Family Doctor Clinic
804 South Acadia
Thibodaux, LA 70301
(985) 446-2680

Account # ____________ Chart # ____________

Resp. Party # ____________ DR ________ LOC ________

I. PATIENT INFORMATION

Patient ____________ (Last) ____________ (First) ____________ (Middle) Title: Mr./Mrs./Other ________ Suffix: Jr./Sr./Other ________

Mailing Address ____________ ____________ (City) ________ (State) ________ (Zip)

Hm.Ph. ________ Wk.Ph. ________ Ext. ____ Date of Birth ________ Sex: M or F

Social Security # ____________ Marital Status: Married Single Widowed Divorced (circle one)

Employer ____________ Student: Full Part-time (circle one)

Referred by ____________ Employment Status: (circle one) Full-time Self Employed Part-time Not Employed Unknown Retired Military Active

Date of Injury ____________ Is the injury work related? ____________

ALLERGIC TO: ____________ Cell Phone No. ____________

II. RESPONSIBLE PARTY INFORMATION

SEND STATEMENT TO

Responsible Party ____________ (Last) ____________ (First) ____________ (Middle) Title: Mr./Mrs./Other ________ Suffix: Jr./Sr./Other ________

Mailing Address ____________ ____________ (City) ________ (State) ________ (Zip)

Hm.Ph. ________ Wk.Ph ________ Ext. ____ Date of Birth ________ Sex: M or F

Social Security #: ____________ Employment Status: (circle one) Full-time Self Employed Part-time Not Employed Unknown Retired Military Active

Employer ____________

III. INSURANCE INFORMATION

PRIMARY

Insurance Company ____________

Address ____________

____________ (City) ________ (State) ________ (Zip)

Patient's Relationship to Insured: Self Child Mate Other

Group # ________ Policy # ________

CoPay: Primary Care ________ Specialist ________

Insured's Name ____________ (Last) ____________ (First) ____________ (Middle)

SECONDARY/SUPPLEMENTAL

Insurance Company ____________

Address ____________

____________ (City) ________ (State) ________ (Zip)

Patient's Relationship to Insured: Self Child Mate Other

Group # ________ Policy # ________

CoPay: Primary Care ________ Specialist ________

Insured's Name ____________ (Last) ____________ (First) ____________ (Middle)

V. INSURED INFORMATION

INSURANCE POLICY HOLDER

Address ____________ | Address ____________

____________ (City) ________ (State) ________ (Zip) | ____________ (City) ________ (State) ________ (Zip)

Hm.Ph. ________ Wk.Ph ________ Ext. ____ | Hm.Ph. ________ Wk.Ph ________ Ext. ____

Date of Birth ________ Sex M or F | Date of Birth ________ Sex M or F

Employer ________ Status ________ | Employer ________ Status ________

I hereby authorize the above listed insurance companies to pay directly to Family Doctor Clinic benefits due me, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be paid. I authorize Family Doctor Clinic and to release information to the insurance company for my claims to be paid. Please attach copy of insurance card.

____________ Signature ____________ Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FINANCIAL POLICIES

COMMERCIAL HEALTH INSURANCE

As a courtesy to me, the physicians at The Family Doctor Clinic will file claims for healthcare services provided on my behalf directly to my health insurance carrier. I hereby assign directly to my physician(s) and any and all health insurance benefits to which I am entitled and which are payable to me for any such services rendered.

I understand that independent of my health insurance policy, I assume personal financial responsibility for all charges incurred for services provided by my physician(s) on my behalf.

MEDICARE

The physicians at The Family Doctor Clinic accept Medicare assignment on Medcare approved charges. I understand that I am personally financially responsible for any required deductible(s) and/or co-payment(s).

As a courtesy to me, the physicians at The Family Doctor Clinic will file claims for healthcare services provided on my behalf directly to my Medicare Supplemental health insurance carrier. I hereby assign directly to my physician(s) any and all such supplemental health insurance benefits to which I am entitled and which are payable to me for any such services rendered.

NO INSURANCE

If there is no health insurance or other such coverage for the charges incurred on this account, I agree to pay the full balance of such charges at the time of services or in accordance with payment terms agreed upon by The Family Doctor Clinic.

