Patient Information & Consents
North Caddo Medical Center's Rural Health Clinics

SSN: _____

Patient's Name: Last:_____ **First:** _____**MI:**_____

Mailing Address: _____ **City:**_____ _____**ST:**_____ **Zip:**_____

Home Telephone: _____ _____**Cell Phone #:** _____

Date of Birth: _____ **Race:** _____ ☐ **Male** ☐ **Female**

Ethnicity: ☐ **Hispanic/Latino** ☐ **Non Hispanic/Non Latino** **Preferred Language:** ☐ **English** ☐ **Spanish** ☐ **Other**

EMAIL ADDRESS: _____

Marital Status: (Circle One) **SINGLE** **MARRIED** **WIDOWED** **DIVORCED**

☐ **I HAVE AN ADVANCED DIRECTIVE** ☐ **I DO NOT HAVE AN ADVANDED DIRECTIVE**

Responsible Party: Name Last:_____ **First:**_____ **MI:** _____

Mailing Address:_____ _____**City:**_____ **ST:**_____ **Zip:** _____

Home Telephone #:_____ _____**Relationship to Patient:** _____

Responsible Party's SSN:_____ **Date of Birth:**_____

Employer's Name: _____ **Employer's Telephone #**_____

Responsible Party's Spouses Name (if applicable):_____

In Case of Emergency: (Who May We Notify)

Name: _____ _____**Relationship to Patient:** _____

Home Telephone #: _____ **Cell Phone #:** _____

Insurance Coverage: **Is your illness/injury due to an Auto/Work Accident?** ☐ **YES** ☐ **NO**

Primary Insurance: _____

Policy #: _____ _____ **Group #:** _____

Policy Holder's Date of Birth: _____ _____ **Policy Holder's SSN:** _____

Employer:_____ _____ **Guarantor:** _____

Secondary Insurance: _____

Policy #:_____ **Group #:** _____

Policy Holder's Date of Birth: _____ **Policy Holder's SSN:** _____

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IDENTIFICATION DATA (Please print the following information)

Date: _____ Age: _____

Name_____ M____ F____ Date of Birth: ____/____/____

Address _____ Marital Status: ___S ___M ___Sep ___D ___W

_____ Home Phone: _____

Business Phone: _____

FAMILY HISTORY-List immediate family members who have died (Mother, Father, siblings, etc.)

_____

_____

_____

Circle illnesses immediate family members have had:

Tuberculosis	Heart Disease	Hay Fever	Glaucoma
Diabetes	High Blood Pressure	Asthma	
Cancer	Allergies	Sickle Cell Anemia	

PATIENT HISTORY-Please check if your medical history includes:

Date of last dental exam: _____

EYE, EAR, NOSE, THROAT
1. Hay Fever _____
2. Ear Infection _____
3. Hearing Loss _____
4. Eye Problems _____

GASTROINTESTINAL
5. Stomach Pain _____
6. Ulcers _____
7. Change in bowel habits _____
8. Rectal Bleeding _____
9. Jaundice (Hepatitis) _____

CARDIO-RESPIRATORY
10. Trouble Breathing _____
11. Cough (if chronic) _____
12. Asthma _____
13. High Blood Pressure _____
14. Rheumatic Fever _____
15. Heart Disease _____
16. Activity Limitation _____
17. EKG-Last Date _____
18. Chest Xray-Date _____

GENITO-URINARY
19. Difficulty starting stream _____
20. Night time urination _____
21. Kidney Disease _____
22. Urinary Infection _____

NEURO-MUSCULAR
23. Weakness _____
24. Numbness/Tingling _____
25. Muscle Pain _____
26. Seizures/Epilepsy _____
27. Paralysis _____
28. Migraine/Headaches _____

SKELETAL
29. Joint Pain or Swelling _____
30. Back Problems _____
31. Arthritis _____

ENDOCRINE
32. Diabetes _____
33. Thyroid Problems _____
34. Recent Wt Gain/Loss (10#) _____

HEMATOLOGIC
35. Sickle Cell Disease _____
36. Anemia _____
37. Bleeding Tendencies _____
38. Thrombophlebitis/blood clots _____

