Natchitoches Regional Medical Center

Multi-Specialty Clinic
Phone: (318) 214-5770 Fax: (318) 214-4633

Date: __________ **Referring Doctor:** ____________________ **Primary Doctor:** _________________

Legal Name: ______________________________________ **Preferred Name:** ___________________

Physical Address: ___________________________ **City:** _____________ **State:** ______ **Zip:**________

Mailing Address: ___________________________ **City:** _____________ **State:** ______ **Zip:** ________

Home Phone: ________________ **Cell Phone:** __________________ **Other:**______________________

Email: ____

Notification Preference (circle one)**: Phone Call / Text / Email**

Sex: M F Date of Birth: _______________ **Social Security Number:** _______________________

Marital Status: Single / Married / Divorced / Widowed / Domestic Partner / Other: ______________

Race (circle one)**: Caucasian / African American / American Indian / Asian / Other** _______________

Ethnicity (circle one)**: Not Hispanic or Latino / Hispanic or Latino**

Preferred Language: English or Other (specify) ___________________

Are you a Veteran? ‣ Yes ▪ No

Do you have a Living Will? ‣ Yes ▪ No

Are you an Organ Donor? ‣ Yes ▪ No

Employer: _____________________ **Address:** ________________________ **Phone:** _____________

Primary Insurance: _________________________ **ID #** _________________ **Group #** __________

Secondary Insurance: _______________________ **ID #** _________________ **Group #** __________

Responsible Party (complete only if person responsible for payment or subscriber of insurance is other than patient)

Name: _____________________________ **Relationship to Patient:** _____________________

Address: ____________________________ **City:** _____________ **State:** ________ **Zip:** ________

Home Phone: _____________ **Date of Birth:** ___________ **Social Security Number:** ___________

Employer: ___________________ **Address:** __________________________ **Phone:** ____________

Pharmacy: ____ **Phone:** ___________________________

Emergency Contact Person (other than your home number)

Name of Contact: __________________________ **Relation:** _______________ **Phone:** ____________

Which hand do you write with? Left Right (Please circle one)

What do you do for fun? ____

Occupation: _______________________ **Retired: Y or N**

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AUTHORIZATION

All of the personnel of NRMC Multi-Specialty Clinic take your medical confidentiality **very** seriously. We will not and cannot release information without your written authorization.

The authorization form, when completed and signed, allows our staff members to speak only with the individual(s) you designate in the event that you are not able to receive our phone calls or you have an adult family member that helps coordinate your medical care. **You should NOT designate a physician.**

If you feel, for example, comfortable allowing us to talk with another person regarding an appointment, then you would check that box. Please check all boxes that apply to your needs. If there is an additional person, you wish to authorize, please complete the next sections as you did the first.

I authorize the employees of NRMC Multi-Specialty Clinic to speak with the following persons:

NAME: ________________________
PHONE#: ______________________

□ APPOINTMENTS
□ ACCOUNTS/BILLS
□ LAB RESULTS
□ TEST RESULTS
□ MEDICAL CARE

NAME: ________________________
PHONE#: ______________________

□ APPOINTMENTS
□ ACCOUNTS/BILLS
□ LAB RESULTS
□ TEST RESULTS
□ MEDICAL CARE

□ I do not authorize anyone to receive information regarding my medical care.

- I authorize the employees of NRMC Multi-Specialty Clinic to review all medications and medication history.
  - ▸ Yes ▪ No – (Please Circle One)
- Information regarding any of the above may also be left on my answering machine or voicemail.
  - ▸ Yes ▪ No – (Please Circle One)

Signature: ____________________________________ Date: ______________________________

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HIPAA Notice of Privacy Practices

***** 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. *****

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. **<u>Uses and disclosures of Protected Health Information</u>**
   a. **For Treatment**
      i. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your personal health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnosis and treat you.
   b. **For Payment**
      i. Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
   c. **Health Care Operations**
      i. We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to: quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
      ii. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker’ Compensation: Inmates: Requires Uses and Disclosures. Under the law, we must make disclosures to you and when requires by the Secretary of the Department of Health and Human Services to investigate and determine out compliance with the requirements of Section 164.500.
      iii. Other Permitted and Required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.
      iv. You may revoke this authorization, at any time, in writing, except to extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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2. **Your Rights**
    a. Following is a statement of your rights and respect to your protected health information.

3. **You have the right to request a restriction of your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information that is subject to law prohibits access to protected health information.

4. **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as directed in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

5. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternative, i.e. electronically.**

6. **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with use and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

7. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

- You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violates by use.
- You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **January 1, 2016**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: ____

Signature: ____ **Date:** ________________________________

Natchitoches Regional Medical Center

Multi-Specialty Clinic

Authorization for Release of Information

Patient Identification

Printed Name: ____ Date of Birth: _______________________

Address: ____

Social Security #: ____________________________________ Telephone: _________________________________

Information to be Released – Covering the Periods of Health Care

From ____

(date) ____________________ to (date) _________________________

Please check the type of information to be released:

□ Complete Health Record	□ Diagnosis & Treatment Codes	□ Discharge summary
□ History and Physical Exam	□ Consultation reports	□ Progress notes
□ Laboratory test results	□ X-Ray reports	□ X-Ray films/images
□ Photographs, Videotapes	□ Complete billing record	□ Itemized bill

□ Other (specify) ____

Purpose of Request

□ Treatment or Consultation	□ At the request of the patient	□ Billing or claims payment

□ Other (specify) ____

Who and Where to Send/Release Information

Name: Natchitoches Regional Medical Center - Multi–Specialty Clinic

Address: P.O. Box 2475, Natchitoches, LA 71457

Phone: 318-214-5770 Fax: 318-214-4633

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice, in writing, to the facility Privacy Officer at Natchitoches Regional Medical Center P.O. Box 2009, Natchitoches, LA, 71457. Unless revoked, this authorization will expire on the following date or event or 180 days from the date of signature.

