Please scan and email form to lisa@lisasharf.com

LISA SHARF, M.S.N., A.R.N.P., P.A.

LISA SHARF, M.S.N., A.R.N.P.
LIC. #: ARNP1190912
Cell.#: (786) 356-9342 Fax #: (305) 667-7839

PATIENT INFORMATION FORM

GENERAL INFORMATION:

Date:_____

Patient's Last Name: _____ **First:** _____ **M.I.:** _____

Date of Birth:_____ **Age:**_____ **Sex: M**_____ **F**____ **SSN:**_____

HomeAddress:_____
Street **Apt. #**

_____ **Marital Status:**_____
City **State** **Zip Code**

Home Phone: _____ ***Work Phone:** _____ **Cell Phone:**_____
(Parent's if Pt. Is Child)

Emergency Contact:_____ **Relationship:**_____ **Phone #:**_____

Employer's Name or School & Grade:_____

Job Description: _____

Referred By:_____

Email Address: _____

Chief Complaint: _____

Family Physician:_____ **Phone #:**_____

Describe Past or Present Medical Condition(s)_____

_____

Current Number of Persons Living in Your Household: _____

Names, Ages & Relationship:_____

_____.

INSURANCE INFORMATION:

Insurance Company Name: _____**Phone:**_____

Name of Primary Insured:_____ **SSN:**_____

Membership #:_____ **Insured's D.O.B.:**_____

Insured's Group/Policy#:_____ **Effective Date:** _____

Relationship of Patient to the insured:_____ **Patient's I.D.#:**_____

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SIGNATURE ON FILE

Consent for treatment:

- **I authorize *Lisa Sharf, M.S.N., A.R.N.P* to provide psychiatric**

  treatment to_____.
  (Name of Patient)

- **I authorize use of this form on all my insurance submissions.**
- **I understand that payment is expected at the time of my appointment.**
- **I understand that I am responsible for my bill.**
- **I understand that *there will be a charge for missed appointments that are cancelled with less than 24 hours notice. I understand that there will be a fee for telephone sessions, written reports, and prescriptions called into the pharmacy if a scheduled appointment is cancelled.***
- **I authorize my doctor/nurse practitioner to act as my agent in helping me obtain payment from my insurance.**
- **I authorize payment directly to my doctor/nurse practitioner.**
- **I permit a copy of this authorization to be used in place of the original.**

Name of Person Signing Form (Print):_____.

Relationship to Patient:_____.

***Signature:_____ Date:_____.**

*** *Signature of parent or guardian is required if patient is a minor.***

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FOR ADULTS ONLY

Patient's Name:_____

Are you having financial problems? ___Y ___N: If yes, Please explain: _____

Are you having legal concerns?___Y ___N: If yes, Please explain: _____

Please list any hobbies or interests:_____

Please circle the frequency of each trait: Circle One

	Never	Occasional	Often
Feeling depressed	1	2	3
Feeling anxious	1	2	3
Mood swings (happy – angry – sad, etc.)	1	2	3
Inappropriate expression of anger	1	2	3
Feeling fatigued	1	2	3
Sleep problems	1	2	3
Eating problems	1	2	3
Trouble concentrating	1	2	3
Easily distracted or unfocused	1	2	3
Racing, uncontrollable thoughts	1	2	3
Disorganized	1	2	3
Constantly shifts from one task to another	1	2	3
Procastination	1	2	3
Problems at work	1	2	3
Feelings of low self-esteem	1	2	3
Withdrawn socially	1	2	3
Feeling lonely	1	2	3
Difficulty making friends	1	2	3
Conflictful relationships with friends and acquaintances	1	2	3
Marital problems	1	2	3

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Communication problems with spouse	**1**	**2**	**3**
Sexual problems	**1**	**2**	**3**

Please circle the frequency of each trait: Circle One

	Never	**Occasional**	**Often**
Relationship problems with children	**1**	**2**	**3**
History of physical abuse	**1**	**2**	**3**
History of sexual abuse	**1**	**2**	**3**
Do you smoke?	**1**	**2**	**3**
Caffeine consumption	**1**	**2**	**3**
History of drug or alcohol abuse	**1**	**2**	**3**
Seeing or hearing things that are not there	**1**	**2**	**3**
Feeling suicidal	**1**	**2**	**3**

Please print all medications presently being taken:

Medication	Date Prescribed	Prescribed by Whom	Dosage	Frequency	Condition

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Consent to use and /to disclose your health information for purposes of treatment, payment, or health care operations

As a condition of providing treatment to you, the provider, (Lisa Sharf, MSN, ARNP) may request your consent to use and disclose protected health information (PHI) about you to carry out treatment, payment, and health care operations.(TPO) You may revoke this consent at any time by notifying the provider in writing except to the extent that the provider has already taken action based on your previous consent.

