

Welcome to Primary Care Plus/Lafayette

Thank you for putting your trust in Primary Care Plus for your healthcare needs. We would like to take this opportunity to welcome you to our practice and look forward to providing you with personalized, comprehensive health care.

Having the most current information is essential in meeting your healthcare needs. We would appreciate your assistance in updating your medical record by completing the forms listed below:

- **Patient Information Form** - provides your physician with thorough knowledge of your current health issues, an accurate medication list, and a family medical history. Also includes your current contact information (phone number, email, text) so we can reach you regarding your healthcare.
- **Responsibility for Payment and Receipt of HIPAA Notice Form** – allows us to bill your insurance company for services provided to you and acknowledges you have received the Notice of Privacy Practices.
- **Consent for Treatment Form** - gives our medical staff permission to provide basic evaluation and treatment of your medical conditions.
- **Designation of Personal Representative Form** - grants a family member or friend permission to discuss medical or billing information on your behalf. Written permission is needed for us to discuss any aspect of your care with anyone else.
- **Authorization for Release of Protected Health Information**-allows us to obtain your medical records from other healthcare providers.

An important part of each visit with your doctor is reviewing all medications you are currently taking from ALL providers - both primary care and specialists. Please bring all medications with you to every visit.

Primary Care Plus is recognized as a Patient Centered Medical Home which is a reflection of our commitment to providing the highest quality care for our patients. We provide proactive care to promote wellness and prevent illness and will be communicating with you by telephone, text message (with your permission) and our patient portal. Please be sure to provide current contact information on the *Patient Information Form*.

As a patient of Primary Care Plus, we are committed to helping you *be well and enjoy life to the fullest*. Please review the additional information about Primary Care Plus that is in this folder. Should you have any questions or comments, please do not hesitate to contact me directly at **(337) 895-6000**.

Referred by: ☐ Family ☐ Friend ☐ Internet ☐ TV ☐ Radio ☐ Mail ☐ Social Media

TODAY'S DATE: _____

Patient Information Form (Please Print)

	Primary Care Physician:			Have you been a patient of Primary Care Plus or Stanocola in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<u>PATIENT</u> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other	Last		First	MI	Date of Birth		Age
	Address				City		State Zip
	Social Security #: _____				Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Street Address (if different from mailing)				City		State Zip
	Phone (Home)		Name of Employer			Employer's Phone #	
	Phone (Mobile)		Employer's Address				
	Preferred Method of Contact? <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone						
	May we send appointment and treatment reminders via text and voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	Email: _____						
	Spouse's Name				Date of Birth		
<u>ADDITIONAL INFORMATION</u>	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Decline to Answer						
	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic			What Language do you prefer? <input type="checkbox"/> English <input type="checkbox"/> Spanish			
	Name of your Pharmacy			Address			
	City State Zip			Phone #			
<u>RESPONSIBLE PARTY</u> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Other	Last		First	MI	Phone Number:		
	Address						
	City				State		Zip
<u>IN CASE OF EMERGENCY NOTIFY</u>	Name				Relation		
	Address				Phone #		
<u>INSURANCE INFORMATION</u>	<u>Primary Insurance</u>			Address			
	Policy Contract #		Group #	City		State	Zip
	Name of Policy Holder			Date of Birth			
	<u>Secondary Insurance</u>			Address			
	Policy Contract #		Group #	City		State	Zip
	Name of Policy Holder			Date of Birth			

Patient's Name: _____ Guardian's Name (if under 18): _____

LIST ALL PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Ordering Provider</u>

YOUR HEALTH HISTORY

(Check if you have had any of the following)

Abnormal Heart Rhythm	Chronic Pain	Heartburn/GERD	Obesity
Allergies (any)	Chronic Kidney Disease	Heart Murmur	Osteoporosis
Anemia	Depression	Hepatitis	Peripheral Vascular Disease
Anxiety/Stress	Diabetes	High Blood Pressure	Seizures/Epilepsy
Asthma	Emphysema/COPD	High Cholesterol	Sleep Apnea
Arthritis	Gallbladder Disease	HIV/AIDS	Stomach Ulcers
Atrial Fibrillation	Gout	Irritable Bowel Syndrome	Stroke
Colitis or Crohn's Disease	Headaches/Migraines	Kidney Failure	Thyroid Disease
Cancer	Heart Attack/Failure	Kidney Stones	

