Primary Care Plus
Handling your health with care

www.PrimaryCarePlus.com

Welcome to Primary Care Plus/Metairie

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 504-836-1575

Sincerely,

Colette Iteld
Clinic Manager

3625 Houma Blvd, Metairie, LA 70006
TEL: 504-836-1575 * FAX: 504-836-1599

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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									
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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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
3625 Houma Blvd
Metairie, LA 70006
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

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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, 3625 Houma Blvd, Metairie, LA 70006
Telephone: (504) 836-1575 Fax: (504) 836-1599

Entity Possessing the PHI: _____

Address: _____

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: _____