LA PRIMARY CARE – New Patient Packet – 5 pages total

PATIENT INFORMATION

Name: First	Middle		Last
Date of Birth	Age	Gender	Race
Street Address			
City	State		Zip
Home Phone	Cell Phone		Other Phone
Social Security #	Email		
Emergency Contact	Relationship / Phone		
Patient Marital Status	Employer / Phone		

INDIVIDUAL RESPONSIBLE FOR PAYMENT

Name: First	Middle	Last
Street Address		
City	State	Zip
Home Phone	Cell Phone	Other Phone
Social Security #	Email	
Employer / Phone		

PRIMARY INSURANCE COMPANY

Company	Policy ID #	Group # □HMO □PPO
Name of Policy Holder	Relationship to Insured	
Policy Holder Social Security #	Policy Holder Date of Birth	

SECONDARY INSURANCE COMPANY

Company	Policy ID #	Group # □HMO □PPO

LOCAL PHARMACY

Name	Phone	
Street Address		
City	State	Zip

MAILORDER PHARMACY

Name	Phone

Referred by / heard about us: _____

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Signature on File, Assignment of Benefits, Financial Agreement

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to LA PRIMARY CARE, for services furnished me by LA PRIMARY CARE. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. LA PRIMARY CARE accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance and non-covered services, as determined by the Medicare carrier.

MEDI-GAP: I understand that if a Medi-Gap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to LA PRIMARY CARE, or if to me to be forwarded immediately to LA PRIMARY CARE.

RELEASE OF INFORMATION: LA PRIMARY CARE may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to LA PRIMARY CARE for reimbursement for services rendered, and (2) any health care provider for continued patient care. LA PRIMARY CARE may also disclose on an anonymous basis any information concerning my case. A copy of this authorization may be used in place of the original.

OTHER INSURANCE: I understand that LA PRIMARY CARE maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that LA PRIMARY CARE has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by LA PRIMARY CARE if I belong to a plan that does not contract with LA PRIMARY CARE.

NON-COVERED SERVICES: I understand that LA PRIMARY CARE's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with LA PRIMARY CARE to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by LA PRIMARY CARE, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to LA PRIMARY CARE for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. I agree that any credit card payment dispute must be concluded in favor of LA PRIMARY CARE, as non-returnable services have already been rendered and must be paid as agreed here. Any benefits of any type, under any policy of insurance insuring the patient or any other party liable to the patient, is hereby assigned to LA PRIMARY CARE. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to LA PRIMARY CARE. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____

Signature of Patient/Beneficiary or Authorized Party Date

_____

Printed Patient/Beneficiary Name

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, LA PRIMARY CARE originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that LA PRIMARY CARE is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that LA PRIMARY CARE, reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should LA PRIMARY CARE, change their notice, they will send a copy of any revised notice to the address I've provided (either U.S. mail, or, if I agree, e-mail).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Acknowledgement of Receipt of Privacy Practices
I have been presented with a copy of LA PRIMARY CARE Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law.

_____

Signature of Patient or Authorized Party Date

_____

Printed Patient Name (and that of Authorized Party if applicable)

LA PRIMARY CARE – New Patient Packet – 5 pages total

LA PRIMARY CARE – Clinical History – Page 1 of 2

Patient Name: _____ Date: _____

Past Medical History -- Please circle active or inactive diagnoses:

High blood pressure	Diabetes	GERD, reflux	Kidney disease	Anxiety
High cholesterol	Thyroid disease	Liver dz / hepatitis	Kidney stones	Depression
Coronary artery dz	Asthma	Pancreatitis	Recurring UTIs	Bipolar disorder
Heart stent / bypass	COPD / Emphysema	Gallstones	Osteoporosis	Alcohol abuse
Angina (chest pain)	Sleep apnea	Diverticulitis	Osteoarthritis	Substance abuse
Congestive heart failure	Headache / migraine	Stomach ulcers	Lupus	Parkinson's
CVA (stroke)	Memory loss	Irritable bowel (IBS)	Fibromyalgia	Alzheimer's
TIA (mini-stroke)	Seizures	Colon polyps	Rheumatoid Arthritis	Blood clots/ DVT
HIV/AIDS	Gout	Cancer (type): _____		

Others: _____

Surgical History:	**Year**

Social History -- Please circle and answer

Smoking:	never	former	current some days	current daily # of years if yes:
Alcoholic Drinks:	no	yes	if yes, number per week:	
Recreational Drugs	no	yes	if yes, which drugs:	
Power of Attorney	no	yes	if yes, to whom:	
Living Will	no	yes	Occupation:	

Family History -- please write in affected blood relative in the box next to the disorder:

High blood pressure		Coronary artery disease		Breast cancer		Colon cancer	
Diabetes		Thyroid disease		Prostate cancer		Skin cancer	
High cholesterol		Mental disorders		Lung Cancer		Others:	

Health Maintenance	**Date**		**Date**		**Date**
Last mammogram		Last colonoscopy		Last tetanus vaccine	
Last Pap smear		Last diabetic eye exam		Last shingles vaccine	
Last bone density / DEXA					
Last Pneumonia vaccine	Please circle: Prevnar 13 Prevnar 20 Pneumovax 23				
Last Covid vaccine	Please circle: Pfizer Moderna Other:				

LA PRIMARY CARE – Clinical History – Page 2 of 2

Current Doctors	Specialty	Current Doctors	Specialty

Prescription Medications	Strength	How often

Vitamins and Supplements – names only please

Drug Allergies	Please list the reaction

I give LA PRIMARY CARE permission to discuss my personal health information with these individuals:

Name	Relationship

I certify that the above clinical information is accurate and complete:

_____

Signature of Patient or Authorized Party Date

_____

Printed Patient Name (and that of Authorized Party if applicable)