ALLERGIES TO MEDICATIONS or ENVIRONMENTAL

<u>Medication or Other (Environmental)</u>	<u>Reaction</u>

OB/GYN HISTORY

Number of Pregnancies		Number of abortions/miscarriages	
Number of full-term babies		Number of living children	
Number of premature babies			

PAST SURGICAL HISTORY

<u>Date</u>	<u>Surgery</u>	<u>Date</u>	<u>Surgery</u>

Please List Any Additional Medical Information:

FAMILY HISTORY

(Please check if your family has a history of any of these diseases)

<u>Condition</u>	<u>Mother</u>	<u>Father</u>	<u>Maternal Grandparents</u>	<u>Paternal Grandparents</u>	<u>Brother</u>	<u>Brother</u>	<u>Sister</u>	<u>Sister</u>	<u>Additional Sibling(s)</u>
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									

Patient's Name: _____ Guardian's Name (if under 18): _____

FAMILY HISTORY - CONTINUED

(Please check if your family has a history of any of these diseases)

<u>Condition</u>	<u>Mother</u>	<u>Father</u>	<u>Maternal Grandparents</u>	<u>Paternal Grandparents</u>	<u>Brother</u>	<u>Brother</u>	<u>Sister</u>	<u>Sister</u>	<u>Additional Sibling(s)</u>
High Cholesterol									
Stroke									
Other									

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

<u>Relationship</u>	<u>Cause of death</u>	<u>Age at death</u>	<u>Relationship</u>	<u>Cause of death</u>	<u>Age at death</u>

HEALTH HABITS HISTORY

Do you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke? ____ How many packs per day? ____

Did you quit? YES NO (circle one) If yes, what year did you quit? _____

How many alcoholic beverages do you drink per week? _____ How many days per week do you exercise? _____

In the past 6 months, have you had a regular problem with pain? YES NO Where? _____

Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Do you use any of the following equipment?

<u>Device</u>	<u>Yes/No</u>	<u>Device</u>	<u>Yes/No</u>	<u>Device</u>	<u>Yes/No</u>
Cane		Walker		Bi-pap (sleep apnea)	
Electronic Scooter		Wheelchair		C-pap (sleep apnea)	

Do you follow a healthy diet? YES NO (circle one) Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

<u>Test</u>	<u>Date</u>	<u>Results</u>	<u>Physician</u>	<u>Vaccine Type</u>	<u>Date</u>
Colonoscopy				Tetanus (Td)	
Cholesterol Screening				Pneumonia	
Cardiac Stress Test				Hepatitis B	
Bone Density				Influenza (Flu)	
Mammogram				Shingles	
Breast Exam				Other	

PHYSICIANS LIST

(Please list any other physicians currently assisting in your care)

<u>Specialty</u>	<u>Physician</u>	<u>Specialty</u>	<u>Physician</u>	<u>Specialty</u>	<u>Physician</u>
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? YES NO (circle one)

If yes, please supply the office with a copy for your chart. If no, would you like one? YES NO (circle one)

ACCIDENTS - TRAUMA:

Have you ever had a severe accident? YES NO Do you have any metal pins/plates in your body? YES NO If yes, please describe:

Consent for Treatment

I, _____, am voluntarily seeking healthcare and hereby consent
(Patient's name)

to medical treatment, procedures, laboratory tests and other health care services. I understand that I have the right to refuse specific treatments or procedures. However, by signing below, I agree in general, to permit laboratory and diagnostic tests, routine medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency procedures as necessary, and hospital services performed at the request of the attending physician or other physicians assisting in my care.

The consent given shall be valid and binding and the physician(s) can rely on this authorization and accept any consent given by the patient until such time as physician receives written notice that the authorization is revoked.

Patient Name (please print)

Date of Birth

Signature of Patient or Legal Representative

Relationship

Date

Responsibility for Payment/Receipt of HIPAA Notice/Patient Communication

I understand that I am fully responsible for all fees due to Primary Care Plus or any associated medical provider (collectively referred to as the "Clinic") as a result of services I have received and that all fees are due and payable at the time of service unless Clinic agrees to accept assignment of my Medicare, Medicaid or other insurance benefits.

If I have insurance coverage other than Medicare:

I understand that assigning benefits to the Clinic and the filing of an insurance claim on my behalf is a courtesy to me and this is not absolving me of my responsibility to pay for services if the insurance company fails to pay for these services or if deductibles and/or co-pays are due. I understand that my insurance policy may not cover the full cost of services, or may consider it an uncovered service or medically unnecessary, or I may not have coverage benefits for these services. I therefore agree to be responsible for those charges incurred, as well as for my co-pay and/or any deductible that has not been met.