IF YOU DO NOT HAVE INSURANCE, NOTIFY RECEPTIONIST PRIOR TO SEEING PHYSICIAN

RELEASE OF INFORMATION

I authorize my physician(s) to release any and all medical information, including but not limited to a photocopy of my medical records, which may be requested by my insurance company and/or which is necessary to process my insurance claim(s) or to secure the payment of health insurance benefits.

Further, I authorize the use of my signature below on all insurance submissions made by my physician(s) for healthcare services provided on my behalf.

I authorize The Family Doctor Clinic (or their designated staff under the physician's direction) to verbally give my test results to the people listed below from this day forward until otherwise notified:

1.____________________ 3.____________________

2.____________________ 4.____________________

I have read and understand the above and I agree to abide by these financial policies of The Family Doctor Clinic. I understand and agree that such policies may be changed from time to time in the sole discretion of The Family Doctor Clinic.

____________________________ ________________

Signature of Patient or Responsible Party *Date*

DATE: ________________

Family Doctor Clinic
OF THIBODAUX

Patient Information Form

Whether you are a new or established patient, please complete this intake form so that we, as your providers, may correctly input your medical information into our electronic medical record system. We thank you for your patience and cooperation.

This is requested by your physicians at Family Doctor Clinic.

Name: ____ Date of Birth: ________________
FIRST MIDDLE LAST

Sex: [ ] Male [ ] Female Height: ______ft ______in

Address: ________________________________ Phone: Home: (______) ______________

________________________________ Work: (______) ______________

________________________________ Cell: (______) ______________

If under 18, parents name: ____

Preferred Pharmacy: ________________________________ City: ________________

Current Medications:

Medication Name	Dose	Frequency

Drug Allergies:

[ ] No drug allergies

Allergy	Reaction

(COMPLETE REVERSE SIDE ALSO)

Past Medical History (circle all that apply):

Allergies	Cirrhosis	Glaucoma	Osteoporosis
Anemia	Congestive heart failure	Gout	Prostate enlargement
Anxiety	Coronary artery disease	Heart attack***	Seizures
Arthritis	COPD	Hepatitis	Skin condition*
Asthma	Depression	High blood pressure	Sleep apnea
Atrial fibrillation	Diabetes	High cholesterol	Stomach problems*
Autoimmune disorder*	Diverticulosis	Kidney failure	Stroke
Bladder incontinence	Esophageal Reflux	Kidney stones	Thyroid problem*
Cancer**	Fibromyalgia	Migraines	

Other:____

*Type of disorder/problem: ____

**Cancer type/year of diagnosis: ____

***Date(s) of heart attack(s): ____

Past Surgical History (circle all that apply):

Adenoidectomy	Ear tubes	Heart valve replace	Lithotripsy
Appendectomy	Esophageal reflux	Hip replacement – L/R	Neck surgery
Back surgery	Fracture repair*	Hysterectomy - part/comp	Pacemaker placement
Bladder	Gallbladder	Intestinal surgery	Prostate surgery
Breast	Gastric bypass	Kidney Surgery – L/R	Sinus surgery
Carotid – L/R	Heart bypass	Knee replacement – L/R	Thyroid surgery
Cataract	Heart stent(s)	Lap Band	Tonsillectomy

Other: ____

*Location of Fracture repair: ____

Immunization History: Is patient up to date on age appropriate immunizations? (circle one) YES NO

(Please provide documentation of immunizations)

Family History: (any family medical problems, up to grandparents; circle all that apply):

Cancer	Diabetes	High blood pressure
Coronary Artery Disease	Heart attack	Stroke

Social History:

Marital Status: [ ] Single [ ]Married/Partnered [ ] Divorced [ ]Widowed

Occupation: Current_____________________ Previous_____________________

Tobacco: [ ] Never Smoked

[ ] Current Smoker: Amount_______cigs/packs per day, Number of years ___________

[ ] Former smoker: Quit month/year_______________ Age when quit: ___________

Alcohol: [ ] Never [ ] Current: [ ] socially [ ] daily [ ] weekly, amount_______________

[ ] Former drinker: Quit month/year_______________

Family Doctor Clinic
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Last Name: ______________________________

First Name: ______________________________

Date of Birth: _____/_____/__________

Federal Government Guidelines require that this information, in this format, be included in your health record. We cannot complete your medical record without your responses. Please answer all 3 questions. Thank you for your cooperation.

