Emily Garber APRN PLLC
6515 Main St 7L
Trumbull, CT 06611

Demographic Information

First Name: _____
Middle Initial: _____
Last Name: _____
Date of Birth: _____
Social Security Number (Optional): _____
Sex at birth: M/ F
Current gender: M/ F/ MTF/ FTM/ Non-binary/ Agender
Marital Status:_____
Address: _____
City:_____
State: _____
Zip Code: _____
Phone Number: _____
Email Address: _____
Referring Physician Name (Optional): _____
Preferred
Pronouns:_____

Insurance Information

Primary Insurance Company: _____
Subscriber ID # (including letters): _____
Group Number: _____
Secondary Insurance Company (If applicable): _____

Subscriber ID # (including letters): _____
Group Number: _____
Insurance Policyholder Full Name: _____
Insurance Policyholder Date of Birth: _____
Insurance Policyholder Address: _____
Insurance Policyholder Relationship: Self/ Spouse/ Child/ Other:_____

I understand that payment, such as copays, is due at the time services are rendered:

_____ _____ _____
Signature Printed name Date

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General Consent to Treat:

TO THE PATIENT: Welcome to our practice. At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical or diagnostic procedure to be used. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

This consent also gives permission for your nurse practitioner to use telehealth to assess, diagnose and treat you should you desire to do so. Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner, using technology like video, telephone and e-mail. You can talk to your provider from any place, including your home. You don't go to a clinic or hospital. Some of the limitations of telemedicine include: you and your provider won't be in the same room, the provider cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits), your provider may decide you still need an office visit for an in-person exam and technical problems may interrupt or stop your visit before you are done.

I voluntarily request a nurse practitioner, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name of Patient or Representative Relationship

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law. • The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed and their phone number:

_____

Phone number:_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature:_____

Date: _____

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Cancellation and No-Show Policy:

Thank you for trusting your medical care to Emily Garber APRN PLLC. When you schedule an appointment with Emily Garber APRN PLLC we set aside enough time to provide you with the highest quality care. It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of healthcare to other patients, some who are quite ill. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

• Effective January 1, 2022 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $50.00 fee.
• Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a $50.00 fee.
• If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be discharged from the practice.
• Any new patient who fails to show for their initial visit will not be rescheduled.
• The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
• As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office manager, who may be able to waive the No Show fee. You may contact Emily Garber APRN PLLC 24 hours a day, 7 days a week at 203-551-4173. Should it be after regular business hours Monday, Thursdays, and Fridays, you may leave a message.

_____ _____ _____

Signature Printed Name Date

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Pharmacy Notification:

The practice has been receiving a large volume of calls from patients lately advising that they are not getting texts or automated calls from their pharmacy, particularly from corporate chains, that their prescription is ready. It has been our finding that these stores are now not consistently sending notification when prescriptions have been received and when they are ready to be picked up. We ask that if you do not receive notification from your pharmacy that you contact them directly by phone or in-person first and then, if there is an issue, contact the office due to the volume of calls received about this matter. We can also advise on local community pharmacies that we have had good experiences with in the past in Trumbull, Fairfield, Bridgeport, Stratford, Orange, Milford, West Haven, New Haven, Westport and Darien should you like more information.

Thank you for your understanding.

_____

Signature Date