TENSAS & VIDALIA COMMUNITY HEALTH CENTERS

NEW PATIENT PAPERWORK

PATIENT INFORMATION

Today's date:_____

Mr. Mrs. Ms. Dr. *(circle one)* Name: First_____ MI_____ Last_____

Mailing Address:_____ City_____ State_____ ZIP_____

Physical Address: _____ City_____ State_____ ZIP_____

SS#:_____ Birthdate:_____ ☐ Male ☐ Female

Home #:_____ Work #:_____ Cell#:_____

Preferred Method of Contact: *(circle one)* Home Work Cell

Email Address: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Driver's License #:_____ Occupation: _____

Primary Care Physician *(Shown on Insurance Card)*:_____

Race: *(check one)* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ More than one Race

Ethnicity: *(check one)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Sexual Orientation: *(check one)* ☐ Straight/Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Refuse to Answer Other *(explain)* _____

Gender Identity: *(check one)* ☐ Male ☐ Female ☐ Transgendered ☐ Refuse to Answer Other *(explain)*_____

RESPONSIBLE PARTY

Mr. Mrs. Ms. Dr. *(circle one)* Name: First_____ MI_____ Last_____

Home #:_____ Work #:_____ Cell#: _____

Billing Address:_____

SS#:_____ Birthdate:_____ Male/Female_____

Relationship to Patient:_____

EMERGENCY CONTACT *(Neighbor or Relative not living with you)*

His/Her Name:_____ Relation:_____

Home #:_____ Work #:_____ Cell#:_____

INSURANCE INFORMATION *(Please check the type of health insurance:)*

___ **Medicaid/Healthy Louisiana Plan** *(formerly Bayou Health)* #:_____

☐ Amerigroup Real Solutions LA ☐ AmeriHealth Caritas LA ☐ Aetna Better Health LA

☐ LA Healthcare Connections ☐ United Healthcare Community Plan LA

___**Medicaid (dental) #:**_____

___ **Medicare #:**_____

___ **No Insurance**

___ **Private/Other Insurance Name**_____

Employer/ Address:_____ Phone #:_____

Policy #:_____ Group #:_____ Effective Date:_____

Name of policy holder:_____ Relation:_____

Policy holder date of birth:_____ Policy holder Social Security #:_____

Does your insurance pay for prescriptions? ☐ No ☐ Yes Dental Coverage? ☐ No ☐ Yes

___ **Secondary Insurance Name**_____

Employer/ Address:_____ Phone #:_____

Policy #:_____ Group #:_____ Effective Date:_____

Name of policy holder:_____ Relation:_____

Policy holder date of birth:_____ Policy holder Social Security #:_____

Does your insurance pay for prescriptions? ☐ No ☐ Yes Dental Coverage? ☐ No ☐ Yes

PREFERRED PHARMACY

Name: _____ Street:_____Phone: _____

TENSAS & VIDALIA
COMMUNITY HEALTH CENTERS

PATIENT REVIEW

Today's date: _____

Mr. Mrs. Ms. Dr. *(circle one)* Name: First_____ MI_____ Last _____

Reason for todays visit:_____

Last menstrual period: _____ **ARE YOU PREGNANT? Y / N**

List any other doctors you currently use: _____

_____

Do You: __ Smoke Cigarettes __Use Tobacco Products __Drink Alcohol __Use Recreational Drugs?

Previous Surgeries or Hospitalizations? Please list with dates: _____

_____

_____

Current Medications:_____

_____

_____

Allergies _____

_____

Pharmacy to be used today: _____

TENSAS & VIDALIA
COMMUNITY HEALTH CENTERS

MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS? *(If Yes Please Circle "Y")*

HISTORY OF:

N Y Asthma
N Y Musculoskeletal problems
N Y Alcohol/Drug abuse
N Y Alzheimer's/Dementia
N Y Aneurysm
N Y Cancer
N Y Lung problems
N Y Liver Cirrhosis
N Y Colon Cancer
N Y GI/stomach problems
N Y Cardiac problems
N Y Diabetes
N Y Gout
N Y Migraine Headaches
N Y Hepatitis
N Y High Cholesterol
N Y High Blood Pressure
N Y Parkinson's
N Y Seizures
N Y Stroke
N Y Autoimmune Disease
N Y Thyroid problems
N Y TB
N Y Depression/Anxiety
N Y Bipolar

