Lake Area Family Medicine

4150 Nelson Rd. Building G Suite 5 Lake Charles, LA 70605
337-562-3761/337-562-3690(Fax)

Today's Date _____

Patients Name: _____ Date of Birth: _____ Sex: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip Code: _____

Marital Status: S/M/D/Widow Race: _____ Ethnicity: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Can we contact you on your cell phone number? YES NO NA
Can we contact you at your place of employment? YES NO NA

Employer: _____

To whom may we release your medical/billing information?
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Responsible Party: _____ Date of Birth: _____ Sex: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip Code: _____
Relationship to patient:_____ Phone : _____

Emergency Contact:
Name: _____ Phone: _____
Name: _____ Phone: _____

Signature: _____ Date: _____
Relationship to Patient: _____

Lake Area Family Medicine
Health History Questionnaire

Patient Name: _____ DOB: _____

What Pharmacy do you prefer? _____

☐ Establish Primary Care Provider
☐ Sick Visit. Current problem: _____

Medication Allergies _____ Food Allergies _____

Medication Name	Dose	Times Daily

Did you have a flu vaccine this season (Oct-Apr)? ☐ No ☐ Yes When? _____
Have you ever had a pneumonia vaccine? ☐ No ☐ Yes When? _____
When was your last tetanus vaccine? _____

SCREENINGS: (Month and Year)

Last Pap smear date: _____ **Last mammogram date:** _____

PAST MEDICAL HISTORY (Please check all that apply):

- ☐ ADHD/ADD
- ☐ Asthma
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Blood Clots
- ☐ Bowel Problems
- ☐ Bladder Problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Ear Problems
- ☐ Eye Problems
- ☐ Emphysema
- ☐ Female Problems
- ☐ Fibromyalgia
- ☐ GI Bleeding
- ☐ Head Trauma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Obesity
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Renal Failure
- ☐ Seizure
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Urinary Problems
- ☐ Other: _____

FAMILY HISTORY

Mother: ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Other _____
Father: ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Other _____
Brother: ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Other _____
Sister: ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Other _____
Other Relative: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner
Do you currently Smoke? ☐ No ☐ Yes How much? _____
Do you currently Drink Alcohol? ☐ No ☐ Yes How much? _____

PREGNANCY HISTORY: Total # of pregnancies: _____ Miscarriages: _____ Abortions: _____

Preterm: _____ Term: _____

Past Surgery	Date

Specialist/Doctors currently treating you	Address and Phone number

Prescription Policy

- This is a good practice to ensure that you do not run out of your medication. **It is your responsibility to request the refill when you have a 7 day supply remaining.**
- Refill requests are to be requested from the pharmacy by fax. The pharmacy will then forward the request to us for authorization.
- Please allow us **24 - 48 hours** to fulfill your request. If medications are not available in this time period, please contact our office.
- All prescriptions for controlled substances that need to be in hard copy form are to be obtained at the clinic and they are your responsibility to hand-carry to your pharmacy, unless the pharmacy accepts them by fax.
- Controlled substance prescriptions **WILL NOT** be refilled early due to lost, stolen or misplaced, no exceptions.
- If refills are needed at the time of your scheduled appointment, it is your responsibility to request these from the staff and/or physician.
- Prescriptions **WILL NOT** be refilled over the weekend. You must call your pharmacy for a refill when you have a 7 day supply remaining.
- This policy is necessary to ensure that we are being as efficient as possible to better serve you and your family.

If you have any suggestions and/or comments feel free to let the physician and/or the staff know.

By signing this form, you understand and agree to comply with this policy. Thank you for your cooperation.

_____ _____

Patient Signature Date

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**

I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice.

3. **NOTICE OF PRIVACY PRACTICES:**

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**

I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

I hereby consent to engaging in virtual health/telemedicine services, where available, as part of my treatment. I understand that "virtual health" or telemedicine services includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications.

5. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**

Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.

Please check one:

- ☐ I have executed an advance directive and have supplied a copy to the Physician Clinic.
- ☐ I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
- ☐ I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).

Patient Label

☐ I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.

☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

6. RESEARCH STUDIES:

Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)* _____

Who can the Physician Clinic contact with questions about the Study? _____ .

7. CONSENT TO PHOTO/VIDEO:

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

8. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

9. E-MAIL:

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

Email Address:

10. CELL PHONES:

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

11. VIDEOTAPING/RECORDING:

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

ROI

Patient's Name				Date of Birth	Medical Record Number
Address	City	State	Zip	Telephone Number	Email Address

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information				
Address	City	State	Zip	Telephone Number

Agency or Individual(s) Authorized to Receive my Health Information				
Address	City	State	Zip	Telephone Number

Health Information that may be used / disclosed is limited to the following:
☐ Progress Notes ☐ Emergency Room Record
☐ Discharge Summary ☐ History and Physical ☐ Consultation(s) ☐ Lab ☐ Pathology Report
☐ Operative Note(s) ☐ Imaging/X-Ray Films ☐ X-Ray Reports ☐ Entire Record ☐ Fetal Heart Monitor Strips
☐ Other *(specify)* _____

Health Information that may be used / disclosed is limited to the following periods of healthcare:
From (date): _____ To (date): _____ Account Number: _____
From (date): _____ To (date): _____ Account Number: _____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):
☐ Treatment/Consultation ☐ At Request of Patient ☐ Research ☐ Marketing ☐ Billing or Claims Payment
☐ At Request of Employer ☐ Other _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

☐ **Yes** ☐ **No** If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature*		Date	Time
Relationship to Patient / Authority to Act on Patient's Behalf		Interpreter, if Utilized	
Witness's Signature	Date / Time	Expiration Date or Event	

☐ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*
☐ Electronic copy requested.

Patient Label