Centerpoint
FAMILY PRACTICE
Convenient, Family-Centered Medical Care

New Patient Information

Patient Name: _____ **Marital Status:** S M D W

Last First MI

Date of birth: _____ **Social Security number:** _____

Address: _____**Apt#**_____

City: _____ **State:** _____ **Zip:** _____

Phone: Home (_____)_____

Cellphone (_____)_____ May we text you reminders of upcoming appointments? **Y / N**

Work (_____)_____

Email Address: _____

Employer: _____ **Occupation:** _____

Race: O White **Gender:** O Male **Ethnicity:** O Hispanic or Latino

O Black O Asian O Female O Not Hispanic or Latino

O American Indian or Alaska Native

O Native Hawaiian or other Pacific Islander

O Other or mixed

Preferred language: O English

O other_____

Spouses Name or Parent Name, if child: _____

Is this the person responsible for the bills? O Yes O No, bill patient

Address, if different than patient_____

Date of birth: _____ Employer: _____

Work Phone (_____)_____ Cell (_____)_____ SS# _____

Emergency Contact: _____

Work Phone (_____)_____ Cell (_____)_____

Would you like to be reminded of upcoming office visits? O Yes O No

If so, **which method do you prefer?** O Home Phone O Cell Phone O Work Phone

(Check all that apply): O Mail O Email

May we leave a message (voice-mail) for you regarding test results, reminders, etc.? O Yes O No

If so, which method do you prefer? O Home Phone O Cell Phone O Work Phone

(Check all that apply): O Mail O Email

Do you have an Advance Directive (Living Will)? O Yes O No

(If yes, please provide our office with a copy for your records at your earliest convenience.)

Diana L. Corley, FNP, LLC, 1015 Hwy 107,
Centerpoint, LA 71323

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GENERAL CONSENT FOR MEDICAL TREATMENT:

As a patient of Centerpoint Family Practice, the Clinic, I understand that the clinic has an obligation to provide screening and emergency medical treatment when appropriate and to provide appropriate care and treatment of all patients. I hereby authorize the clinic, and its affiliated physicians and other licensed providers to order and/or provide direct and indirect services in efforts to diagnose and treat diseases, disorders, injuries, or other conditions. I understand that the providers will act in good faith to provide quality care and treatment. However, a specific cure or resolution cannot be promised. My patient rights include my participation in my care plans and treatment options. I may revoke this consent for general treatment. Additional informed consent shall be given for medical procedures or treatments for which I need to specifically consent.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT:

By signing this form, I acknowledge receipt of the notice of privacy practices of the clinic. Our notice of privacy provides information about how we may use and disclose your protected health information. We are required by federal law to obtain your acknowledgement that you have received this Notice. If you have any questions about our notice of privacy practices, please contact us at the above telephone number.

REASSIGNMENT OF BENEFITS AND PAYMENT GUARANTEE:

I authorize the clinic to bill my insurance company or other designated third-party payer for the services provided as related to my care. I acknowledge that the clinic will file claims on my behalf as a courtesy and that I, as guarantor of the account, remain responsible for payment of services. I acknowledge that I am also responsible for deductibles, co-insurance amounts, co-payment amounts, and non-covered services. I/we agree to pay the established rates of the clinic for all services rendered for the patient named below. I also acknowledge that I am aware that the clinic may have policies for financial counseling and assistance.

_____ _____ _____

Name Printed Signature Date

MISC CONSENTS: (PLEASE CIRCLE Y or N)

PHOTOGRAPHIC CONSENT:

In certain instances, the physician or her assistants may take photographs for use in your personal medical record only (ie, for the purposes of establishing a baseline prior to therapy, to document response to therapy, or to document a biopsy site). Do you consent to this? **Y N**

PERMISSION TO CONTACT YOU:

May we send postcards to your address above with promotional information? **Y N**
May we leave a message on your home answering machine? **Y N**
May we leave a message for you at work to call us? **Y N**

PERMISSION TO DISCUSS YOUR CONDITION WITH A FRIEND OR FAMILY MEMBER:

May we discuss your medical condition with another person? **Y N**

If yes, whom_____ Relationship:_____ Phone:

Patient Name:_____ Date of Birth_____

Signature: _____ Date: _____

1015 Hwy 107, Centerpoint, LA 71323
318-409-4125

Centerpoint
FAMILY PRACTICE
Convenient, Family-Centered Medical Care

INSURANCE AND FINANCIAL AUTHORIZATION

We appreciate your confidence in choosing us for your medical care. Please take a moment to review your responsibilities and financial obligations.

