Lisa A. Sellers
APRN, MSN, FNP-C, CDP
True Lily Health Solutions LLC

772-538-3896 Office
888-440-2762 Fax
6425 21st ST SW
Vero Beach FL 32968

Dear New Patient,

Thank you for making an appointment with us. We are looking forward to assisting you with your health and wellness needs. This consultation requires approximately 1 to 1-1/2 hours for the first visit. We have dedicated a large amount of time to your initial consultation, and it is particularly important that you allow us 48 hours' notice or more if you find it necessary to cancel or reschedule your appointment.

Please carefully fill out the health questionnaire. This will enable us to spend more time with you concerning your present well-being, and/or to focus on your specific problems. As an overall therapeutic and wellness provider your detailed medical history is especially important for background information. Please complete these forms as thoroughly as possible.

We have a patient portal and a smart phone app to facilitate better and secure communication with our office. Through the portal you will be able to securely communicate with the office, view your Personal Health Records, review your downloaded lab results, review statements, and request appointments and prescription refills. Be sure to provide your email address so that you can be "web-enabled".

You will need to provide your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually so we may update your information.

All payments, co-pays, and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

Sincerely,

Lisa A. Sellers
APRN, MSN, FNP-C, CDP
True Lily Health Solutions LLC

Please take a moment to fill out the following forms as thoroughly as possible.

Patient Name:_____Date of Birth:_____.Age: _____

Mailing Address: _____Email: _____

City:_____State:_____Zip:_____

Home phone:_____Cell phone: _____Work Phone:_____

Sex:_____ Marital Status: _____Social Security Number: _____

Language spoken: _____Race: _____Ethnicity (circle one): Hispanic Non-Hispanic

Referring Physician: _____Phone number: _____

Pharmacy Name: _____Phone number:_____

Notify in case of emergency:_____Phone: _____Relation: ___ _

Name of Primary insurance:_____

Insured's Name:_____

Insured's Date of Birth: _____

Name of Secondary insurance:_____

Insured's Name:_____

Insured's Date of Birth: _____

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)

Name of Medication	Dose	How often taken	Start Date	Stop Date
1.				
2.				
3.				
4.				
5.				

6. _____

7. _____

8. _____

9. _____

10. _____

*use an additional sheet of paper if necessary

MEDICAL HISTORY/ CURRENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY, FILL IN ANY OTHERS)

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Spinal Stenosis
- ☐ Prostate Problems
- ☐ Bladder Problems: _____
- ☐ Kidney Problems
- ☐ High Blood Pressure
- ☐ Blood or Bleeding Disorders
- ☐ Sleep Apnea
- ☐ Anxiety
- ☐ Chronic Pain
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Neurological Disorders
- ☐ Heart Disease: _____
- ☐ Heart Attack
- ☐ Atrial Fibrillation
- ☐ High Cholesterol
- ☐ Emphysema / Asthma
- ☐ Reflux / GERD
- ☐ Stomach / GI Problems: _____
- ☐ Depression
- ☐ Thyroid Disorder
- ☐ Cancer, type: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
_____	_____
_____	_____
_____	_____
_____	_____

SURGERIES

TYPE OF SURGERY	DATE

FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)

Family Member	Year of birth	Cancer	Diabetes	Hypertension	Heart Disease	Other
Father	_____	☐	☐	☐	☐	☐
Mother	_____	☐	☐	☐	☐	☐
Paternal Grand Father	_____	☐	☐	☐	☐	☐
Paternal Grand Mother	_____	☐	☐	☐	☐	☐
Maternal Grand Father	_____	☐	☐	☐	☐	☐
Maternal Grand Mother	_____	☐	☐	☐	☐	☐
Siblings	_____	☐	☐	☐	☐	☐
Children	_____	☐	☐	☐	☐	☐

SOCIAL HISTORY/ HABITS

☐ Smoking: Packs/day_____ ☐ Non-smoker ☐ Quit smoking in_____

Alcohol use: ☐ Yes (drinks/week: _____) ☐ No

☐ Married ☐ Widowed ☐ Divorced ☐ Single

☐ Occupation: _____ ☐ Retired

☐ I exercise regularly ☐ I exercise rarely ☐ I do not exercise ☐ Type exercise _____

☐ I have traveled outside the United States in the past three months.

☐ Recreational drug use. Type:_____ ☐ Never

REVIEW OF SYMPTOMS: Please mark the symptoms you have been having recently.

