information in order to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you be telephone, email, or text to remind you of your appointments.

If we have to share your protected health information to third party "business associates" such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may also use and disclose your protected health information for marketing activities. For example, we might send you a thank you card in the mail with a coupon for specialized services or products. We may also send you information about products or services that might be of interest to you. You can contact us at any point to stop receiving this information.

We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written Authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.

Appointment reminders: We may contact you as a reminder that you have an appointment for your initial visit, follow up visit, or lab work via text, phone or email.

Consent for Photographing or Other Recording for Security and/or Healthcare Operations: I consent to photographs, digital or audio recordings and/or images of myself for patient care, security purposes or healthcare operations ie: quality improvement. This includes digital documents I may upload to my patient portal.

Others Involved in Your Health Care: We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need.

I authorize disclosure of my Protected Health Information to the following family members/friends: (Note, this may be revoked or modified in writing, at any time.)

Name	Relationship	Contact Number	Full Access	Financial Access only
1.			☐	☐
2.			☐	☐
3.			☐	☐

I authorize the following family member/Friend to pick-up a prescription order (script) from this office. Photo identification will be required, as will the signature of the individual receiving the prescription.

Individuals authorized to pick up a prescription on my behalf:

Name	Relationship to Patient

☐ **I do not want** to authorize anyone but myself to pick up prescriptions on my behalf

Research; We will not use or disclose your health information for research purposes unless you give us authorization to do so.

Organ Donation: If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation if it is necessary to facilitate this process.

Public Health Risks: We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.

Health Oversight Activities: We may disclose protected health information to health oversight agencies for audits, investigations, inspections, or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.

Required by Law: We will disclose protected health information about you when required to do so by federal, state and/or local law.

Workman's compensation: We may disclose your protected health information to workman's comp or similar programs.

Lawsuits: We may disclose your protected health information in response to a court action, administrative action or a subpoena.

Law Enforcement: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to medical records: You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written

request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.

Amendment: If you believe the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information You will need to submit a written request on why you feel the health information should be amended. We may deny your request to amend if you did not send a written request or give a reason on why it should be amended. If we deny your request, we will provide you a written explanation. We may deny your request if we believe the protected health information is accurate and complete.

Accounting of Disclosures: You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this "accounting of disclosures" to the individual listed at the bottom of this policy. After your request has been approved, we will provide you the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. This information may not be longer than 6 years ago prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.

Restriction Requests: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law (HIPAA Privacy Standards). We require this be a written request submitted to the individual at the end of this policy.

Confidential Communication: You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.

Paper copy of this notice: You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Name of Contact Person: _____

Please sign and date indicating you have read and understand your Patient Rights and HIPAA Privacy Policy.

Name_____Date_____