Primary Care Plus
Handling your health with care

www.PrimaryCarePlus.com

Welcome to Primary Care Plus/Perkins

Thank you for putting your trust in Primary Care Plus for your healthcare needs. We would like to take this opportunity to welcome you to our practice and look forward to providing you with personalized, comprehensive health care.

Having the most current information is essential in meeting your healthcare needs. We would appreciate your assistance in updating your medical record by completing the forms listed below:

- Patient Information Form - provides your physician with thorough knowledge of your current health issues, an accurate medication list, and a family medical history. Also includes your current contact information (phone number, email, text) so we can reach you regarding your healthcare.

- Responsibility for Payment and Receipt of HIPAA Notice Form – allows us to bill your insurance company for services provided to you and acknowledges you have received the Notice of Privacy Practices.

- Consent for Treatment Form - gives our medical staff permission to provide basic evaluation and treatment of your medical conditions.

- Designation of Personal Representative Form - grants a family member or friend permission to discuss medical or billing information on your behalf. Written permission is needed for us to discuss any aspect of your care with anyone else.

- Authorization for Release of Protected Health Information-allows us to obtain your medical records from other healthcare providers.

An important part of each visit with your doctor is reviewing all medications you are currently taking from ALL providers - both primary care and specialists. Please bring all medications with you to every visit.

Primary Care Plus is recognized as a Patient Centered Medical Home which is a reflection of our commitment to providing the highest quality care for our patients. We provide proactive care to promote wellness and prevent illness and will be communicating with you by telephone, text message (with your permission) and our patient portal. Please be sure to provide current contact information on the *Patient Information Form*.

As a patient of Primary Care Plus, we are committed to helping you *be well and enjoy life to the fullest.* Please review the additional information about Primary Care Plus that is in this folder. Should you have any questions or comments, please do not hesitate to contact me directly at 225-706-3060

Sincerely,

Patricia Davidson
Clinic Manager

7049 Perkins Road, Baton Rouge, LA 70808-3060
TEL 225-706-3060 FAX 225-706-3061

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Referred by: Name:_____ TODAY'S DATE:_____

Patient Information Form (Please Print)

	Primary Care Physician:	**Have you been a patient of Primary Care Plus or Stanocola in the past?** ☐ Yes ☐ No

PATIENT

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other

Last	**First**	**MI**	**Date of Birth**	**Age**
Address	**City**		**State**	**Zip**
Sex: ☐Male ☐Female			**Are you a student?** ☐ Yes ☐ No	
Street Address (if different from mailing)	**City**		**State**	**Zip**
Phone (Home)	**Name of Employer**		**Employer's Phone #**	
Phone (Mobile)	**Employer's Address**			

Preferred Method of Contact? ☐Home Phone ☐Mobile Phone
May we send appointment and treatment reminders via text and voicemail? ☐Yes ☐No

Email:

Spouse's Name	**Date of Birth**

ADDITIONAL INFORMATION

Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific ☐Black ☐White ☐Hispanic ☐Other ☐Decline to Answer

Ethnicity: ☐Hispanic ☐Non-Hispanic | What Language do you prefer? ☐English ☐Spanish

Name of your Pharmacy		**Address**	
City	**State**	**Zip**	**Phone #**

RESPONSIBLE PARTY

☐ Self
☐ Spouse
☐ Guardian
☐ Other

Last	**First**	**MI**	**Phone Number:**
Address			
City		**State**	**Zip**

IN CASE OF EMERGENCY NOTIFY

Name	**Relation**
Address	**Phone #**

INSURANCE INFORMATION

Primary Insurance		**Address**	
Policy Contract #	**Group #**	**City**	**State** **Zip**
Name of Policy Holder		**Date of Birth**	
Secondary Insurance		**Address**	
Policy Contract #	**Group #**	**City**	**State** **Zip**
Name of Policy Holder		**Date of Birth**	

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Date:_____

PATIENT INFORMATION FORM

Patient's Name: _____ Guardian's Name (if under 18): _____

ALLERGIES TO MEDICATIONS or ENVIRONMENTAL

Medication or Other (Environmental)	Reaction

FAMILY HISTORY

(Please check if your family has a history of any of these diseases)

Condition	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brother	Brother	Sister	Sister	Additional Sibling(s)
Cancer	x								
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Stroke									
Other									

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

Relationship	Cause of death	Age at death	Relationship	Cause of death	Age at death

YOUR HEALTH HISTORY

(Check if you have had any of the following)