GENERAL
- ☐ fever
- ☐ chills
- ☐ night sweats
- ☐ malaise
- ☐ fatigue
- ☐ weight loss
- ☐ weight gain
- ☐ loss of appetite
- ☐ insomnia

RESPIRATORY
- ☐ shortness of breath
- ☐ chest pain
- ☐ cough
- ☐ coughing blood
- ☐ wheezing
- ☐ congestion

NEUROLOGY
- ☐ headache
- ☐ tingling/numbness
- ☐ weakness
- ☐ gait difficulties
- ☐ tremors/shaking
- ☐ restless legs
- ☐ peripheral neuropathy
- ☐ memory loss
- ☐ seizures

PSYCHOLOGY
- ☐ depression
- ☐ high stress level
- ☐ sleep problems
- ☐ suicidal thinking
- ☐ eating disorder
- ☐ panic attacks
- ☐ grief

MUSCULOSKELETAL
- ☐ joint stiffness
- ☐ joint pain
- ☐ joint swelling
- ☐ muscle pain
- ☐ back pain
- ☐ neck pain

CARDIOLOGY
- ☐ chest pain
- ☐ palpitations
- ☐ leg swelling
- ☐ dizziness
- ☐ passing out

UROLOGY
- ☐ burning
- ☐ blood in urine
- ☐ urgency to urinate
- ☐ increased frequency
- ☐ leaking
- ☐ recurrent UTI
- ☐ nocturia

ALLERGY
- ☐ runny nose
- ☐ scratchy throat
- ☐ itchy eyes
- ☐ ear fullness
- ☐ sinus fullness
- ☐ stuffy nose

EAR/NOSE/THROAT
- ☐ scalp tenderness
- ☐ dry mouth
- ☐ hair loss
- ☐ postnasal drip
- ☐ thrush
- ☐ jaw pain
- ☐ oral sores
- ☐ sore throat
- ☐ cold
- ☐ cough
- ☐ coughing blood
- ☐ nosebleed
- ☐ change in voice

GASTROENTEROLOGY
- ☐ nausea
- ☐ heartburn
- ☐ vomiting
- ☐ diarrhea
- ☐ difficulty swallowing

☐bloating/belching
☐abdominal pain
☐constipation
☐change in bowel habits
☐blood in stool
☐black tarry stool

ENDOCRINE

☐excessive sweating
☐excessive thirst
☐excessive urination
☐heat intolerance
☐cold intolerance

EYES

☐decreased vision
☐red eyes
☐blurry vision
☐vision loss
☐dry eyes
☐seasonal eye

SKIN

☐rash
☐itching
☐hives
☐skin cancers
☐wound
☐bruising
☐psoriasis
☐sun sensitivity
☐shingles
☐rosacea
☐eczema

BLOOD/LYMPH

☐swollen glands
☐loss of appetite
☐night sweats
☐fevers
☐easy bruising

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO:_____ _____
Name of person/physician/facility Fax number

By signing this authorization, I authorize True Lily Health Solutions LLC/Lisa A. Sellers, FNP-C to use and/or disclose certain protected health information (PHI) about me from the above.

Please fax the following individually identifiable health information about me to True Lily Health Solutions LLC, FNP-C at 888-440-2762

1. All pertinent Information
2. Office notes
3. Lab results
4. X-ray and imaging results
5. Bone Density results

The information will be used or disclosed for the continuity of medical care. This authorization will expire on:
The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from True Lily Health Solutions LLC/Lisa A. Sellers, FNP-C. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPM Privacy Rule. I have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address below.

Signature of Patient or Legal Guardian _____Date _____

_____ _____
Print Name of Patient or Legal Guardian Date of Birth of Patient

By entering into this agreement, the parties to this agreement are giving up their constitutional and statutory rights to have any dispute involving health care services decided before a judge or jury and instead are accepting mandatory and binding arbitration to resolve any dispute.

Arbitration Agreement for Health Care Services

Whereas, on this ____day of_____, 20__ the undersigned patient or the patient's legal representative has entered into this agreement with True Lily Health Solutions LLC/Lisa A. Sellers, FNP-C to arbitrate any dispute involving the rendition of healthcare services by True Lily Health Solutions LLC/Lisa A. Sellers, FNP-C and its providers, employees, agents, partners and assigns (True Lily Health Solutions LLC/Lisa A. Sellers, FNP-C and its providers, employees, agents, partners and assigns shall be called *"health care provider")* and have agreed to the following terms and conditions.

Article 1. Full Consideration For This Agreement. The undersigned parties agree that this agreement has been made for full consideration, which consideration includes, but is not limited to, their mutual desire to have any healthcare service dispute or controversy resolved in a fair and expeditious manner by use of mandatory and binding arbitration.

