609 East Worthey Street, Gonzales, LA 70737 Ph:225-647-6533 Fax:225-644-7533

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (MI)_____

Also Known As Name (Last)_____(First)_____

Date of Birth ____/____/____ ☐ Female ☐ Male Social Security Number ____-____-____

Phone Numbers Home_____ Cell _____ Work_____

Mailing Address_____

City, State, ZIP (+4)_____

Physical Address (if different from mailing)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Island ☐ Black/African American ☐ White/Caucasian

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language:_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

E-Mail Address_____(used for online surveys only)

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient ☐ Mother ☐ Father ☐ Other:_____

List the names of your child's Parents/Guardians below

Name:_____ Rel:_____ Name:_____ Rel:_____

Name:_____ Rel:_____ Name:_____ Rel:_____

RESPONSIBLE PARTY INFORMATION ***Statements will be addressed to the Responsible Party***

Responsible Party Name (Last)_____ (First)_____ (MI)_____

Also Known As Name (Last)_____(First)_____

Date of Birth ____/____/____ ☐ Female ☐ Male Social Security Number ____-____-____

Phone Numbers Home_____ Cell_____ Work_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Subscriber_____ Patient Relationship to Subscriber_____

Date of Birth____/____/____ Social Security Number ____-____-____

Phone Numbers Home_____ Cell _____ Work_____

Address:_____City/State/Zip:_____

Insurance Plan Name:_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Subscriber_____ Patient Relationship to Subscriber_____

Date of Birth____/____/____ Social Security Number ____-____-____

Phone Numbers Home_____ Cell _____ Work_____

Address:_____City/State/Zip:_____

Insurance Plan Name:_____

ASSIGNMENT & RELEASE

I, the undersigned, have insurance coverage with _____and assign directly to **P.S.O.C. Caro Clinic** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I authorize the use of this signature on all my insurance submissions.

Signature of Patient, Parent, Guardian, or Personal Representative Date Please Print Patient, Parent, Guardian, or Personal Representative Date

Bank Fees, Service Charges, Collection Agency and/or Attorney Fees

A $25.00 fee will be assessed for each returned check or any account balance that is past due. I understand that I am financially responsible for all related bank or service charges. I also understand that if my past due balance is sent to a collection agency for non-payment, I will be responsible for any collection and/or attorney fees.

Signature of Patient, Parent, Guardian, or Personal Representative Date Please Print Patient, Parent, Guardian, or Personal Representative

Release of Medical Records

I, the undersigned, authorize the release of information, including financial information, confidential health information and medical records regarding services rendered during this episode of care or any related services to my insurance carrier(s), managed care plan or other payor, and/or independent contractor physicians such as anesthesiologist and/or pathologist. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, substance abuse, mental illness or psychiatric treatment. I give specific authorization for these records to be released and thereby release **P.S.O.C. Caro Clinic** and their staff from all legal responsibility that may arise from the act hereby authorized.

Signature of Patient, Parent, Guardian, or Personal Representative Date Please Print Patient, Parent, Guardian, or Personal Representative

I the undersigned authorize **P.S.O.C. Caro Clinic** to speak with the listed persons regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by **P.S.O.C. Caro Clinic** to the listed persons and thereby release **P.S.O.C. Caro Clinic** and their staff from all legal responsibility that may arise from the act hereby authorized.

AUTHORIZED PERSON	DATE OF BIRTH	RELATIONSHIP	PHONE NUMBER

Signature of Patient, Parent, Guardian, or Personal Representative Date Please Print Patient, Parent, Guardian, or Personal Representative

Patient Health History

Patient Name:		
Birth Date:	Age:	Date:
Referring Provider:	Primary Care Provider:	

PAST MEDICAL HISTORY

Please list current or previous medical conditions and treating physician. (Examples High Blood Pressure, Heart Attack, Stroke, Diabetes, Cancer, Thyroid problems, Depression, Arthritis, Blood Clots, etc):

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

SURGICAL HISTORY (ALL)

Date (M/Y)	Procedure	Surgeon	Date (M/Y)	Procedure	Surgeon

CURRENT MEDICATIONS
(include all over the counter medications and herbal remedies)

MEDICATION	Dose	# per day	Physician	MEDICATION	Dose	# per day	Physician

ALLERGIES

Allergy (please list)	Reaction	Are you allergic to any of the following:	
		X-ray Contrast	Latex/ Rubber
		Band-Aids/ Tape	Betadine (Iodine soap)

Date updated:_____ Initial:_____
Date updated:_____ Initial:_____
Date updated:_____ Initial:_____

Date updated:_____ Initial:_____
Date updated:_____ Initial:_____
Date updated:_____ Initial:_____

Are you able to take care of yourself? ☐ Y ☐ N | If no, name of caregiver

Do you have assisted living? ☐ Y ☐ N | If yes, at ☐ home or ☐ retirement center

☐ Y ☐ N I have an Advance Directive, i.e. DNR? (If yes, please bring a copy to your next appointment.)

