

The Surgery Clinic of Northeast Louisiana

PATIENT INFORMATION:

Date of Appointment _____

How did you hear about us? TV Radio Direct Mail Newspaper Friend/Family Physician Website Health Fair

Referred by: _____ Primary Care Doctor: _____

Patient's Name: _____
First Middle Last PreferredAddress: _____
Number and Street Apt/Lot City State Zip

SSN: _____ - _____ - _____ Date of Birth: _____ Marital Status: _____

 Male Female Race: _____ Language: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best Way to contact you: Phone Email Do you Have Insurance: Yes No

Employer: _____ Occupation: _____ School: _____

PAYMENT INFORMATION:

Person Responsible for Payment/bill: _____
First Middle LastAddress: _____
Number and Street Apt/Lot City State Zip Main Phone

Relationship to Patient: _____ SSN: _____ - _____ - _____ Date of Birth: _____

Best Way to Contact Individual: Phone Mail Email Address: _____

INSURANCE INFORMATION:

Insurance Company: _____ Policy Number: _____

Policyholder's Name: _____
First Middle LastAddress: _____
Number and Street Apt/Lot City State Zip

Relationship to Patient: _____ SSN: _____ - _____ - _____ Date of Birth: _____

Main Phone: _____ 2nd Phone: _____ Email: _____

Employer: _____ Occupation: _____

2nd Insurance Company: _____ Policy Number: _____

PATIENT'S CONTACTS:

Pharmacy: _____ Location: _____

Legal Guardian: _____
Name Relationship Main Phone 2nd PhonePrimary Caregiver: _____
Name Relationship Main Phone 2nd PhoneEmergency Contact: _____
Name Relationship Main Phone 2nd Phone

All professional services rendered are the financial responsibility of the patient. Payment is expected upon the provision of services. For insured patients, we are pleased to assist in the filing of your insurance claims. *By signing below, I hereby consent to my insurance carrier releasing all necessary information to The Surgery Clinic of Northeast Louisiana regarding the status of my claims. Further, I hereby authorize The Surgery Clinic of Northeast Louisiana to furnish information to my insurance carrier concerning my medical history, illness and treatments. Further, I authorize my insurance carrier to pay directly to The Surgery Clinic of Northeast Louisiana all benefits to which I and/or my dependents may be eligible for the provision of healthcare services.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS ABOVE

SIGNATURE: _____

DATE: _____

CONSENT:

I hereby voluntarily give consent for the necessary medical treatment for the above named patient.

Signature of Legal Guardian_____
Date

The Surgery Clinic of Northeast Louisiana

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA's privacy rules generally give you the right to request a restriction on uses and disclosures of your protected health information (PHI). You are also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to your office instead of your home. To better serve you, please complete the following:

PLEASE CONTACT ME IN THE FOLLOWING MANNER:

VERBAL COMMUNICATION:

Home / Cell / Work

Please Identify Your Preferred Phone Number: (____) ____ - _____

- Leave message with detailed information.
- Leave message with call back number only.

WRITTEN COMMUNICATION:

- Mail to this address: _____
- Fax to this number: _____
- Email address: _____

FAMILY MEMBER(S) OR FRIEND(S) WITH WHOM WE MAY DISCUSS YOUR MEDICAL CONDITION:

Name: _____ Address: _____ Phone: _____
Relationship: _____

Name: _____ Address: _____ Phone: _____
Relationship: _____

Name: _____ Address: _____ Phone: _____
Relationship: _____

Name: _____ Address: _____ Phone: _____
Relationship: _____

I understand it is my responsibility to provide this office with written changes to the release of my PHI.

Patient's Printed Name: _____

Patient Signature: _____ Date: _____

The Surgery Clinic of Northeast Louisiana

Patient Name: _____

CONSENT TO TREATMENT

1. I hereby voluntarily consent to care at and by The Surgery Clinic of Northeast Louisiana, which may encompass certain routine out-patient procedures and certain diagnostic procedures, examinations and medical treatment including but not limited to routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribed by the provider.
2. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by The Surgery Clinic of Northeast Louisiana and its providers as is necessary in the medical staff's judgment.
3. If attached, I have reviewed and understand the supplemental information provided by my physician regarding specific treatment and/or procedures that may be provided.
4. In consenting to treatment, you are authorizing The Surgery Clinic of Northeast Louisiana to send you appointment reminders through automated phone calls and/or text messages. If at any time you no longer want to receive appointment reminders, please advise us in writing (email or letter), and we will discontinue that service.
5. I understand that The Surgery Clinic of Northeast Louisiana consists of specialty healthcare providers. The Surgery Clinic of Northeast Louisiana maintains its records electronically. This allows my medical information to be available throughout The Surgery Clinic of Northeast Louisiana.
6. I hereby authorize my insurance carrier(s) to pay The Surgery Clinic of Northeast Louisiana, all benefits due me, if any, by reason of service described in the statements rendered and as provided for by the policy contract with my insurance carrier(s).
7. I understand that this Consent Form will be valid and remain in effect as long as I (he/she) attend The Surgery Clinic of Northeast Louisiana.
8. This form has been explained to me, along with any attachment, and I understand their contents.