Article 2. Health Care Services Are Arbitrable. The undersigned parties agree that any and all issues involving healthcare services rendered by the *health care provider* including but not limited to dispute or controversy involving malpractice or negligence involving the diagnosis, treatment or care of the patient by the *health care provider* are arbitrable issues that shall be submitted to mandatory and binding arbitration as provided in this agreement. Further, the undersigned parties agree that any and all disputes or controversy involving healthcare services rendered prior to the execution of this agreement are also arbitrable and shall also be submitted to mandatory and binding arbitration as provided in this agreement.

Article 3. Agreement To Arbitrate Disputes Under Rules of the American Arbitration Association. The undersigned parties agree that any and all disputes or controversy involving healthcare services provided by the *health care provider* to the patient shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and the Supplementary Procedures for Large, Complex Disputes, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

Article 4. Notice of Demand to Arbitrate. A party to this agreement shall give written notice of demand to arbitrate controversy or dispute which involves healthcare services provided by the *health care provider* to the patient, which notice shall specify the allegations or issues in disputes and shall appoint an arbitrator. Within 20 days of receipt of the written demand for arbitration, the responding party shall have the right to name an arbitrator (failing to name an arbitrator within this twenty-day period shall be considered a consent to the claimant's appointed arbitrator). If the responding party has appointed an arbitrator, then within 20 days of the appointment of an arbitrator by the responding party, the two arbitrators shall select a third arbitrator (provided however if the arbitrators are unable or fail to agree upon a third arbitrator, then the third arbitrator shall be selected by the American Arbitration Association). The third arbitrator shall serve as chair of the arbitration panel. Within a reasonable period of time after the arbitrator(s) has accepted his or her appointment, the arbitrator(s) shall provide an oath or undertaking of impartiality. Provided however, whomever is appointed as an arbitrator shall have experience and knowledge of healthcare service issues.

Article 5. Discovery. Consistent with the expedited nature of arbitration, each party will, upon the written request of the other party, promptly provide the other with copies of documents relevant to the issues raised by any claim or counterclaim. Any dispute regarding discovery, or the relevance or scope thereof, shall be determined by the chair of the arbitration panel (or arbitrator if only one arbitrator is serving). All discovery shall be completed within 60 days following the appointment of the final appointed arbitrator. At the request of the other party, the

arbitrator(s) shall have the discretion to order examination by deposition of witnesses to the extent the arbitrator deems such additional discovery relevant and appropriate. Depositions shall be limited to a maximum of three per party and shall be held within 30 days of the making of a request. Additional depositions may be scheduled only with the permission of the chair of the arbitration panel, and for good cause shown. Each deposition shall be limited to a maximum of three hours duration. All objections are reserved for the arbitration hearing except for objections based on privilege and proprietary or confidential information.

Article 6. Location of Arbitration. The place of arbitration shall be within fifty miles of offices of the health care provider.

Article 7. Patient's Right to Cancel Arbitration Agreement. The patient has a right to rescind this agreement by written notice to the *healthcare provider* within one (1) calendar week after this agreement has been signed and executed. The patient may rescind by merely writing "cancelled" on the face of one of his copies of the agreement, signing his name under such word, and mailing, by certified mail, return receipt requested, such copy to the *healthcare provider* within such one (1) calendar week.

Article 8. Arbitration is Exclusive Remedy. With respect to any dispute or controversy that is made subject arbitration under the terms of this agreement, no suit at law or in equity based on such dispute or controversy shall be instituted by either party, except to enforce the award of the arbitrator's.

Article 9. General Provisions.

A. This agreement shall be governed by and interpreted in accordance with the loss of the State of Florida.

8. This agreement shall be binding on each parties' assigns, heirs, personal representatives and assigns. Further, the parties intend that this agreement shall bind all parties whose claims may arise out of or relate to treatment or healthcare services provided by the *healthcare provider,* including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to the claim.

The substantially prevailing party shall be entitled to an award of reasonable attorney fees. Further, the arbitrator(s) shall award to the substantially prevailing party, if any, as determined by the arbitrators, all of its cost and fees. "Cost and fees" mean all reasonable pre-award expenses of the arbitration, including arbitrator's fees, administrative fees, travel expenses, out-of-pocket expenses such as copying and telephone, court costs, witness fees and attorney fees.

Except as may be required by law, neither a party nor an arbitrator may disclose existence, content, or

results of any arbitration hereunder without the prior written consent of both parties.

The damages awardable at arbitration are limited to those available under Florida law.

Both parties to this contract acknowledge that they each have constitutional and statutory rights to have disputes involving healthcare services decided before a judge or jury and instead are accepting mandatory and binding arbitration to resolve any dispute.