OTHER: _____

PREVENTATIVE (List Date of Last:)

Dental Exam: _____

PAP: _____

Ob-Gyn Doctor: _____

Mammogram: _____

Colonoscopy: _____

Gastroenterologist: _____

Eye Exam: _____

Flu Vaccine: _____

Pneumonia Vaccine: _____

A1C: _____

GENERAL QUESTIONS

Answering the following questions will help us determine what other services the clinic offers that you may qualify for:

YES NO

___ ___ Do you have reliable transportation?

___ ___ Do you have prescription drug coverage?

___ ___ Do you currently qualify for any government programs such as Medicaid, WIC, welfare, food stamps, Social Security disability or unemployment?
If yes, please list _____

___ ___ If you do not currently have Medicaid, have you ever applied for Medicaid?
What was the outcome? _____

FAMILY HISTORY

HAS ANY IN YOUR FAMILY HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

	None	Mother	Father	Sibling	Children	MGM	MGF	PGM	PGF
Unknown									
Adopted									
Asthma									
Arthritis									
Alcohol abuse									
Allergies									
Alzheimers Disease									
Aneurysm									
Anxiety									
Bilateral Hearing Loss									
Blindness									
Cancer									
Lung Disease									
Cirrhosis of Liver									
Colon Cancer									
Congestive Heart Failure									
Coronary Artery Disease									
Dementia									
Diabetes									
Emphysema									
Fibromyalgia									
Gout									
Migraines/Headaches									
Hepatitis C									
Cardiovascular/Heart Disease									
High Cholesterol									
Hypertension/High Blood pressure									
Myocardial Infarction/Heart Attack									
Parkinsons Disease									
Psychiatric hospitalizations									
Rheumatoid Arthritis									
Seizures									
Stroke									
Lupus									
Thyroid Disease									
TB									
Bipolar									
Depression									
Drug Addiction									
Mental Illness									
Schizophrenia									
Suicide									
Other									

Please explain:

TENSAS & VIDALIA
COMMUNITY HEALTH CENTERS

NOTICE OF PRIVACY PRACTICES

I have been provided with and understand the contents of the NOTICE OF PRIVACY PRACTICES for Tensas Community Health Center and its' entities. I understand that I have 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 and that Tensas Community Health Center and its' entities are not required to agree to the restrictions requested.

ASSIGNMENT AND RELEASE OF BENEFITS

PRIVATE INSURANCE: The undersigned assigns and hereby authorizes whether he/she signs as agent or as patient, direct payment to the clinic of all insurance and plan benefits otherwise payable to or on behalf of the patient for medical services. It is agreed that payment to the clinic pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

MEDICARE/MEDICAID: I certify that the information given by me in applying for payment under Title 18 of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that the payment of authorized benefits be made in my behalf. I assign payment for any unpaid charges for the clinic is authorized to bill in connection with its services. I understand that I am responsible for any remaining balance not covered by other insurance.

GENERAL POLICIES

1. All co-pays and deductible amounts must be paid at the time of service unless other signed arrangements have been made.
2. All returned checks are subject to a $25.00 (or 5% of check, whichever is higher) service charge.
3. All delinquent accounts are automatically turned over to collection after 90 days if no response of payment is received.
4. All patients will be seen on a first come first serve basis or by scheduled appointments, although Tensas Community Health Center, has the right to take patients with medical emergencies first.
5. This is a "SMOKE FREE" campus. All smoking is prohibited.
6. No alcohol or drug use is allowed on the premises. Anyone abusing this policy will be asked to vacate the premises. If this request is not followed, Law Enforcement will be called.
7. No firearms/weapons are allowed on the premises. Law Enforcement will be called and said persons will be banned from any Tensas Community Health Center, property.

I understand and agree to abide by the general office policies.

Patient's Signature *(Parent/Guardian's Signature):* _____ Date: _____

Witness Signature _____

TENSAS & VIDALIA
COMMUNITY HEALTH CENTERS

PATIENT CONSENT

GENERAL CONSENT TO TREATMENT:

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hearby consent to medical care and treatment as my providers, in their professional judgement, deem necessary for my health and well-being. This consent includes my consent for all medical services rendered under the general or specific instructions or a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant) and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law) and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

CONSENT TO CALL, EMAIL AND TEXT:

I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand I may opt out of receiving all such communications from my provider by notifying my provider's staff.

