



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_(____) _____

Work_(____) _____

Email Address: _____

Employer: _____ Occupation: _____

Spouses Name or Parent Name, if child: _____

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

Address, if different than patient _____

Date of birth: _____ Employer: _____

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

Race: ☐ White ☐ Other or mixed Gender: ☐ Male ☐ Female

☐ Black ☐ Asian

☐ American Indian or Alaska Native

Ethnicity: ☐ Hispanic or Latino

☐ Native Hawaiian or other Pacific Islander

☐ Not Hispanic or Latino

Preferred language: ☐ English ☐ other _____

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

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

(Check all that apply): ☐ Mail ☐ Email

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

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

(Check all that apply): ☐ Mail ☐ Email

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

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

Please list your medical insurance company(companies)

1. _____ Insured _____ Policy# _____ Grp# _____

2. _____ Insured _____ Policy# _____ Grp# _____

3. _____ Insured _____ Policy# _____ Grp# _____

1015 Hwy 107, Centerpoint, LA 71323



RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of Centerpoint Family Practice's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Signature Patient/Guardian

Date

**ASSIGNMENT OF BENEFITS
ALL INSURANCE EXCEPT MEDICARE**

I authorize my insurance company to pay benefits on my behalf directly to Centerpoint Family Practice. I authorize Centerpoint Family Practice to provide to my insurance company, any information necessary to process claims for services rendered to me.

Signature

Date

MEDICARE ONLY

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card

Date

MEDIGAP (MEDICARE ONLY)

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be paid on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP Card

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 or Guardian Name

Signature

Date

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



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.

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



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 may 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 We 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



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

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

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) | | |



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

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

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

[illegible]

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? _____

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: _____