☐ Abnormal Heart Rhythm	☐ Chronic Pain	☐ Heartburn/GERD	☐ Obesity
☐ Allergies (any)	☐ Chronic Kidney Disease	☐ Heart Murmur	☐ Osteoporosis
☐ Anemia	☐ Depression	☐ Hepatitis	☐ Peripheral Vascular Disease
☐ Anxiety/Stress	☐ Diabetes	☐ High Blood Pressure	☐ Seizures/Epilepsy
☐ Asthma	☐ Emphysema/COPD	☐ High Cholesterol	☐ Sleep Apnea
☐ Arthritis	☐ Gallbladder Disease	☐ HIV/AIDS	☐ Stomach Ulcers
☐ Atrial Fibrillation	☐ Gout	☐ Irritable Bowel Syndrome	☐ Stroke
☐ Colitis or Crohn's Disease	☐ Headaches/Migraines	☐ Kidney Failure	☐ Thyroid Disease
☐ Cancer	☐ Heart Attack/Failure	☐ Kidney Stones	

PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

Test	Date	Results	Physician
Colonoscopy			
Cholesterol Screening			
Cardiac Stress Test			
Bone Density			
Mammogram			
Breast Exam			

Vaccine Type	Date
Tetanus (Td)	
Pneumonia	
Hepatitis B	
Influenza (Flu)	
Shingles	
Other	

OB/GYN HISTORY

Number of Pregnancies	
Number of full term babies	
Number of premature babies	
Number of abortions/miscarriages	
Number of living children	

ACCIDENTS - TRAUMA:

Have you ever had a severe accident? **YES NO** Do you have any metal pins/plates in your body? **YES NO** **If yes, please describe**

NAME:_____ Date:_____

PAST SURGICAL HISTORY			
Date	**Surgery**	**Date**	**Surgery**

Please List Any Additional Medical Information:

_____

HEALTH HABITS HISTORY

Do you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke? ___ How many packs per day? ___

Did you quit? YES NO (circle one) If yes, what year did you quit? _____

How many alcoholic beverages do you drink per week? _____ How many days per week do you exercise? _____

In the past 6 months, have you had a regular problem with pain? YES NO Where? _____

Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Do you use any of the following equipment?

Device	Yes/No	Device	Yes/No	Device	Yes/No
Cane		Walker		Bi-pap (sleep apnea)	
Electronic Scooter		Wheelchair		C-pap (sleep apnea)	

Do you follow a healthy diet? YES NO (circle one) Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

_____

LIST *ALL* PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS			
Name	**Dose**	**Frequency**	**Ordering Provider**

PHYSICIANS LIST (Please list any other physicians currently assisting in your care)					
Specialty	**Physician**	**Specialty**	**Physician**	**Specialty**	**Physician**
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? **YES NO (circle one)**

If yes, please supply the office with a copy for your chart. If no, would you like one? **YES NO (circle one)**

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Responsibility for Payment/Receipt of HIPAA Notice/Patient Communication

I understand that I am fully responsible for all fees due to Primary Care Plus or any associated medical provider (collectively referred to as the "Clinic") as a result of services I have received and that all fees are due and payable at the time of service unless Clinic agrees to accept assignment of my Medicare, Medicaid or other insurance benefits.

If I have insurance coverage other than Medicare:
I understand that assigning benefits to the Clinic and the filing of an insurance claim on my behalf is a courtesy to me and this is not absolving me of my responsibility to pay for services if the insurance company fails to pay for these services or if deductibles and/or co-pays are due. I understand that my insurance policy may not cover the full cost of services, or may consider it an uncovered service or medically unnecessary, or I may not have coverage benefits for these services. I therefore agree to be responsible for those charges incurred, as well as for my co-pay and/or any deductible that has not been met.

I further understand that any verification of my insurance benefits by the Clinic is not a guarantee of payment by my insurance company. If my insurance company does not pay for the services I have received, or fails to pay within 60 days of service, I understand that the Clinic will bill me for these services and I agree to pay any amounts due within 10 days of receipt of a bill for these services. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by my insurance company and the actual charge for that service.

If I am covered under Medicare or a Medicare Advantage health plan :
I understand that I will be responsible for my co-pay and/or any deductible that has not been met either through my Medicare coverage or any supplemental policy that I may also have. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by Medicare and the actual charge for that service.

I further understand that I will be notified in advance by an Advanced Beneficiary Notice of Noncoverage if Medicare likely will not pay for items or services. I will then have the right to make an informed choice whether or not to receive the items or services. If I choose to receive the items or services, I am aware that I will be responsible for paying for such items or services.

I request that payment of authorized Medicare, Medicaid or other insurance benefits be made on my behalf to the Clinic for any services furnished to me subject to any regulations pertaining to their assignment of benefits. I authorize any holder of my medical information to release to the Centers for Medicare & Medicaid Services, Social Security Administration and its agents, intermediaries or carriers, or to any other third-party sources or insurance companies and its agents any information or documentation needed to determine these benefits or the benefits payable for related services. A copy of this authorization may be used in place of an original and this authorization shall remain in force until revoked by me in writing.