TELEMEDICINE:

I hereby authorize the use of telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. I understand the rationale for using telemedicine in place of in-person services, as well as the risks and benefits of the utilization of telemedicine, including privacy related risks, and acknowledge that all electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws. I acknowledge that I have had the opportunity to ask my questions regarding the use of telemedicine and the risks and benefits of alternative methods, including the risks and benefits of no treatment.

TO THE PATIENT:

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Print Name:_____Signature:_____Date:_____

TENSAS & VIDALIA
COMMUNITY HEALTH CENTERS

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

TO OUR VALUED PATIENTS:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) 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 uses of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and or patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

TENSAS & VIDALIA
COMMUNITY HEALTH CENTERS

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 CAREFULLY, SIGN THIS FORM, AND RETURN TO THE RECEPTIONIST.

OUR COMMITMENT

Tensas Community Health Center, Inc. ("Clinic") remains committed to protecting the privacy of our patients' protected health information ("PHI") and is dedicated to complying with laws governing the privacy of PHI. This Notice explains our privacy practices, legal duties, and your rights concerning your PHI. PHI includes information about your health care and treatment combined with information like your name, age, birth date, address, or financial information. This Notice is effective as of August, 24, 2020 and will remain in effect until revised.

We protect your PHI by:

- Treating all PHI as confidential.
- Maintaining policies and practices that govern our staff in handling your PHI, as well as provide sanctions for violations.
- Restricting access to your PHI to only those that need it in providing services to you.
- Disclosing only the PHI that is minimally necessary for an outside service to perform a function on behalf of the Clinic and requiring that they agree to confidentiality of PHI disclosed.
- Maintaining administrative, physical, and technical safeguards to protect your PHI.

TYPES OF USES AND DISCLOSURES OF YOUR PHI

We will use and disclose health information about you for treatment, payment and health care operations. For example:

- **Treatment:** We may use and disclose your PHI to other healthcare providers currently treating you to assist in such treatment.

- **Payment:** We may use and disclose your PHI to obtain payment for services we provide to you.

- **Healthcare Operations:** We may use and disclose your PHI for our healthcare operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training and educational programs, accreditation, certification, licensing, or credentialing activities.

OTHER PURPOSES FOR WHICH CLINIC IS AUTHORIZED TO USE OR DISCLOSE YOUR PHI

- **Your Authorization:** In addition to our use of your PHI for treatment, payment, or healthcare operations, you may give us written authorization to use or disclose your PHI for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

- **Persons Involved in Care:** We may use or disclose PHI to notify, or assist in the notification of a family member, your personal representative, or another person responsible for your care, of your location, general condition, or death. If you are present and capacitated, then we will provide you with an opportunity to object to such uses or disclosures. In the event of your in capacity or emergency circumstances, we will use our professional judgment to determine if disclosure is in your best interest and only disclose PHI that is directly relevant to the person's involvement in your care.

- **Required by Law:** We may use or disclose your health information when we are required to do so by law, including, but not limited to, court orders, warrants, subpoenas, discovery requests, or other lawful process.

- **Public Health Activities:** We may use or disclose your PHI to a public health authority for public health activities such as preventing the spread of a communicable disease.

- **Abuse or Neglect:** We may disclose your PHI to a government authority if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes.

- **To Avert a Serious Threat to Health or Safety:** We may disclose your PHI to the extent necessary to avert a serious threat to health or safety.

- **Workers' Compensation:** We may disclose your PHI to a workers' compensation insurer when related to treatment of an injured worker.

- Clinic will not use or disclose your psychotherapy notes or any PHI for marketing or sale. However, PHI may be used or disclosed in connection with the future sale of all or part of Clinic. In the event that PHI is used for fundraising purposes, you have the right to opt out of such communications.

PATIENT RIGHTS

You have the right to request all of the following:

- **Restriction Requests:** You have the right to request a restriction on the uses and disclosures of your PHI. Although we are not always required to grant a restriction, those granted will be upheld. Further, you have the right to request restriction, and such request will be granted, re garding certain disclosures of PHI to a health plan where the individual or someone on his or her behalf pays out of pocket for the health care item or service provided.

