LA PRIMARY CARE – New Patient Packet – 5 pages total

PATIENT INFORMATION:

First Name	Middle	Last	
Birth Date / /	Age	Gender: MALE FEMALE	
Street Address	City	State	Zip
Check if OK for appointment reminders by phone call: by text: by email:			
Home Phone ( )	Cell Phone ( )	Other Phone ( )	Social Security # - -
Employer	Employer phone		
Next of Kin/Emergency Contact Name	Relationship	Phone # ( )	
Patient Marital Status (please circle): Single - Married - Divorced - Widowed - Legally Separated			
Race:	Email:		

INDIVIDUAL RESPONSIBLE FOR PAYMENT:

First Name	Middle	Last	
Street Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Employer	Social Security # - -

PRIMARY INSURANCE COMPANY

Company	Policy ID #	Group #	**HMO** or **PPO**
Name of Policy Holder	DOB	SSN	Relationship to Insured

SECONDARY INSURANCE COMPANY

Company	Policy ID #	Group #	**HMO** or **PPO**

PHARMACY NAME, ADDRESS, PHONE (If mailorder, include name of company)

Signature on File, Assignment of Benefits, Financial Agreement

1. 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, coinsurance and non-covered services, as determined by the Medicare carrier.

2. 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.

3. 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.

4. 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 appear on the above mentioned list.

5. 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.

6. 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.

Signed: _____

Beneficiary Signature or Authorized Party Date

Beneficiary Name (print): _____

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.

Signed: _____ Date: _____

(If other than patient, please give relationship)

_____

Please print name

LA PRIMARY CARE – Clinical History (1 of 2 pages)

PLEASE PRINT NAME: _____ DATE: _____

Past Medical History (active or inactive) Please circle:

High blood pressure	Diabetes	GERD, reflux	Kidney disease	Anxiety
High cholesterol	Thyroid disease	Liver disease/hepatitis	Kidney stones	Depression
Coronary artery disease	Asthma	Pancreatitis	Recurring UTIs	Bipolar disorder
Coronary 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 syndrome	Fibromyalgia	Alzheimer's
TIA (mini-stroke)	Seizures	Colon polyps	Rheumatoid Arthritis	
Blood clots/ DVT	HIV/AIDS	Gout	Cancer (type): _____	

Comments/Other:_____

Surgical History: Type of surgery and reason Year

_____ _____
_____ _____
_____ _____
_____ _____

Social History:

Smoking (circle): never former current every day current some day years of use: _____
Do you drink alcohol? Yes No How many drinks per week? _____
Do you use recreational drugs? Yes No Which drugs? _____
Have a Living Will? Yes No
Power of Attorney? Yes No To whom? _____
What is your occupation? _____

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

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

Health Maintenance: Date Date

Tetanus vaccine (circle Td or Tdap): _____ Last mammogram: _____
Last colonoscopy: _____ Shingles vaccine: _____
Last bone density/DEXA: _____ Last Pap smear: _____
Last eye exam: _____
Pneumonia vaccine (please circle prevnar 13 and/or pneumovax 23): _____

Name of Other Providers You See: **Specialty:**

_____ _____
_____ _____
_____ _____
_____ _____

LA PRIMARY CARE – Clinical History continued (2 of 2 pages)

Medications: List all current prescription and non-prescription medications, vitamins, and herbal products. Please include even occasionally used medications such as Tylenol, aspirin, or anti-inflammatories.

Medications	Strength?	How often?

Supplements	Strength?	How often?

Allergies: Please include all medication allergies and those to medical supplies, such as latex, iodine, or tape.

Name of medication/product	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:

_____ _____

Patient Signature Date

_____

Patient Name (please print)