I further understand that any verification of my insurance benefits by the Clinic is not a guarantee of payment by my insurance company. If my insurance company does not pay for the services I have received, or fails to pay within 60 days of service, I understand that the Clinic will bill me for these services and I agree to pay any amounts due within 30 days of receipt of a bill for these services. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by my insurance company and the actual charge for that service.

If I am covered under Medicare or a Medicare Advantage healthplan :

I understand that I will be responsible for my co-pay and/or any deductible that has not been met either through my Medicare coverage or any supplemental policy that I may also have. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by Medicare and the actual charge for that service.

I further understand that I will be notified in advance by an Advanced Beneficiary Notice of Noncoverage if Medicare likely will not pay for items or services. I will then have the right to make an informed choice whether or not to receive the items or services. If I choose to receive the items or services, I am aware that I will be responsible for paying for such items or services.

I request that payment of authorized Medicare, Medicaid or other insurance benefits be made on my behalf to the Clinic for any services furnished to me subject to any regulations pertaining to their assignment of benefits. I authorize any holder of my medical information to release to the Centers for Medicare & Medicaid Services, Social Security Administration and its agents, intermediaries or carriers, or to any other third-party sources or insurance companies and its agents any information or documentation needed to determine these benefits or the benefits payable for related services. A copy of this authorization may be used in place of an original and this authorization shall remain in force until revoked by me in writing.

I certify that the insurance information given by me is current and accurate to the best of my knowledge and I understand and agree to abide by the terms outlined above.

***I further acknowledge that a copy of the Clinic's Notice of Privacy Practices and Patient's Rights & Responsibilities has been made available to me.**

***I agree to receive appointment and treatment reminders via text and voicemail.** ☐ Yes ☐ No

Patient Name (Please Print)

Date

Patient or Responsible Party Signature

Relationship to Patient

Reason Patient Cannot Sign (if applicable)

Authorization for the Release of Protected Health Information (PHI)

Patient Name (Last, First, Middle): _____ Date of Birth: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip code: _____
Contact Phone Number(s): _____

I hereby authorize the following entity to release the Protected Health Information (PHI) below to:

Primary Care Plus, 318 Guilbeau Rd., Lafayette, LA 70506

Attention: Administration: Telephone: (337) 895-6000 Fax: (337) 895-6024

Entity Possessing the PHI: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number(s): _____ Fax: _____

If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

PHI and Dates of PHI Authorized for Use of Disclosure

<u>Description</u>	<u>Start & End Date of PHI</u>	<u>Description</u>	<u>Start & End Date of PHI</u>
<input type="checkbox"/> All PHI Records	_____	<input type="checkbox"/> History & Physical Exam	_____
<input type="checkbox"/> Laboratory Test	_____	<input type="checkbox"/> X-Ray Tests/Reports	_____
<input type="checkbox"/> Progress Notes	_____	<input type="checkbox"/> Discharge Summary	_____
<input type="checkbox"/> Consultation Reports	_____	<input type="checkbox"/> Itemized Billing Statement	_____
<input type="checkbox"/> Other _____	_____		

****The following information will be released unless you indicate DO NOT RELEASE by checking the appropriate box**

☐ AIDS/HIV OR STD treatment ☐ Psychiatric/Mental Care ☐ Alcohol/Drug/Substance Abuse ☐ Genetic Screening

Other, please specify: _____

I understand that:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed.
- I have the right to receive a COPY of this form after I sign it.
- I will receive a photocopy only of my medical record and that the original will remain with Primary Care Plus

Signature of Patient or Patient's Representative (if applicable): _____ Date: _____

Personal Representative's Relationship to Patient and Description of Authority to Act: _____

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person(s) as your "personal representative." You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I, _____ Date of Birth _____ (print name and date of birth)
hereby appoint the following person(s) to act as my personal representative(s) with respect to decisions involving the use and/or disclosure of health information that pertains to me.

<u>Name of Personal Representative(s)</u>	<u>Relationship To Patient</u>	<u>Phone Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The Authority of this person when serving as my "personal representative" is restricted to the following functions:

Description:

- ☐ This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.
- ☐ This person is restricted to the following information about my health care:

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to:

Primary Care Plus - Lafayette
318 Guilbeau Rd.
Lafayette, LA 70506
Attention: Clinic Manager

I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

Signature

Date

REVOCATION SECTION:

I hereby revoke the designation of _____ as my personal representative.

Patient Signature

Date