A more complete description of the uses and disclosures of PHI are available in the provider's Notice of Privacy Practices. (NPP). Please review prior to signing this consent. The provider reserves the right to change their privacy practices. A copy of the NPP and any revisions are available upon your request.

You have the right to request that the provider restrict the manner in which information for treatment, payment, or administrative purposes is used or disclosed. The provider, however, is not required to agree to such restrictions. If an agreement on restrictions is made, however, it will be honored.

I hereby consent to the use and disclosure by my provider, his/her workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

Signature_____

PRINTED
NAME_____

Signature of Personal
Representative of the Client_____

Description of Personal Representative
To the Client_____

Date of NPP_____

COPY given to Client/Parent/Representative

Please scan and email form to lisa@lisasharf.com

LISA SHARF, M.S.N., A.R.N.P., P.A.

License – ARNP 1190912

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client
Name:_____
DOB: _____
SSN:_____

I acknowledge that I have received a Summary and have been given an opportunity to read a copy of the Notice of Privacy Practices for **Lisa Sharf, M.S.N., A.R.N.P., P.A.** I understand that if I have any questions regarding the Notice or my privacy rights, I can contact **Lisa Sharf, M.S.N., A.R.N.P., Privacy Information Officer at (786) 9342.**

_____
Signature of Patient/Client **Date**

_____
Signature or Parent, Guardian or Personal Representative **Date**

_____

____ If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

_____
Signature of Staff Member **Date**

2000 South Dixie Highway #104
Coconut Grove, FL. 33133
Phone-786-356-9342

2450 Hollywood Blvd. #303A
Hollywood, FL. 33020
Fax 305-667-7839

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LISA SHARF, M.S.N., A.R.N.P., P.A.

License – ARNP 1190912

Authorization To Receive and/or Release Personal Health Information (PHI)

Patient Name: Lisa Sharf **ID Number:** _____

I hereby authorize the use or disclosure of my personal health information as described below.

Persons /Organizations I authorize to receive my PHI	**Persons / Organizations I authorize to release my PHI**
Lisa Sharf	Meridian Spine and Pain

If this Authorization is for psychotherapy notes, no other type of protected information may be listed on the same form.

Specific description of information to be disclosed Lab Results from Quest

This information is to be disseminated through :

_____ Verbal Communication __x__ Written Communication Via FAX

Expiration:

I understand that this Authorization shall remain in effect until (fill in expiration date) _____, or until (fill in an event that relates to the individual or the purpose of the use or disclosure) _____.

Revoke Authorization:

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to the privacy officer, Joann Gruber, ARNP - BC. I further understand that the revocation of the Authorization is not effective to the extent that action has been taken in reliance on the Authorization.

Redisclosures:

I understand that the information used or disclosed pursuant to the Authorization may be subject to redisclosure by the recipient of my information, and may no longer be protected by the HIPAA Privacy Policy.

I may request a copy of this Authorization for my records. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction, and that I understand this Authorization form and all of its contents.

_____
Name of Patient (Printed)

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****

www.lisasharf.com
lisa@lisasharf.com
Phone: 786-356-9342
Fax: 305-667-7839

Please scan and email form to lisa@lisasharf.com

LISA SHARF, M.S.N., A.R.N.P., P.A.

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PATIENT RECORD OF DISCLOSURES & COMMUNICATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

_____ Home Telephone _____
____O.K. to leave message with detailed information
____Leave message with call-back number only

_____Work Telephone _____
____O.K. to leave message with detailed information
____Leave message with call-back number only

_____Written Communication
____O.K. to mail to my home address
____O.K. to mail to my work/office address
____O.K. to fax to this number_____
____O.K. to email me @_____

____Other _____
_____

_____
Patient's Name

_____
Date

_____
Print Signature

_____
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T = Treatment Records, P=Payment Information, O=Healthcare Operations
(3) Enter how disclosure was made: F = Fax, P = Phone, E= E-Mail, M= Mail, O= Other