True Lily Health Solutions LLC
Lisa A. Sellers FNP-C

Dated this____ day of_____, 20__

By:_____

Lisa A. Sellers, FNP-C

Dated this_____day of _____, 20___

By:_____

Patient or Patient's Legal Representative

_____

Printed name of Patient or Patient's Legal Representative

True Lily Health Solutions LLC
Lisa A. Sellers, FNP-C

Patient Name:_____

I **hereby give consent for the necessary medical treatment for the above-named patient for whom I am legally responsible. This consent for treatment includes medical care provided today and those of subsequent appointments.**

Privacy Notice

In accordance with the Health Insurance Portability and Accountability Act of 1996, patients of the **Practice** are entitled to the greatest degree of privacy possible. The release of medical information to any insurance carrier, other entities directly associated with True Lily Health Solutions/Lisa A. Sellers, FNP-C, primary care provider and/or referral physician in connection with treatment is authorized. This office will strive to ensure that patient information is used only for authorized purposes as agreed by the patient. No other disclosures will be made without written authorization from the patient or guardian. Patients are advised that they have a right to review their medical files upon reasonable notice to the practice and during normal business hours and to make comments to the same. All requests must be made in writing.

Assignment of Benefits

I hereby authorize and assigned to the **Practice** all payments and/or insurance benefits for services rendered. I agree to complete any additional forms which may be required by me in insurance plan for assignment of benefits. I hereby authorize the **Practice** to release medical information necessary to obtain payment. understand that I am financially responsible for all amounts not covered by insurance plan.

Financial Responsibility

I understand that and in consideration of the services provided to the patient, I am directly and primarily responsible for paying the amount of all charges incurred for services and procedures rendered at the **Practice.** It is my responsibility to know and understand my insurance policy. I am responsible for payment of any applicable but deductible, copayment or coinsurance prior to the provision of services. I understand that by law, deductible, copayment, and coinsurance cannot be waived. The **Practice** will provide me with an estimate of my total financial responsibility. I understand that this amount is only an estimate based on what my insurance plan may pay. In the event that fees exceed the amount of the estimate, I will be financially responsible for the balance. I understand that such payment is not contingent on any insurance, settlement, or judgment payment. I further understand that such payment is not contingent on the results of any treatment. The **Practice** does not refund any payment for services rendered. The **Practice** will file a claim for payment with my insurance plan as a courtesy to me. If the insurance plan fails to pay the **Practice** in a timely manner for any reason, I understand that I will be responsible for prompt payment of all amounts owed to the **Practice.** I will receive a statement once a month if I have a balance owing. Failure to pay a balance by the third billing statement will result in my account being turned over to the collection process. **SHOULD MY ACCOUNT BE REFERRED TO A COLLECTION AGENCY OR ATTORNEY FOR COLLECTION, THEN I WILL PAY ALL COSTS OF COLLECTION, INCLUDING A REASONABLE ATTORNEY'S FEE.**

True Lily Health Solutions LLC
Lisa A. Sellers, FNP-C

Authorization for treatment/Release of information

In connection with the medical services that I AM receiving from the above-named provider or provider's group, I hereby authorize the above-named provider and/or group/associate to disclose any/all information concerning my medical condition and treatment (including, but not limited to, super confidential information concerning sexually transmitted diseases, mental health, chemical dependence, or other such information), including copies of applicable hospital and medical records, to:

A. Any third-party payer covering the medical services with the patient;
B. Other healthcare professionals and institutions involved in the delivery of healthcare;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employee and agents for the Practice, to the degree necessary to facilitate the provisions of Healthcare Services and provide for such payment of services;
E. Pharmacies; and
F. As otherwise required by law

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I have read and understand the above. I further understand that I have been given access to the provider's privacy notice and that copy of which was available for my taking. I have had the opportunity to place special restrictions upon the consent given hereby. I further understand that special requests for restrictions must be submitted to the practice in writing and must be reviewed and approved by the designated Privacy Officer. I also hereby authorize the disclosure of personal health information to the individuals listed below and via answering machine.
To the following individuals:

_____Relationship _____

_____Relationship_____

I hereby acknowledge that I am responsible, and it is in my best medical interest to attend any scheduled appointments and/or follow-up appointments with Lindsey R. Porth, FNP-BC, as recommended by my provider. I further understand that if my provider orders/recommend outpatient diagnostic imaging testing, a sleep study, PFTs, or laboratory testing, it is because he/she feels it is in my best interest. Finally, I understand that the practice has a no-show policy in effect, which requires 24-hour notice if I must cancel my appointment. If I fail to abide by this policy, I will be responsible for charge of $50 per occurrence. This must be paid prior to seeing the provider for any other appointments.
This consent is valid from the date executed until revoked in writing by the patient.

_____

Patient Signature Date

_____

Witness Signature Date