OTHER (Additional space on back)
39. Cancer _____
40. Mental/Emotional Problems _____
41. V.D. History _____
42. Tetanus Immunization _____
Last Date:_____

REVIEWER NOTES

FOR WOMEN ONLY

43. Irregularity of Periods _____ 44. Abnormal Flow _____ 45. PID/Pelvic Pain _____ 46. Breast Disease _____
47. Last Menstrual Period, Date: _____ 48. Last Pelvic/Pap Smear Date: _____
49. Birth Control? If so, what type:_____ 50. No. of Pregnancies: _____ No. of Births: _____

PLEASE LIST ALL SURGERIES, HOSPITALIZATIONS, AND/OR SERIOUS INJURIES:

_____

_____

_____

PLEASE LIST ALL CURRENT MEDICATIONS TO INCLUDE HERBAL AND OVER THE COUNTER:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE NAME ANY DRUG ALLERGIES/ADVERSE REACTIONS:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT LIFE STYLE: Name your current occupation: _____

PREFERRED PHARMACY: _____

	NO	YES
Do you use alcohol more than four times per week?	_____	_____
Do you smoke?	_____	_____
Do you ever use drugs recreationally?	_____	_____
Do you feel safe in your environment?	_____	_____

INDICATE ANY ABNORMALITY	YES	NO	DESCRIPTION
A. Eyes	_____	_____	_____
B. Ears, Nose, Throat	_____	_____	_____
C. Skin	_____	_____	_____
D. Nervous System	_____	_____	_____
E. Chest	_____	_____	_____
F. Heart	_____	_____	_____
G. Abdomen	_____	_____	_____
H. Genito-Urinary System	_____	_____	_____
I. Pelvic	_____	_____	_____
J. Extremities	_____	_____	_____
K. Back	_____	_____	_____
L. Pain-Location	_____	_____	Pain Scale 0 1 2 3 4 5 6 7 8 9 10

PATIENT HISTORY INFORMATION

Name: _____ **Date:** _____

Date of last colonoscopy: _____

Date of last eye exam: _____ **Glasses:** _____ **Contacts:** _____

Date of last Bone Density Scan: _____

Date of last cholesterol lab work: _____

Date of last Pneumonia Vaccine: _____

Do you smoke or use tobacco products: Yes____ No____ If yes, how much a day? _____

Date of last pap smear or pelvic exam: _____ **Results:** _____

Hysterectomy: Yes___ No___ Menopause: Yes___ No___

Date of last mammogram: _____ **Results:** _____

Date of last prostate exam: _____ **Results:** _____

Date of last stress test: _____

Date of last Echocardiogram: _____

Do you have a cardiologist: Yes___ No___ Physician Name: _____

Do you have diabetes: Yes___ No___ Date of last diabetic screening: _____

Is there a history of cancer in your family? Yes___ No___

If yes, what types of cancer: _____

_____

Patient Portal
FollowMyHealth (FMH)

Full Name: _____

Date of Birth: _____ **Zip Code:** _____

Email: _____

Cell Phone: _____

Last four digits of patient's social security number: _____

___ Yes, please send me an invite to the patient portal.

___ NO. I decline the invitation to the patient portal.

I hereby authorize the office(s) of North Caddo Medical Center to create my FollowMyHealth (FMH) patient portal and agree to all its terms and conditions. A copy of these agreements will be in my patient portal account. By signing, I acknowledge that NCMC is releasing my medical records in electronic form and that if I share an email, this invitation will be open to the parties with whom I share that email. Once I establish my secure connection, there will be no concern, as I will protect my information with a password.