Question #1 Race:
- ◯ American Indian/Alaskan Native
- ◯ Asian
- ◯ Black/African American
- ◯ Hawaiian/Pacific Islander
- ◯ White
- ◯ Other

Question #2 Ethnicty:
- ◯ Hispanic/Latino
- ◯ Not Hispanic/Latino

Question #3 Primary Language: ______________________________

Family Doctor Clinic
OF THIBODAUX

Patient's Consent for Provider to Disclose PHI to Authorized Persons

1. <u>Authorization to Disclose PHI (Protected Health Information).</u> I hereby authorize you, my healthcare provider (**Family Doctor Clinic of Thibodaux**), to disclose any and all of my medical and protected health information ("**PHI**") to the persons indicated below.

2. <u>Persons to Whom Disclosure May be Made.</u> Provider may disclose my PHI to the following persons:

Name	Relationship, If Any
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

3. <u>Purpose of Disclosure</u>. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

4. <u>Expiration of Authorization.</u> This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

5. <u>Conditioning of Treatment</u>. Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

6. <u>Redisclosure by Recipient.</u> I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.

7. <u>Acknowledgment of Reading and Agreement.</u> I have read and understand this authorization.

Patient's Name:______________________________ **Date of Birth:**____________________

Patient's Signature:____________________________ **Date:**__________________________

If You Are Not the Patient and are a Representative

Personal Representatives include, for example, parents on behalf of their children, tutors on behalf of their wards (such as intellectually disabled individuals), administrators on behalf of those incapable of handling their own estates for mental or physical reasons, and succession representatives on behalf of the estates of decedents.

Representative's Name:____________________________ **Date of Birth:**________________________

Representative's Signature:____________________________ **Date:**__________________________

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the **Family Doctor Clinic of Thibodaux** a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

Patient's Name:____________________ **Date of Birth:**____________________

Patient's Signature:____________________ **Date:**____________________

If You Are Not the Patient and are a Representative

Personal Representatives include, for example, parents on behalf of their children, tutors on behalf of their wards (such as intellectually disabled individuals), administrators on behalf of those incapable of handling their own estates for mental or physical reasons, and succession representatives on behalf of the estates of decedents.

Representative's Name:____________________ **Date of Birth:**____________________

Representative's Signature: ____________________ **Date:**____________________

permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Workers Compensation. We will use and disclose your PHI for workers compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. If you are an inmate, we will use and disclose your PHI to a correctional institution or law enforcement official only if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Other Services and/or Fundraising. We may use your PHI to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your PHI to contact you in an effort to raise funds for our operations, however, you have the right to opt out of receiving any fundraising communications by sending a letter to our Privacy Officer in writing at the address at which you are treated.

Uses and Disclosures to which You have an Opportunity to Object

Others Involved in Your Care. We may provide relevant portions of your PHI to a family member, a relative, a close friend, or any other person you identify as being involved in your medical care or payment for care. If you bring someone with you into a treatment room, you are hereby notified that you will have identified that person to us as being involved in your care or payment for your care, by voluntarily bringing them in the room. If you do not object to us discussing your PHI in front of them, we may discuss your PHI in their presence because you did not object. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it after the emergency, and give you the opportunity to object to future disclosures to family and friends.

Uses and Disclosures that Require Your Signed Authorization

There are certain uses and disclosures of your PHI that require your written authorization. For example, most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require your signed authorization. Also, any use or disclosure of your PHI not described in this Notice requires your signed authorization.

Your Right to Revoke Your Authorization

If you sign an authorization allowing us to use or disclose your PHI outside of the uses and disclosures made in this Notice, you may revoke that authorization by advising us in writing with a letter addressed to Privacy Officer, at the address where we treat you. Your revocation will become effective as soon as we are reasonably able to enter it into our records, which is typically within 5 business days after we receive the letter. Your revocation will not affect our prior reliance on your authorization prior to the effective date of revocation.