Please note that you will be responsible for the amount not covered by your primary insurance unless a secondary policy is in place at time of service and there will be a $25 fee for appointment "no shows".

CO-PAYMENTS
If you are an enrollee of a managed care plan (HMO or PPO) that we are contracted with, you are required to pay the co-payment each time you are seen for medical reasons.

PROCEDURE DEDUCTIBLES
Please be advised that biopsies, intralesional injections of steroids, removal of benign or malignant lesions, incision and drainage, acne surgery, and the destruction of warts, molluscum, precancers, inflamed seborrheic keratoses, and other lesions by methods such as freezing, scraping, burning, or the application of chemicals, are considered procedures and are applied toward any procedure deductible even when performed in the setting of an office visit.

ANNUAL DEDUCTIBLES
In addition to the co-payment, some insurance plans also have an annual deductible. If your deductible has not been met, you are required to pay this deductible amount at the time of service. If there is a balance due from you after your insurance carrier has paid its portion, we will bill you for the patient portion due. If you have any questions regarding a billing statement you received from our office, please do not hesitate to contact our billing staff.

BIOPSY AND LABORATORY STUDIES
Skin biopsies, cultures, and blood work are sent to outside facilities. You and /or your insurance company will receive a separate bill for these services.

YOUR RESPONSIBILITIES
It is your responsibility to understand your insurance carrier's requirements for coverage. Some insurance plans do not cover services performed by physicians outside their network and others reimburse those services at a lesser rate, often with a deductible preceding coverage for benefits. For maximal coverage, it is your responsibility to insure the physician you choose is a provider for your insurance plan.

AUTHORIZATIONS
I request that payment for medical benefits be made to the physician for services rendered. I authorize and consent to the release of my medical and other information to my insurance carrier to process my insurance claim.

I understand and agree that I will be responsible for any fees incurred by Centerpoint Family Practice to collect fees for services rendered, including collection agency fees, attorney's fees, bank fees and court costs. Please sign below acknowledging that you have reviewed the above information and understand your financial obligations.

_____ _____ _____
Name Printed Signature Date

1015 Hwy 107, Centerpoint, LA 71323
318-409-4125

Centerpoint FAMILY PRACTICE

Convenient, Family-Centered Medical Care

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.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. *For example* – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment

We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations

We will use and disclose your protected health information to support the business activities of our practice. *For example* – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders

We may contact you by phone, or in writing, to provide appointment reminders about scheduled appointments or treatment.

Treatment Alternatives or other Health-Related Benefits or Services

We may use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

Others Involved in Your Care

We may use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research

We my use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may also create de-identified health information by removing all reference to individually identifiable information.

As Required by Law.

We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety

We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation

We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates

We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Disclosures the Require and Authorization

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses of psychotherapy notes.
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and healthcare operations
- Disclosures that constitute a sale of PHI under HIPAA
- Other uses and disclosures not described in this notice

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You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorizations.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice

You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy

You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our Practice Manager at **Red River Dermatology**, **3335 Prescott Road Alexandria, LA 71301**. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment

You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information was not created by us, or the person who created it is no longer available to make the amendment;
- The information is not part of the record which you are permitted to inspect and copy;
- The information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions.

You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

Additionally, if you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures

You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications

You have the right to request how we communicate with you to preserve your privacy. *For example* – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint

If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Department of Health and Human Services, Office of Civil Rights.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it attention to Privacy Officer, **Centerpoint Family Practice, 1015 Hwy 107, Centerpoint, LA 71323.** You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our Practice Manager at (318)623-9578.

