TENSAS & VIDALIA COMMUNITY HEALTH CENTERS

NEW PATIENT PAPERWORK

PATIENT INFORMATION			**Today's date:**
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: *First*	*MI*	*Last*	
Mailing Address:	*City*	*State*	*ZIP*
Physical Address:	*City*	*State*	*ZIP*
SS#:	Birthdate:		
Home #:	Work #:	Cell#:	
Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell Occupation:			
Email Address:	Driver's License #:		
Primary Care Physician *(Shown on Insurance Card):*			

Birth Sex ☐Male ☐Female

Sexual Orientation

☐ Straight *(not lesbian or gay)* ☐ Lesbian or Gay

☐ Bisexual ☐ Other ☐ Don't know

☐ Prefer not to disclose

Gender Identity

☐ Male ☐ Female

☐ Transgender Male *(female to male)*

☐ Transgender Female *(male to female)*

☐ Genderqueer *(neither exclusively male or female)*

☐ Other ☐ Don't know ☐ Prefer not to disclose

Marital Status ☐ Single ☐ Married ☐Divorced ☐Widowed ☐Separated

Race*(check one)* ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Caucasian ☐ Black/African American ☐ American Indian/Alaska Native ☐ More than one race ☐ Prefer not to disclose

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Are you a Veteran ☐No ☐Yes

Housing Status ☐ Rent/Own ☐ Transitional ☐ Homeless ☐ Street ☐ Doubling Up ☐ N/A

Agricultural Status ☐ Migrant Worker ☐ Seasonal Worker ☐ Dependent of Migrant ☐ Dependent of Seasonal ☐N/A

Annual Household Income ☐Less than $10,000 ☐$10,001-$20,000 ☐$20,001-$40,000 ☐$40,001-$60,000 ☐$60,001-$100,000 ☐$100,000+ ☐Prefer not to disclose

Number of people living in your household: _____

RESPONSIBLE PARTY

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: *First* *MI* *Last*

Home #: Work #: Cell#:

Billing Address:

SS#: Birthdate: ☐ Male ☐ Female Relation:

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)* #:

☐ Healthy Blue ☐ 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

GENERAL INFORMATION

Pharmacy Name: Phone:

Do you have reliable transportation? ☐ No ☐ Yes Do you have prescription drug coverage? ☐ No ☐ Yes

Do you currently qualify for any government programs? (*such as Medicaid, WIC, welfare, food stamps, Social Security disability or unemployment)* ☐ No ☐ Yes , Please list:

If you do not currently have Medicaid, have you ever applied for Medicaid? ☐ No ☐ Yes

What was the outcome?

TENSAS & VIDALIA COMMUNITY HEALTH CENTERS

PATIENT REVIEW

REASON FOR TODAYS VISIT:

Last menstrual period: **ARE YOU PREGNANT?** ☐ No ☐ Yes

Do You: ☐ Smoke Cigarettes ☐Use Tobacco Products ☐ Vape ☐Drink Alcohol ☐Use Recreational Drugs

Previous Surgeries or Hospitalizations? Please list with dates:

Current Medications:

Allergies

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

☐ No ☐ Yes Asthma
☐ No ☐ Yes Musculoskeletal problems
☐ No ☐ Yes Alcohol/Drug abuse
☐ No ☐ Yes Alzheimer's/Dementia
☐ No ☐ Yes Aneurysm
☐ No ☐ Yes Cancer
☐ No ☐ Yes Lung problems
☐ No ☐ Yes Liver Cirrhosis
☐ No ☐ Yes Colon Cancer
☐ No ☐ Yes GI/stomach problems
☐ No ☐ Yes Cardiac problems
☐ No ☐ Yes Diabetes
☐ No ☐ Yes Gout
☐ No ☐ Yes Migraine Headaches
☐ No ☐ Yes Hepatitis
☐ No ☐ Yes High Cholesterol
☐ No ☐ Yes High Blood Pressure
☐ No ☐ Yes Parkinson's
☐ No ☐ Yes Seizures
☐ No ☐ Yes Stroke
☐ No ☐ Yes Autoimmune Disease
☐ No ☐ Yes Thyroid problems
☐ No ☐ Yes TB
☐ No ☐ Yes Depression/Anxiety
☐ No ☐ Yes Bipolar

OTHER: _____

PREVENTATIVE *(List Date of Last:)*

Dental Exam: _____

PAP: _____

Ob-Gyn Doctor: _____

Mammogram: _____

Colonoscopy: _____

Gastroenterologist: _____

Eye Exam: _____

Flu Vaccine: _____

Pneumonia Vaccine: _____

A1C: _____

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, hereby consent to medical care and treatment as my providers, in their professional judgment, 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.

HEALTH INFORMATION EXCHANGE:

We participate in a Health Information Exchange (HIE). When you seek treatment at an organization participating in a HIE, your health information from other facilities where you have received medical treatment is accessible to our providers. You have the right to opt out of this exchange. If you choose to opt out, your health information will not be accessible even in an emergency situation.

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:

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

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