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize NRMC Multi-Specialty Clinic to release the protected Health Information specified above.

Signature: ____ Date: _______________________________

Authority to Sign (if not patient): ____

Witness: ____

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Patient Medical History

Patient: ______________________________ Age: _______ Height: ________ Weight: _________
Previous Surgeries: ____YES ____NO Medication Allergies: ____________________________________
If yes, explain. ____

Have you ever had:

	No	Yes	Describe		No	Yes	Describe
Heart Problems				**Diabetes**			
High Blood Pressure				**Tuberculosis**			
Stroke				**COPD/Emphysema**			
Blood Clots				**Glaucoma**			
Anemia				**Ulcers**			
Bleeding Problems				**Epilepsy/Seizures**			
Cancer				**Psychiatric Treatment**			
Asthma				**Depression**			
Kidney Problems				**Contagious Disease**			
Liver Problems				**HIV/AIDS**			
Hepatitis				**Other Illnesses**			
Arthritis				**Urology Problems**			
Gout				**Prostate Problems**			
Thyroid Problems							

Are you ALLERGIC to the X-Ray/CT Scan Dye	**Yes**	**No**
If you selected NO, are you allergic to seafood?	**Yes**	**No**

Have you ever used TOBACCO?	**No**	**Yes**	**If so, when did you start? ________________________** **How many packs per day? __________** **When did you quit (if you quit)? __________________**
Do you drink ALCOHOL?	**No**	**Yes**	**How often?**
Are you PREGNANT?	**No**	**Yes**	**Possibly?**
Do you use Marijuana	**No**	**Yes**	**Medical or Recreational (circle one)**
Do you use any other drugs for fun?	**No**	**Yes**	**If yes, what and how much?________________________**

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If you have experienced any of the following within the past 2 weeks, please mark below.

Constitutional:	___ No symptoms	
___ Fever	___ Chills	___ Headaches
Eye Symptoms:	___ No eye symptoms	
___ Double Vision	___ Blurred Vision	___ Photophobia (light sensitivity)
ENMT:	___ No ENMT symptoms	
___ Nasal Congestion	___ Earache	___ Sore Throat
___ Nasal Drainage	___ Tinnitus (ringing in ears)	___ Dysphagia (difficulty swallowing)
Neck:	___ No neck symptoms	___ A lump or swelling in the neck
___ Neck Pain	___ Neck Stiffness	___ Swollen Glands
Breast:	___ No breast symptoms	___ Breast Pain
___ Nipple Discharge	___ Change in breast skin	___ Breast Lump
Respiratory:	___ No respiratory symptoms	
___ Cough	___ Wheezing	___ Coughing up Sputum (mucus)
___ Shortness of Breath	___ Difficulty breathing	___ Pneumonia
Cardiovascular:	___ No cardiovascular symptoms	
___ Chest pain	___ Heart Palpitations	___ Cold hands or feet
___ Shortness of Breath on Exertion	___ Claudication	___ Shortness of breath laying
Gastrointestinal:	___ No GI symptoms	
___ Nausea	___ Vomiting	___ Diarrhea
___ Abdominal pain	___ Melena (dark stool)	___ Hematochezia (blood in stool)
Genitourinary:	___ No GU symptoms	
___ Dysuria	___ Burning with urination	___ Hesitancy
___ Hematuria (blood in urine)	___ Urgency	___ Frequency
Skin:	___ No skin symptoms	
___ Rash	___ Itching	___ Urticaria (hives)
___ Bruising	___ Eczema	___ Lesions
Musculoskeletal:	___ No musculoskeletal symptoms	
___ Back Pain	___ Myalgias (muscle pain)	___ Arthralgia (joint pain)
___ Leg Pain	___ Feet/Ankle swelling	___ Joint Stiffness
Neurological:	___ No neurological symptoms	
___ Difficulty walking	___ Confusion	___ Syncope (fainting)
___ Dizziness	___ Numbness	___ Tingling
___ Speech difficulties	___ Paresis	___ Tremors
Psychiatric:	___ No psychiatric symptoms	
___ Anxiety	___ Fatigue	___ Sleep Disturbances
___ Decreased energy	___ Depression	
Hematologic:	___ No hematological symptoms	
___ Easy bleeding tendency	___ Easy bruising tendency	
Endocrine:	___ No endocrine symptoms	
___ Polyuria (excessive urination)	___ Polydipsia (excessive thirst)	___ Temperature intolerance

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No Show / Late Arrival Policy

No Show / Cancellation Policy:

A "no show" is a patient who fails to appear for a scheduled appointment. A patient who consistently fails to present themselves for scheduled appointments is a chronic no show. A patient who is a no show more than three (3) times may be dismissed from the MSC.

Late Arrival Policy:

A grace period of 15 minutes will be permitted for unforeseen delays a patient may encounter while traveling to the clinic location for their appointment. If a patient arrives more than 15 minutes late for their appointment, the patient will be given the option of either being seen that day as a work-in IF the schedule permits or rescheduled for a later date.

Print Name: ___________________________________ Date: ________________________

Signature:_____________________________________