EDUCATION

Please mark level of highest education completed

☐ Elementary ☐ High School/ GED ☐ College ☐ Graduate/ Post Grad ☐ Other

Preferred method of learning

☐ Demonstration ☐ Written words ☐ Visual ☐ Other ( )

Please list any barriers to learning:

WORK HISTORY

☐ Working? If yes, list job title:			Length at job:
☐ Full time	☐ Part time	Hrs/ Day	Hrs/ Week
☐ Retired	When		From what position
☐ Medical leave	When		
☐ Disability	What %	When	Reason for disability
☐ Unemployed	When	Reason for unemployment:	

☐ Do you have any vocational concerns? Please list:

Is your pain the result of one of the following ☐ Vehicle Accident ☐ On the job injury

DRUGS/ ALCOHOL

☐ Y ☐ N Do you drink caffeine? How many beverages a day?

☐ Y ☐ N Do you use tobacco in any form? How many packs a day: Cans a week: #Years:

☐ Y ☐ N Are you a former tobacco user? When quit: Age at that time:

☐ Y ☐ N Do you use alcohol? How many beverages a day?

☐ Y ☐ N Do you have a history of alcoholism? When did you quit:

☐ Y ☐ N Do you have a history of street drug or prescription drug abuse? When did you quit:

☐ Y ☐ N Is there any substance abuse in your household? If yes list:

Are you using or have you used in the past year any street drugs? If yes, check below:

☐ Heroin ☐ Cocaine ☐ Crank ☐ Marijuana ☐ Amphetamines ☐ Other:

EMOTIONAL /PSYCHOLOGICAL

☐ Y ☐ N Any significant life changes in the last year (i.e. move, death, divorce, financial, job) Please describe:

☐ Y ☐ N Have you ever been hospitalized for a psychiatric condition (suicidal, depression, anxiety, etc)?

Where: Date(s):

☐ Y ☐ N Have you ever seen a: ☐ psychiatrist ☐ psychologist ☐ counselor

Name: Reason:

How do you feel emotionally right now?

☐ Anxious ☐ Fearful ☐ Hopeless ☐ Angry ☐ Guilty ☐ Peaceful ☐ Hopeful ☐ Sad

Please check the number below that describes your level of DEPRESSION:

No depression: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unbearable depression

Please check the number below that describes your level of your ANXIETY:

No anxiety: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extreme anxiety

Do you have any financial, social, cultural, religious concerns that might impact treatment? ☐ Yes ☐ No

If yes, please explain:

Patient Name: _____ Birthdate: _____

NOTICE OF PRIVACY PRACTICES

Pelican State Outpatient Center – Caro Clinic, LLC – HIPAA PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose protected health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. In order to release any psychotherapy notes separate from this office's health record, any information the office might use for marketing, or any sale of your information, your consent must be explicitly obtained prior to any of these actions taking place.

If you wish to keep private the results of a test or procedure for which you have paid in full out of pocket, you may request to do so in writing spelling out what information should be restricted and from what insurance company. By doing this, you will ensure that the only people who have knowledge of this information are yourself and the treating physician. It will never be included in the release of your PHI unless you request in writing to do so. Also, as a patient, you have the right to request specific amendments to your PHI by completing an Amendment to PHI Request Form. For more information, please contact the HIPAA Privacy Officer.

If you have any objections to this form, please ask to speak with our HIPAA Privacy Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

COMPLIANCE ASSURANCE NOTIFICATIONS FOR OUR PATIENTS

To our valued patients:

The misuse of Protected Health Information (PHI) has been identified as a national problem. We want you to know that all of our entire staff continually undergoes training so that we may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the Privacy Rule. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with government rules, laws, and regulations. We want to ensure that our practice does not contribute to the growing problem of improper disclosure of PHI. As part of this plan, we have conducted a risk assessment and implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

Mistakes are sometimes made, so it is our policy to listen to our employees and our patients without any thought of penalization if they feel an event in any way compromises our policy of integrity. Questions, complaints and suggestions regarding our HIPAA policies and procedures should be directed to our HIPAA Privacy Officer. Ask any clinic employee for the name and contact information of our HIPAA Privacy Officer.

If a mistake leads to a breach of your PHI, this office will notify you in writing and carry out the respective steps necessary to mitigate the breach.

If you would like an electronic copy of this consent form, please leave your email with the front desk and one will be sent to you.

THANK YOU FOR SUPPORTING OUR CLINIC AND OUR COMMUNITY

Signed:_____ Date: _____

Printed Patient Name/Legal Guardian