Effective Date: March 1, 2020

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COMPREHENSIVE PATIENT MEDICAL HISTORY FORM

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or date. Thank you!

PERSONAL INFORMATION:

Preferred Name:_____ DOB:_____ Date: _____

Current Health Concerns: _____

_____

_____

_____

MEDICATIONS: (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

Drug Allergies or Reactions to Medications / Foods / Other Agents: ☐ Yes ☐ No Please list:

_____

_____

PERSONAL MEDICAL HISTORY: Do you have any of the following?

☐ Acid Reflux (heartburn)
☐ Alcoholism
☐ Allergies (environmental)
☐ Anxiety
☐ Asthma
☐ Atrial Fibrillation
☐ Cancer (list below)
☐ Cholesterol Problem
☐ Coagulation (bleeding) Problem
☐ Chronic Low Back Pain
☐ Depression
☐ Diabetes
☐ Erectile Dysfunction
☐ Gout
☐ High Blood Pressure
☐ Heart Disease (explain below)
☐ Migraines
☐ Osteopenia / Osteoporosis
☐ Prostate Problems
☐ Thyroid Problems
☐ Other Chronic or Recurring Medical Problems (Please list below)

_____

_____

_____

_____

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Patient Name:_____ Date: _____

PRIOR SURGERIES AND HOSPITALIZATIONS: ☐ Yes ☐ No (Please list all prior operations and hospitalizations)

DATE	SURGERY OR HOSPITALIZATION	DATE	SURGERY OR HOSPITALIZATION

Have you received a blood transfusion? ☐ Yes ☐ No When? _____

FAMILY HISTORY: Please indicate with a check any family members who have had any of the following conditions:

Check here if you don't know your family history ☐

MEDICAL CONDITION	MOM	DAD	BRO	SIS	DAUG	SON	OTHER CLOSE RELATIVES	MEDICAL CONDITION	MOM	DAD	BRO	SIS	DAUG	SON	OTHER CLOSE RELATIVES
Alcoholism								Genetic Diseases							
Anemia								Glaucoma							
Anesthesia Problem								Allergies							
Arthritis								High Cholesterol							
Asthma								Heart Disease (Heart attack, stent or bypass surgery)							
Birth Defects								High Blood Pressure							
Cancer, Breast								Kidney Disease							
Cancer, Colon								Migraine Headaches							
Cancer, Melanoma								Osteoporosis							
Cancer, Other Skin								Rheumatoid Arthritis							
Cancer, Ovary								Seizures							
Cancer, Prostate								Strokes							
Cancer (other list below)								Thyroid Disorders							
Colon Polyps								Tuberculosis							
Depression								Other:							
Diabetes, Type 1															
Diabetes, Type 2															

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Patient Name:_____ Date: _____

SOCIAL HISTORY:

Tobacco Use

Please check one

☐ I have never smoked

☐ I have smoked, but rarely

When was the last time?_____

☐ I have quit smoking. Quit Date:_____

How many packs/day?_____ How many yrs?_____

☐ I currently smoke_____pack(s)/day.

How many yrs._____

Other Tobacco: ☐ pipe ☐ cigar ☐ snuff ☐ chew

Are you interested in quitting? ☐ Y ☐ N

Alcohol Use

Do you drink alcohol? ☐ Y ☐ N

☐ never ☐ occasionally ☐ regularly

Average # drinks/week? 5 oz. wine_____

12 oz. beer_____ 1.5 oz. hard liquor_____

Is alcohol use a concern for you or others? ☐ Y ☐ N

Drug Use

Do you use recreational drugs? ☐ Y ☐ N

Have you ever used needles? ☐ Y ☐ N

Sexual History

Are you sexually active? ☐ Y ☐ N ☐ Not currently

Current sexual partner(s) is/are ☐ male ☐ female

Birth control method:_____

Have you ever had any sexually transmitted diseases (STD's)? ☐ Y ☐ N Date:_____ Which STD?_____

Are you interested in being screened for sexually transmitted diseases? ☐ Y ☐ N

Exercise

Do you exercise? ☐ Y ☐ N How often? ☐ Daily ☐ 4 – 6x a week ☐ 1 – 3x a week ☐ less than one time a week