I certify that the insurance information given by me is current and accurate to the best of my knowledge and I understand and agree to abide by the terms outlined above.

I further acknowledge that I have received a copy of the Clinic's Notice of Privacy Practices.
I agree to receive appointment and treatment reminders via text and voicemail: YES ☐ NO ☐

_____ _____
Patient Name (Please Print) Date Patient or Responsible Party Signature

_____ _____
Relationship to Patient Reason Patient Cannot Sign (if applicable)

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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.

At Primary Care Plus (PCP), we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information, to send you this notice, and to abide by the terms of this notice. We maintain physical, electronic and procedural safeguards that comply with state and federal regulations to guard non-public personal information from unauthorized access, use and disclosure. We are also required by law to notify affected individuals following a breach of unsecured protected health information.

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about "information" or "health information" in this notice we mean the following: Any information on a patient of PCP that reveals the state of a person's health; identifies individuals in such a way that it gives a reasonable basis for determining a person's identity; and is created or received by a healthcare organization.

How We May Use and Disclose Your Health Information

Under the law, we may use or disclose your health information in certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your health information to facilitate medical treatment or services by providers. We may disclose information about you to providers, including doctors, nurses, technicians, medical students, or other health care professionals who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your health information to determine your eligibility for insurance benefits or coverage or to facilitate payment for the treatment and services you receive from our health care providers. For example, we may give information about medical treatment you received from us to your health plan so it can pay us or reimburse you for the services provided. We may also tell your health plan about a treatment you are going to receive so we can get prior payment approval or learn if your plan will pay for the treatment.

For Health Care Operations. We may use or disclose your health information for our health care operations. These uses and disclosures are necessary to operate PCP. For example, we may use health information to help us maintain and improve patient care or determine whether or not to continue offering certain services to patients. We may also disclose information to doctors, nurses, technicians, medical students, and other persons at PCP for learning and quality improvement purposes. We may remove information that identifies you so people outside PCP can study your health information without knowing who you are.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as business associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, business associates will receive, create, maintain, transmit, use, and/or disclose your health information, but only after they agree in writing with us to implement appropriate safeguards regarding your health information. For example, we may disclose your health information to a business associate so the business associate can update or copy medical records on our behalf, but only after the business associate enters into a business associate agreement with us.

As Required by Law. We will disclose your health information when required to do so by federal, state, or local law. For example, we may disclose your health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your health information in a proceeding regarding the licensure of a physician.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness. However, your health information cannot be used for employment purposes without your specific authorization.

Public Health Risks. We may disclose your health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- 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 that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if we receive satisfactory assurance from the party seeking the information that he, she or it has made efforts to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your health 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 unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your health information to researchers when:

(1) the individual identifiers have been removed; or
(2) an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your health information we are required to make.

Government Audits. We are required to disclose your health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with appropriate authorization (e.g., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
(2) treating such person as your personal representative could endanger you; and
(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Authorizations. Other uses or disclosures of your health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychotherapy notes; we will not use or disclose your health information for marketing purposes; and we will not sell your health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

What Are Your Rights?

The following are your rights with respect to your health information. If you would like to exercise the following rights, please write the Privacy Officer at the PCP address listed at the end of this statement.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or healthcare operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your healthcare or payment for your healthcare. *However, we are not required under law to agree to these restrictions except when the protected health information pertains solely to a health care item or service for which the individual or person other than a health plan has paid in full.*

You have the right to ask to receive confidential communications of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate your reasonable requests as explained above.

You have the right to inspect and obtain a copy of information that we maintain about you in your designated record set. A "designated record set" is comprised of both (1) your medical records and billing records, and (2) your enrollment, payment, claims adjudication, and case or medical management record systems maintained by us; or for a health plan, which are used, in whole or in part, by or for the covered entity to make decisions about your healthcare.
However, **you do not have the right to access certain types of information** and we may decide not to provide you with copies of the following information:

- contained in psychotherapy notes;
- compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and
- subject to certain federal laws governing biological products and clinical laboratories.

In certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

You have the right to ask us to make changes to information we maintain about you in your designated record set. These changes are known as amendments. Your request must be in writing and you must provide a reason for your request. We will respond to your request no later than 60 days after we receive it. If we are unable to act within 60 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify you of the delay in writing and the date by which we will complete action on your request.
If we make the amendment, we will notify you in writing that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the amendment to other persons identified by you.
If we deny your request to amend, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to respond to your statement. However, you have the right to request that your written request, our written denial and your statement of disagreement be included with your information for any future disclosures.