Signature of Patient or
Person Authorized to Consent for Patient

Date

If patient is a minor or is unable to consent, _____
Patient Name

A. Patient is a minor _____ years of age. Name of legal Guardian _____

B. Patient is unable to consent because _____

Signature of Person Authorized to Consent for Patient

Relationship

REQUIRED RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of medical information necessary to process my claim. As a courtesy to The Surgery Clinic of Northeast Louisiana's patients, we will file the claim with your insurance carrier with the understanding that if your insurance company does not pay, you are responsible for payment of this account.

Patient (or Guardian): _____
Print Sign Date

NOTICE OF PRIVACY PRACTICES
The Surgery Clinic of Northeast Louisiana

The attached information describes how information about you may be used and disclosed and how you gain access to this information. Please review it carefully.

UNDERSTANDING YOUR HEALTH RECORD INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit should be made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care. This information is often referred to as your health or medical records and serves as a basis for planning your care and treatment. These records foster communications among the healthcare professionals who may contribute to your care. These records also provide a means by which you or a third party payer can verify that services billed were actually provided.

**CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND
HEALTHCARE OPERATIONS**

I, hereby authorize **The Surgery Clinic of Northeast Louisiana** to use or carry out my treatment, payment and healthcare operations. I understand this consent is voluntary. If I refuse to sign this consent, I understand **The Surgery Clinic of Northeast Louisiana** may refuse to treat me.

I understand that I may revoke this consent at any time by notifying **The Surgery Clinic of Northeast Louisiana** in writing. If I revoke my consent, such revocation shall not affect any actions that **The Surgery Clinic of Northeast Louisiana** may have taken prior to receiving notice of my revocation.

I understand that **The Surgery Clinic of Northeast Louisiana** has reserved the right to change its privacy practices and that I may obtain such revised information upon request.

I understand that I have the right to request that **The Surgery Clinic of Northeast Louisiana** restrict how my individually identifiable health information is used and disclosed to carry out treatment, payment, and health operations. I understand that **The Surgery Clinic of Northeast Louisiana** is not obligated to agree to such restrictions, but that once such restrictions are agreed to **The Surgery Clinic of Northeast Louisiana** shall adhere to such restrictions.

The following notice describes how your medical information may be used and disclosed, and how you can gain access to this information. Please review the information carefully.

Your confidential healthcare information may be released to:

- Other healthcare professionals for the purpose of providing you with quality healthcare.
- Your insurance provider for the purpose of **The Surgery Clinic of Northeast Louisiana** receiving payment for providing you with needed healthcare services.
- Public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime, or domestic violence.
- Other healthcare providers in the event you need emergency care.
- A public health organization or federal organization in the event of a communicable disease, to report a defective device, untoward event to a biological product (food or medication), or other statutory reporting requirements.

Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.

Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

You may be contacted by **The Surgery Clinic of Northeast Louisiana** to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

The Surgery Clinic of Northeast Louisiana

Authorization to Release or Obtain Health Information	
Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID# or Social Security #:

The below section is to be filled out in the clinic. Please scroll to the bottom and sign this document.

I authorize:
 Name: _____
 Mailing Address: _____
 City, State, Zip Code: _____
 Relationship: _____ Telephone Number: _____

TO RELEASE INFORMATION TO **OR** **TO OBTAIN Information FROM**
 (Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____
 Mailing Address: _____
 City, State, Zip Code: _____
 Relationship: _____ Telephone Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

Further Medical Care
 Personal
 Legal Investigation or Action
 Changing Physicians
 Research related treatment
 Creating health information for disclosure to third party
 Other _____

I authorize the release of the following protected health information.
 (Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

Entire Record
 Medical History, Examination, Reports
 Surgical Reports
 Treatments or Tests
 Prescriptions
 Immunizations
 Hospital Records including Reports
 Laboratory Reports
 X-Ray Reports
 Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

Alcoholism
 Drug Abuse
 Mental Health
 Vocational Rehabilitation
 HIV (AIDS)
 Sexually Transmitted Diseases
 Genetics
 Psychotherapy Notes
 Other: _____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read this form.