What form of exercise? (e.g., jogging, cycling, swimming) _____

Safety

Do you use seat belts consistently? ☐ Y ☐ N

Is violence at home a concern for you? ☐ Y ☐ N

Are you currently in a relationship? ☐ Y ☐ N

If yes, do you feel safe in this relationship? ☐ Y ☐ N

Other concerns?_____

Socioeconomics

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widow

Occupation: _____

Education completed: ☐ grade school ☐ high school ☐ college ☐ graduate school

Number of children:_____ Who lives at home with you? _____

Frequent foreign travel? ☐ Y ☐ N Where?_____

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Patient Name:_____ Date: _____

Immunizations: Please check any immunizations you were given and your best estimate of the month and year it was given.

Tetanus: ☐ Y ☐ N_____ Pneumonia: ☐ Y ☐ N_____ Chicken Pox: ☐ Y ☐ N_____ Hepatitis A: ☐ Y ☐ N_____

Hepatitis B: ☐ Y ☐ N_____ HPV (genital warts): ☐ Y ☐ N_____ Shingles: ☐ Y ☐ N_____

REVIEW OF SYSTEMS (please circle any *CURRENT* problems you have on the list below)

General
- Fatigue / Weakness
- Restless Sleep
- Daytime Drowsiness
- Unhappiness
- Depression / Sadness
- Feeling "Blue" or Hopeless for More than 2 wks
- Lack of Motivation
- Excessive Irritability
- Feelings of Worthlessness
- Nervous / Anxiety
- Unexplained Fever (> 100.0)
- Frequent Night Sweats
- Unexplained Weight Loss
- Unexplained Weight Gain
- Excessive Thirst

Skin
- Changes in Moles / Unusual Moles
- Concerns re: skin spots / rashes / growths
- Bruise Easily
- Itching
- Excessive Hair Growth
- Hair Loss

Ears / Nose / Throat
- Allergy Symptoms
- Hearing Loss
- Ringing in the Ears
- Dizzy Spells / Dizziness
- Nose Bleeds
- Sinus Problems
- Hoarseness – Frequent

Eyes
- Eye Pain
- Double Vision / Change in Vision
- Itchy / Watery Eyes

Lungs
- Cough / Wheeze
- Snoring / Gasping at Night During Sleep
- Difficulty Breathing
- Positive TB Skin Test

Heart
- Chest Pain / Pressure
- Recent Change in Exercise Tolerance
- Heart Murmur
- Palpitations / Irregular Pulse
- Fainting Spells
- Swollen Ankles
- Leg Pain with Walking / Exercise

Gastrointestinal
- Abdominal Pain
- Heartburn / Indigestion
- Change in Bowel Habits – Recent
- Difficulty Swallowing
- Persistent Nausea / Vomiting
- Diarrhea / Constipation
- Bloody or Black Tarry Stools
- Frequent Laxative Use? How Often?

Musculoskeletal
- Muscle / Joint Pain
- Recurrent or Chronic Back Pain
- Joint Swelling
- Gout

Genitourinary
- Frequent Urine Infections
- Painful Urination
- Frequent Urination
- Urinary Leakage / Incontinence
- Blood in Urine
- Overnight Urination > 2 x
- Sexual Function Problems

Male
- Decrease in Force of Urination
- Erection Problems
- Testicle Lumps / Swelling

Female
- Vaginal Discharge / Itching
- History of Abnormal Pap Smear
- Pain / Bleeding During Sex
- Significant Pain / Cramps with Menses
- Hot Flashes / Night Sweats

Menstrual History
- Age of onset_____ reg. / irreg. / menopause
- Flow: heavy / moderate / light
- Length of cycle_____ Days of flow_____
- # of pregnancies_____ # of births _____
- # of miscarriages / abortions _____

Breast
- Pain / Lumps / Discharge

Neurological
- Frequent Headaches
- Numbness / Tingling
- Memory Loss
- Tremor / Shaking

Explanation:_____