You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. Please note that we are not required to provide you with an accounting of the following information:

- Any information collected or disclosed prior to April 14, 2003;
- Information disclosed or used for treatment, payment, and healthcare operations purposes;
- Information disclosed to you or pursuant to your authorization;
- Information that is incident to a use or disclosure otherwise permitted;
- Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
- Information disclosed for national security or intelligence purposes;
- Information disclosed to correctional institutions or law enforcement officials;
- Information that was disclosed or used as part of a limited data set for research, public health, or healthcare operations purposes.

Your request must be in writing. We will act on your request for an accounting within 60 days. We may need additional time to act on your request. If so, we may take up to an additional 30 days. Your first accounting will be free. We will continue to provide you with one free accounting upon request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Exercising Your Rights

You have a right to receive a copy of this notice upon request at any time.

Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. When we make significant changes in our privacy practices, we will change this notice and post it on our website; we will also make the updated notice available to patients at our office locations.
If you have any questions about this notice or about how we use or share your health information, please contact Primary Care Plus's Privacy Officer at (504) 681- 8259, write to Primary Care Plus, Attention: Privacy Officer, 3838 N. Causeway Blvd., Suite 2550, Metairie, LA 70002, or send an email to: info@primarycareplus.com. Our office is open to receive written complaints Monday through Friday from 8:00 a.m. to 5:00 p.m.

If you believe your privacy rights have been violated, you may file a complaint with us by calling (504) 681-8259, or by email to: info@primarycareplus.com or writing to the Privacy Officer at the Primary Care Plus address above. You may remain anonymous. You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.**

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Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person(s) as your "personal representative." You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I,_____ Date of Birth_____(print name and date of birth) hereby appoint the following person(s) to act as my personal representative(s) with respect to decisions involving the use and/or disclosure of health information that pertains to me.

PRINT Name of Personal Representative(s)	PRINT Relationship of each to Patient
_____	_____
_____	_____
_____	_____

The Authority of this person when serving as my "personal representative" is restricted to the following functions:

Description:

☐ This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.

☐ This person is restricted to the following information about my health care:

_____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to:

Primary Care Plus
7049 Perkins Road
Baton Rouge, LA 70808
Attention: Clinic Manager

I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____

Signature Date

REVOCATION SECTION:

I hereby revoke the designation of _____ as my personal representative.

_____

Patient Signature Date

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Consent for Treatment

I, _____, am voluntarily seeking healthcare and hereby consent
(Patient's name)
to medical treatment, procedures, laboratory tests and other health care services. I understand that I have the right to refuse specific treatments or procedures. However, by signing below, I agree in general , to permit laboratory and diagnostic tests, routine medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency procedures as necessary, and hospital services performed at the request of the attending physician or other physicians assisting in my care.

The consent given shall be valid and binding and the physician(s) can rely on this authorization and accept any consent given by the patient until such time as physician receives written notice that the authorization is revoked.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Signature of Patient or Legal Representative Relationship

_____
Date

Primary Care Plus
Handling your health with care

Authorization for the Release of Protected Health Information (PHI)

Patient Name (Last, First, Middle): _____ Date of Birth: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip code: _____

Contact Phone Number(s): _____

I hereby authorize the following entity to release the Protected Health Information (PHI) below to:
Primary Care Plus, 7049 Perkins Road, Baton Rouge, LA 70808-4320
Attention: Administration: Telephone: (225) 706-3060 Fax: (225) 706-3061

Entity Possessing the PHI: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip code: _____

Phone Number(s): _____ Fax: _____

If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated

PHI and Dates of PHI Authorized for Use of Disclosure

Description	Start & End Date of PHI	Description	Start & End Date of PHI
☐ All PHI Records	_____	☐ History & Physical Exam	_____
☐ Laboratory Test	_____	☐ X-Ray Tests/Reports	_____
☐ Progress Notes	_____	☐ Discharge Summary	_____
☐ Consultation Reports	_____	☐ Itemized Billing Statement	_____

☐ Other _____

****The following information will be released unless you indicate DO NOT RELEASE by checking the appropriate box**

☐ AIDS/HIV OR STD treatment ☐ Psychiatric/Mental Care ☐ Alcohol/Drug/Substance Abuse ☐ Genetic Screening

Other, please specify: _____

I understand that:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment of eligibility of benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed.
- I have the right to receive a COPY of this form after I sign it.
- I will receive a photocopy only of my medical record and that the original will remain with Primary Care Plus

Signature of Patient or Patient's Representative (if applicable): _____ Date: _____

Personal Representative's Relationship to Patient and Description of Authority to Act: _____