Patient Signature: _____

Date: _____

For office use only:

( ) Invite sent **( ) Decline Portal** **( ) Authorized individual for minor/proxy**

Date: _____ **Patient Account:** _____

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Clinic Registration

1. **CONSENT TO CARE:** I/We consent to North Caddo Medical Center's Rural Health Clinics services, treatment and diagnostic procedures deemed necessary or advisable by my physician and/or consultants selected by my physician. I understand that it is North Caddo Medical Center's (NCMC) policy that the patient has the right to consent to all services, procedures and/or surgeries. It is also the policy of NCMC that the patient has the opportunity to discuss services, procedures and/or surgeries with the patient's physician or provider. I, the patient, or the responsible party, acknowledges responsibility for any or all services and procedures deemed necessary or advisable by the physician or provider.
2. **AUTHORIZATION FOR RELEASE OF INFORMATION:** The employees and agents of North Caddo Medical Center's Rural Health Clinics and North Caddo Medical Center, copy services, and electronic claims processing services under contract with North Caddo Medical Center and North Caddo Medical Center's Rural Health Clinics any third party billing agents, and/or staff physicians and providers of North Caddo Medical Center involved with my care are given permission to release any and all information relating to my care. I am also authorizing permission to release any and all information to any agent or firm working for or with any insurance company and/or third parties paying or obligated to pay, in whole or part, the charges incurred by me and information pertaining to obtaining pre-certification, con-current review and /or retrospective review and/or other utilization reviews of any kind.
3. **PAYMENT GUARANTY AND ASSIGNMENT OF INSURANCE BENEFITS:** I, the undersigned patient, guardian and /or guarantor (hereinafter "Debtor") hereby promise to pay in full North Caddo Medical Center's Rural Health Clinics customary charges for the goods and services rendered to the patient during clinic visits (hereinafter "Indebtedness"). The Debtor acknowledges and agrees that the indebtedness accrued during the clinic visit is due and payable when the services are rendered; that NCMC will accept payments from third –party payers and insurers on behalf of the debtor and apply such payments to the indebtedness to the extent that they are received. The Debtor also acknowledges and accepts that the filing of such insurance and third-party payers is a service of NCMC and in no way relieves the obligation of the debtor to pay the Indebtedness agreed herein above. Debtor hereby absolutely assigns to North Caddo Medical Center's Rural Health Clinics all insurance benefits on all policies of insurance under which the Debtor is an insured and herein assigns North Caddo Medical Center's Rural Health Clinics the proceeds of any judgment or settlement of any claim against a third party in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred for services rendered by the Clinic.
4. **MEDICARE CONSENT:** I certify that the information given by me in applying for payment under XVIII of the Social Security Act (SSA) is correct. I authorize NCMC to provide (SSA) or its intermediaries with access to my medical records for the purpose of processing the Medicare claim. I further request that NCMC provide such copies thereof as may be requested. Copies may be made by NCMC or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for the clinic physicians involved in my care.
5. **RIGHT TO PRIVACY:** NCMC and our medical staff will use and disclose your personal health information to treat you, receive payment for care and for other health care operations. Healthcare operations generally include those activities we perform to improve quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice in our facilities, on our websites and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

   This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to me as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf. If the Patient/Guarantor is unable to sign; I, _____, do hereby state that I have been given the authority to sign for _____, either expressed or implied and that he/she is fully aware of this authority.

X_____ _____ X_____ _____

Signature of Patient/Guardian Date Signature of Guarantor Date

X_____ _____

Printed Name Printed Name

_____ _____

Witness Date

PAYMENT POLICY

I, the undersigned, patient or guarantor, have read and understand the following payment policy:

- Payment arrangements are understood and agreed upon by the patient, guarantor and provider prior to services being rendered.

- North Caddo Medical Center's Rural Health Clinics participates, and accepts, most insurance plans. Patients are required to furnish proof of insurance at time of service. As a courtesy to our patients, we will file insurance claim(s) for services rendered by any providers participating within North Caddo Medical Center's Rural Health Clinics.

- Monthly statements are generated and mailed to the patient/guarantor to make them aware on any outstanding balances. **Any outstanding balances are considered the guarantor's responsibility regardless of insurance coverage.**

- My account will be deemed **delinquent after 90 days** from the date of service or from the date services were denied or paid by the insurance carrier.

- The annual deductible and/or co-insurance amounts will be my/ guarantor obligation, unless prior verification can be obtained from my insurance carrier. If verification is obtained the remainder of my responsibility (such as 20% co-insurance) will be due and payable at the time of the visit.