Signature of Individual or Personal Representative Authorized by Law	Relationship to Patient	Date
Signature of Witness (if signed with an ("X") or mark)	Date	

You have the right to:

- Restrict the use of your confidential healthcare information. However, **The Surgery Clinic of Northeast Louisiana** may choose to refuse your restriction if it is in conflict with providing you with quality healthcare, in the event of an emergency situation, or in conflict with state or federal requirements.
- Receive confidential communication about your health status.
- Review and photocopy any/all portions of your healthcare information.
- Make changes to your healthcare information.
- Know who has accessed your confidential healthcare information and for what purpose.
- Possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

The Surgery Clinic of Northeast Louisiana is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.

The Surgery Clinic of Northeast Louisiana will abide by the terms of this notice. **The Surgery Clinic of Northeast Louisiana** does reserve the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. The latest revision of the Notice of Privacy Practices will be available upon request.

You have the right to file a grievance with **The Surgery Clinic of Northeast Louisiana** if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please send your complaint to:

The Surgery Clinic of Northeast Louisiana
312 Grammont St. Suite 303
Monroe, LA 71201

All grievances will be investigated.

For further information about this Privacy Notice, please contact:

The Surgery Clinic of Northeast Louisiana
(318)398-2984

This notice is effective as of November 1, 2018.

Printed Name of Patient: _____

Signature of Patient/Representative: _____

Date: _____

Patient History Form

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Height: _____ Weight: _____ Referring Doctor: _____ Primary Doctor: _____

1. Chief Complaint (The main reason you are seeing the doctor today)

2. Review of Systems (If patient is **currently experiencing**, please check Yes or No)

CONSTITUTION

Fever Yes No
Chills Yes No
Weight loss Yes No
Fatigue Yes No
Abnormal Sweating Yes No

SKIN

Rash Yes No
Itching Yes No

EARS, NOSE, AND THROAT

Hearing loss Yes No
Ringing in ears Yes No
Ear pain Yes No
Ear discharge Yes No
Nosebleeds Yes No
Congestion Yes No
Sinus pain Yes No
Sore throat Yes No

EYES

Blurred vision Yes No
Double vision Yes No
Photophobia Yes No
Eye pain Yes No
Eye discharge Yes No
Eye redness Yes No

CARDIOVASCULAR

Chest Pain Yes No
Palpitations Yes No
Orthopnea Yes No
Claudication Yes No
Leg swelling Yes No

RESPIRATORY

Cough Yes No
Coughing up blood Yes No
Productive cough Yes No
Shortness of Breath Yes No
Wheezing Yes No

GASTROINTESTINAL

Heartburn Yes No
Nausea Yes No
Vomiting Yes No
Abdominal pain Yes No
Diarrhea Yes No
Constipation Yes No
Blood in stool Yes No

GENITOURINARY

Pain with urination Yes No
Urgency Yes No
Frequency Yes No
Blood in urine Yes No

MUSCULOSKELETAL

Muscle pain Yes No
Neck pain Yes No
Back pain Yes No
Joint pain Yes No
Falls Yes No

ENDOCRINOLOGY

Easy bruise/bleed Yes No
Env allergies Yes No
Excess thirst Yes No

NEUROLOGY

Dizziness Yes No
Headaches Yes No
Tingling / numbness Yes No
Tremor Yes No
Sensory change Yes No
Speech change Yes No
Weakness Yes No
Seizures Yes No

PSYCHOLOGY

Depression Yes No
Suicidal ideas Yes No
Substance abuse Yes No
Hallucinations Yes No
Nervous / Anxious Yes No

3. Medical History (PATIENT'S past medical history)

Allergies: _____

Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	GERD (Reflux) <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle cell anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
CHF <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Clotting disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV / AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No	Substance abuse <input type="checkbox"/> Yes <input type="checkbox"/> No
COPD <input type="checkbox"/> Yes <input type="checkbox"/> No	High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary artery disease <input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Dementia <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

4. Past Surgical History (Please list all operations or procedures patient has had along with the dates)

5. Social History (Patient's social history)

Do you use nicotine? Currently Previous Never Explain: _____
Do you drink alcohol? Currently Previous Never Explain: _____
Do you use drugs? Currently Previous Never Explain: _____
Are you sexually active? Currently Previous Never Birth control: _____

6. Family History (please list any medical conditions for patient's **blood** relative)

Adopted Family History Unknown

Mother: _____ Maternal Grandparent: _____
Father: _____ Paternal Grandparent: _____
Siblings: _____ Other: _____