Please scan and email form to lisa@lisasharf.com

CREDIT CARD PAYMENTS

VISA MASTERCARD DISCOVER

CARD NUMBER:_____

EXPIRATION DATE: _____

SECURITY CODE: _____

NAME ON CARD: _____

AMOUNT PAID: _____

PROVIDER: _____

DATE OF SERVICE: _____

PATIENT: _____

SIGNATURE:_____ **SIGNATURE ON FILE**_____

I AM ALLOWING MY CREDIT CARD TO BE BILLED AT THE TIME OF SERVICE BY PROVIDER FOR ESTABLISHED FEE.

email: lisa@lisasharf.com
786-356-9342 phone number 305-667-7839 fax

Your right to access and control your PHI

You have the following rights regarding your protected health information (PHI), provided that you make a written request:

- The right to request restriction - You may request limitations on your mental health information which could be disclosed in the future. However, we are not required to agree to your request.
- The right to confidential communications - You may request that communications be made in a certain way or at a certain location.
- The right to inspect and copy - You have the right to inspect and copy your mental health information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied, although we may provide a Summary Report of these notes. We may charge you a fee for related copying, mailing and supplies.
- The right to request clarification of the record - If you believe that the PHI we have about you is inaccurate, you may ask to add clarifying information. We are not required to accept the information that you propose.
- The right to accounting of disclosures - You may request a list of the disclosures of your mental health information that have been made to entities other than for routine treatment, payment or health care operations.
- The right to a copy of this notice - You may request a paper copy of the full notice at any time.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with us or the U.S. Dept. of Health and Human Services at 1-877-696-6775.

You will not be penalized or retaliated against in any way for making a complaint. Please speak with the Privacy Officer, Joann Gruber, ARNP-BC, as she will attempt to resolve any concerns amicably.

We are required to provide you with this Notice that governs our privacy practices. We will provide any forms necessary to enforce your rights.

Florida Statutes: Florida statutorily grants patients the right of access to medical records maintained by health care practitioners. The disclosure of patient information by providers is generally prohibited without the patient's consent, subject to specified exceptions. Florida also has numerous laws protecting the confidentiality of health information held by a variety of entities and government agencies.

LISA SHARF, M.S.N., A.R.N.P., P.A.

www.lisasharf.com
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Fax #: (305) 667-7839

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Notice of Privacy Practices

SUMMARY OF NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Federal law, commonly called HIPAA, requires that we describe for you our medical privacy practices and your rights as a patient under this law.

This brochure is a summary of the complete notice that has been made available to you, and it is also posted in the office.

If you have any concerns about your medical privacy, please call our office at:

(786)-356-9342
Effective April 14, 2003

How we may use your personal medical information:

Lisa Sharf, M.S.N., A.R.N.P., P.A. creates and receives medical information about you as a part of your care. This information is called protected health information or PHI. It is personal and private. We may use this information in many ways. We release only the information necessary to accomplish our tasks.

First, we use the information when we treat or refer you for treatment. We may communicate with other professionals and referral agencies.

Second, we may use the information to submit bills for your medical care to insurers, Medicare, Medicaid or third party payers.

Finally, we may use this information for our health care operations, meaning the work we must do to provide quality services to you and all of our patients.

We will seek your authorization when state or federal law requires it.

We may use PHI without your permission for the following reasons:

- As required by state or federal law.
- For public health purposes, such as reporting child or elder abuse, or if you are a danger to yourself or to others.
- To treat you in an emergency.
- To inform you of alternative treatments.
- When ordered by a regulatory agency, such as Health and Human Services.
- For law enforcement purposes or in response to a court order.
- For agencies involved in a disaster situation.
- For lawsuits and disputes.
- To communicate with coroners, medical examiners, and funeral homes when necessary.
- To communicate with federal officials involved in security activities authorized by law.
- To carry out treatment and billing operations through a billing or transcription service.

Your authorization is required for other disclosures.

The following PHI receives special protections under federal and/or state law.

- *Psychotherapy Notes* are kept separate from the medical record and receive special protection.
- *Psychotherapy Notes* exclude: medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.
- Alcohol and drug abuse information has special privacy protections. **Lisa Sharf, M.S.N., A.R.N.P., P.A.,** will not disclose any information identifying an individual as being a patient or provide any mental health or medical information relating to a patient's substance abuse treatment unless: (1) the patient consents in writing, (2) a court order requires disclosure of the information, (3) medical personnel need the information for a medical emergency, or (4) it is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.