Your Right to Restrict Certain PHI to a Health Plan

You have the right to require us to restrict any disclosure of your PHI to a health plan regarding an item or service for which you (or someone on your behalf - other than a health plan) paid out-of-pocket to us the entire amount due for the health care item or service which we provided and billed to you. You must make such a request in writing to us, with a letter addressed to Privacy Officer at the address where you receive your treatment. If you make such a request, we are required to honor it.

Notification in Case of Breach of Unsecured PHI

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. § 164.520

Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("PHI"). PHI consists of individually identifiable health information, which may include demographic information we collect from you or create or receive by another health care provider, a health plan, your employer, or a health care clearinghouse, and that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

We must provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to PHI and make new privacy policies effective for all PHI that we maintain. We will post a copy of our current Notice of Privacy Practices in the waiting room, and keep a copy of the revised Notice at the registration desk, and provide you with a copy upon your request, and if we maintain a website, we will post our Notice of Privacy Practices on our website.

Examples of Uses and Disclosures of Your PHI relating to Treatment, Payment & Operations

HIPAA privacy regulations give us the right to use and disclose your PHI without your consent to carry out (i) treatment, (ii) payment, and (iii) health care operations. Here are some examples of how we intend to use of your PHI in regard to your treatment, payment, and health care operations.

Treatment. In connection with treatment, we will, for example, use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We will disclose your PHI to other providers who may be treating you. Additionally, we may disclose your PHI to another provider who has been requested to be involved in your care.

Payment. We will use your PHI to obtain payment for our services, including sending claims to your insurer or to a federal program, such as Medicare, that pays for your treatment and sending you a bill for any amounts due which your insurer does not pay. We may also employ Business Associates, such as a billing company or collection agency to help us bill and collect. The PHI will include items such as description of your condition(s), our treatment, your diagnosis, supplies and drugs we used, etc.

Health Care Operations. We will use your PHI to support our business activities, such as allowing our auditors, consultants, or attorneys access to your PHI to audit our claims to determine if we billed you accurately for the services we provided to you, or to evaluate our staff to see if they properly cared for you, or to send information about you to third party Business Associates so they may perform some of our business operations.

Description of Other Required or Permitted Uses and Disclosures of Your PHI

Appointment Reminders. We will call you to remind you of an appointment. We may call your residence, office, or any other number we have on file. We will leave a message if you are not in, and we will state the name of our clinic, the date and time of the appointment, and the address at which the appointment is to be kept. We may also mail you a notice of your appointment to any address we have on file.

As Required by Law. We will use and disclose your PHI when required to by federal, state, or local law. For example, we may receive a subpoena for which we are required by law to provide copies of your medical file.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your PHI to public health authorities

In the event of an unauthorized or improper use or disclosure of your PHI (i.e., a "breach"), you have the right to receive, and we will notify you of the circumstances surrounding, the breach, what we have done to investigate and mitigate it, and how to best protect yourself in our opinion.

Patient Rights Related to PHI

In addition to your other rights provided herein, you have the right to:

Request an Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our Privacy Officer, stating what information is incomplete or inaccurate and the reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason that we believe supports the request. We may also deny your request if the information was not created by us, or the person who created it is no longer available to make the amendment.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to the Privacy Officer addressed to the address at which you receive care. We are not required to agree to your request. If we do agree, we will comply with your request except for emergency treatment.

Inspect and Copy. You have the right to inspect and copy the PHI we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer at address at which you receive treatment. We will have 30 days to respond to your request for information that we maintain at our facility. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay. HITECH expands this right, giving individuals the right to access their own e-health record in an electronic format if we maintain your records in an electronic format, and to direct us to send the e-health records directly to a third party. We may only charge for labor costs under electronic transfers of e-health records.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests; however, we will not accommodate a request that we perceive is an attempt to avoid receiving notice of a bill for the payment of our services.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us or directly to the Secretary of the United States Department of Health and Human Services: U.S. Department of Health & Human Services, 200 Independence Avenue, S.W. Washington, D.C.

20201, Phone: (202) 619-0257, Toll Free: (877) 696-6775. To file a complaint with us, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer at the address at which you were treated. No patient will be retaliated against for making a complaint.

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

Contact Person

You may contact our Privacy Officer at the following phone number for any questions:
Phone number: (985) 446-2680 ext.1246

Effective Date

The effective date of this revised Notice of Privacy Practices is October 10, 2017.