- **Confidential Communication:** You have the right to request that communication containing PHI be conducted in an alternate way or at an alternate location.

- **Your Right to Inspect PHI:** You have the right to request and inspect your PHI, subject to

reasonable copying expenses. Inspection will not be allowed if we determine that the information could be harmful to you or another person or if it involves psychotherapy notes, records compiled in reasonable anticipation of litigation, or PHI whose release is prohibited by federal or state laws.

- **Amendment:** You have the right to request an amendment to your PHI in writing.
- **Accounting of Disclosures:** You have the right to request an accounting of disclosures of your PHI, outside of those disclosures permitted without authorization, for the past six (6) years. The accounting will include: the date, name of person or entity, description of the PHI disclosed, the purpose of the disclosure, and other related information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
- **Electronic Notice:** If you received this notice by electronic means, you are entitled to request a paper copy.

DUTIES OF THE CLINIC

Clinic is required by law to maintain the privacy of PHI, to provide this Notice, and to notify affected individuals following a breach of unsecured PHI. Moreover, Clinic is required to abide by the terms contained in this Notice. Clinic reserves the right to change this Notice and make the new Notice effective for all PHI we maintain. In the event of a change, the revised Notice will be posted in the waiting room and website of the Clinic.

COMPLAINTS

You have the right to complain to the Clinic, and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. Complaints may be filed with the Privacy Officer at 402 Levee Street Saint Joseph, LA 71366. Clinic will not engage in any retaliatory acts in response to the filing of a complaint.

TENSAS & VIDALIA
COMMUNITY HEALTH CENTERS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please return this form to Dawn Johnson, Privacy Officer at 402 Levee Street Saint Joseph, LA 71366 acknowledging your receipt and review of Tensas Community Health Center, Inc.'s Notice of Privacy Practices.

Name: _____

Signature: _____

Relationship if not Patient:_____ Date:_____

TENSAS & VIDALIA COMMUNITY HEALTH CENTERS

402 Levee Street St Joseph, LA 71366 Phone: 318.766.1967 Fax: 318.766.9090
900 Carter St, Suite A Vidalia, LA 71373 Phone: 318.414.3020 Fax: 318.414.3021

TENSAS & VIDALIA COMMUNITY HEALTH CENTERS

MEDICAL RELEASE FORM

As required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996, TVCHC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use and disclosure of protected health information described herein.

I, _____understand that the information contained in my

record is confidential. However, I give consent of _____

At _____to release all of my records or information

concerning such records to **Tensas + Vidalia Community Health Centers.**

I understand that the document authorized to be released by me include, but are not limited to, family histories, reports of clinic findings and diagnosis, laboratory test, X-rays, reports of examination and/or evaluation, and any hospital admission or discharge records.

I understand that I may revoke this consent at any time except to the extent that action has been taken thereon. I further understand that this consent will expire upon_____(not to exceed six months) and cannot be renewed without my written consent.

Signature_____

Signature of Witness_____

PATIENT IDENTIFYING DATA

Name: First_____MI_____Last_____

Address:_____City_____State_____ZIP_____

SS#:_____Birthdate:_____

TENSAS & VIDALIA COMMUNITY HEALTH CENTERS

402 Levee Street *St Joseph, LA 71366* *Phone: 318.766.1967* *Fax: 318.766.9090*

900 Carter St, Suite A *Vidalia, LA 71373* *Phone: 318.414.3020* *Fax: 318.414.3021*

TENSAS & VIDALIA COMMUNITY HEALTH CENTERS

MEDICAL RELEASE FORM

PATIENT NAME:

Address: Phone #:

SS#: D.O.B.

Name of Person/Organization to RECEIVE medical information:

Address: Fax:

Information to be released: *(Please check all applicable records to release)*

___All Records ___Immunization Records ___Other:

Name of Person/Organization to RECEIVE medical information:

Address: Fax:

Information to be released: *(Please check all applicable records to release)*

___All Records ___Immunization Records ___Other:

Name of Person/Organization to RECEIVE medical information:

Address: Fax:

Information to be released: *(Please check all applicable records to release)*

___All Records ___Immunization Records ___Other:

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is recevied in this office and will not apply retroactively.

Patient/Guardian Print Name: Relationship:

Signature: Date:

TENSAS & VIDALIA COMMUNITY HEALTH CENTERS

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