- **Co-payments must be paid at the time of service and will be collected at check-in before the physician sees me/patient. Balance billing for a patient's co-pay is a violation of many managed care/P.P.O. contracts. It is North Caddo Medical Center's Rural Health Clinics policy not to patient bill co-pay amounts. I agree to reschedule my appointment if this requirement cannot be fulfilled at tine of check-in.**

- If a patient or responsible party expresses an inability to pay for services; alternate payment plans and assistance are available upon request. The clinic manager must approve monthly payment plans and the patient must agree in writing to the payment plan prior to seeing the provider, this is applicable to balances considered patient liability and do not apply to co-payments as discussed previously.

X _____ _____
Patient signature (over 18 years of age) Date

X_____ _____
Guarantor signature (if patient is a minor) Date

RELEASE OF INFORMATION

I, _____, give North Caddo Medical Center's Rural Health Clinics permission to release medical information such as lab results, clinical information, ECT. to the person(s) listed below. I will not hold North Caddo Medical Center's Rural Health Clinics liable for misrepresentations of information released to the indicated person(s). I also understand that this release is valid until other written documentation from me is submitted indicating otherwise.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name;_____Relationship:_____

☐ I do not give permission for North Caddo Medical Center's Rural Health Clinics to release any medical information.

Patient/Guarantor Signature:_____ Date:_____

Printed Name:_____ Date of Birth:_____

Witness:_____ Date:_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS COPY IS FOR YOUR RECORDS.

If you have any questions about this notice, please contact (318) 375-4006 or North Caddo Medical Center, 815 S. Pine St., Vivian, LA. 71082.

We are required by law to maintain the privacy of your Protected Health Information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarized our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

North Caddo Medical Center's Rural Health Clinics use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of North Caddo Memorial Hospital Service District.

WHO WILL FOLLOW THIS NOTICE?

Any health care professional authorized to enter information into your medical chart; all employees, business associates and agents, students, contractors, staff and other personnel of North Caddo Medical Center's Rural Health Clinics and our Medical Staff granted access to Protected Health Information (PHI).

HOW North Caddo Medical Center's Rural Health Clinics MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

1. **Treatment.** We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.
2. **Payment.** We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment.

3. Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel and others to:

- evaluate the performance of our staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and determine how to continually improve the quality and effectiveness of the health care we provide.

4. Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also provide information to someone who helps pay for your care.

5. As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

6. Law Enforcement. We may release medical information if asked to do so by a law enforcement official; in response to a court order, subpoena,

warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime if, under certain limited circumstances, we are able to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at the hospital; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description of location of the person who committed the crime.

7. Public Health. We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a
  disease or condition;
- to notify the appropriate government authority if we believe the patient has been a victim of abuse, neglect or
  domestic violence. We will only make this disclosure if you agree or when required by law.

8. Health and Safety. We may disclose your health information to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

9. Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

10. Workers Compensation. We may use or disclose your health information in order to comply with laws and regulations related to Workers Compensation case.

11. Other Uses of Medical Information. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for

(cont.) the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR HEALTH INFORMATION RIGHTS

You have the right to:

- Inspect and Copy to your medical information. Your rights to look and copy your records are subject to clinic medical records procedures and there may be a fee associated with the copying of your medical information.
- To amend your medical information; request must be made in writing and if we do not agree with the request will we tell you why in writing and provide information of your rights
- An accounting of disclosures of your medical information; you have the right to disclosures made six years prior to the date of your request. This applies to all disclosures that we are required to keep record.
- To request restrictions of your medical information; different from what we normally do; we do not have to agree with the request.
- Request Confidential communications; you have the right to request the way we send medical information to you, if the request is reasonable we must comply with your request.
- A copy of this notice at no charge
- To file a complaint- You may complain to North Caddo Medical Center and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

OUR OBLIGATIONS

North Caddo Medical Center's Rural Health Clinics are required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at
  alternative locations.

(cont.) We reserve the right to change this Notice of Privacy Practices. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the clinic. The notice will contain on the first page, in the top right-hand corner, the effective date. On your first visit to the clinic, you will be given a copy of this notice. Subsequently, you can request a copy at any time. If we change the notice, the revised notice will be posted in our clinic.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- To obtain payment from third-party payers;
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date:_____