WellSmart Health
SURGICAL ASSOCIATES
An Affiliate of Opelousas General Health System

627 East Prudhomme - Opelousas, Louisiana 70570/3521
Hwy 190, Suite X-Eunice, Louisiana 70535
(337) 594-3446 Office (337) 942-5940 Fax

PATIENT INFORMATION QUESTIONNAIRE

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security Number:_____ Gender: ☐ Male ☐ Female

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address:_____ City:_____ State: _____ Zip: _____

Home Ph: _____Work/Alternate Ph:_____ Cell Ph:_____

Email Address:_____

Referred by: _____ Primary Doctor: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced
Race: ☐ Black/African American ☐ White/Caucasian ☐ Hispanic ☐ Asian ☐ Other _____
Ethnicity: ☐ Hispanic or Latino ☐NOT Hispanic or Latino
Primary Language: ☐ English ☐ Other _____
Employment Status: ☐ Full-time ☐ Not employed ☐ Part-time ☐ Military Active ☐ Retired ☐ Self-Employed ☐ Unknown ☐ Student

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: Home: _____ Work: _____ Cell: _____

Insurance Policy Holder Information:

Policy Holder Last Name:_____First Name:_____MI:_____

Mailing Address:_____City/State:_____Zip:_____

Home Phone: (___) ____-_____ Cell Phone: (___) ____-_____ Work Number: (___) ____-_____

Date of Birth ___/____/____ Social Security Number:____-____-_____ Gender □ Male □ Female

Current Employer: _____City/State:_____

Relation to Patient: □Spouse □Parent □Guardian □Other_____

PHARMACY PREFERENCE:

Primary Pharmacy Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Receipt of Notice of Privacy Practices: I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Opelousas General Health System that includes Surgical Associates of Opelousas medical practice. This Notice of Privacy Practices describes how my protected health information may be used and shared. I understand that this notice may be changed at any time. I may obtain a current copy by contacting this office or via the hospital web site at opelousasgeneral.com.

Patient No Show Policy and Timely Arrival to Appointments: If you are more than **15 minutes** late for your appointment, we will have to reschedule your appointment for a later date. If you are unable to keep your appointment, you are required to cancel your appointment with appropriate prior notice (24 hours is appreciated). Failure of you to cancel your appointment without a 24-hour notice is considered a "No Show" and you will be charged **$25.00** fee for purposes of this policy. If **two** or more appointments are missed, then you may be dismissed from our practice. We make every effort to see you in a timely manner and we ask that you respect our time and others time by arriving in a timely manner.
By signing below, I hereby acknowledge that I understand the above Patient No Show Policy and Timely Arrival to Appointments with Surgical Associates of Opelousas.

Evaluation and Treatment: I hereby authorize any of the providers of Surgical Associates of Opelousas to evaluate and recommend any testing and/or additional treatment. I understand that I have the right to refuse any such recommendations/treatment.

Payment Terms: I understand that charges not covered by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify this information is true and accurate as of the below indicated date. I hereby authorize the attached insurance companies to pay directly to Opelousas General Health System Physician Practices benefits due on my behalf, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance and acknowledge outstanding amounts due from me, greater than 30 days, could be assessed a finance charge of 1.5% per month.

MEDICATIONS: Please ***bring all medications***, in their original bottles, with you to ***each and every appointment***. It is very important for us to keep an accurate record of all prescriptions, over the counter (OTC), herbs, and vitamins that you are currently taking. We will reschedule your appointment if you do not bring your medication or an updated list with you to your visit.
The *quickest* way to get your medications refilled is to call your pharmacy and ask them e-scribe (electronically submit) to our office. Certain conditions may require a follow-up appointment before your doctor will issue a refill.

e-Prescribing Consent: ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MAM) of 2003 listed standards that have to be included in an ePrescribe program. These include:
Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan
Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them the patient's prescription has been picked up, not picked up or partially filled.
There are some prescription drugs that may NOT be sent electronically (i.e., narcotics) and scripts must be given in person.

By signing this consent form, you are agreeing that any of the providers of Surgical Associates of Opelousas can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to any of the providers of Surgical Associates of Opelousas to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Opelousas General Health System, "OGHS" and our physician practices participate in the heath information exchange programs listed below: CommonWell Health Alliance, "CWHA", and Carequality Interoperability Framework, "CIF", secure computer networks, collect the electronically available medical records you have with any health care provider who participates in "CWHA" (a "Participating Provider") and "CIF" (a "Participating Provider") and make them available to all your other health care providers who are Participating Providers. You must complete this Election Form to indicate whether you want your electronically available medical records to be shared with your other Participating Providers through CWHA and CIF. Regardless of your decision, it will not affect your ability to get medical care or health insurance coverage.

I APPROVE SENDING DATA TO THE FOLLOWING EXCHANGES
_____ CWHA
_____ CIF

I **DO NOT** APPROVE SENDING DATA TO THE FOLLOWNG EXCHANGES
_____ CWHA
_____ CIF

If you opt out of CWHA and CIF, your electronically available medical records will not be shared through CWHA and CIF for any purpose, including in an emergency. However, OGHS may still share your medical records with other health care providers through means other than CWHA and CIF to the extent permitted by state and federal law.

****By signing below, I hereby acknowledge that I have read and understand the above clinic policies and consents listed above.****
****I have had the chance to ask questions and all of my questions have been answered to my satisfaction****

_____ _____
Signature Date

_____
Relationship to patient

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RELEASE OF PERSONAL HEALTH INFORMATION (PHI) to FAMILY MEMBERS/FRIENDS

PATIENT'S INFORMATION: Gender: ☐ M ☐ F

Last Name: _____ First Name: _____ Date of Birth: _____

I, _____ hereby give authorization to Surgical Associates of Opelousas to release ALL of my health information to the following people:

_____Relationship to patient:_____

_____Relationship to patient:_____

_____ _____

Signature **Date**

_____ _____

Relationship to Patient **Date**

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WELCOME TO THE PATIENT PORTAL

In our ongoing efforts to improve quality of care that **Surgical Associates** provides our patients, we are offering a new way to communicate with us online. The Patient Portal is a secure, web-based system that allows real time access to certain elements of your medical record including:

- Ask the doctors, nurses, or receptionists a question.
- Provide up-to-date personal and medical information.
- Request appointments and medication refills.
- Review existing appointments and receive e-mail reminders.

This two-way messaging allows you to contact our office electronically, and also allows our doctors and office staff to communicate with you. There is no obligation to use this new system and we still remain available to you by phone during office hours. Using the portal will allow you to bypass voicemails and communicate with us at your convenience from any internet device, including cell phones with internet access. **Please note that this service is for non-urgent communication only.**

When you connect to the portal, you are NOT connecting to our actual office computer system, but a secure website hosted elsewhere. Only the limited information you see is stored on the portal, the actual records are maintained in our office.

You will need to have a **permanent email address** that you check regularly. Private health information will not be sent to your email; instead the email will alert you that you have a new message posted on the patient portal. We want to keep your health information secure and confidential. Therefore, the system will lock you out with three (3) failed attempts to enter the portal. Call our office to unlock your portal account.

Once you sign up for the portal, we do assume you will use it. If you ever decide you would rather forego the portal, please let us know and we will deactivate the account.

Important Information about the Patient Portal:

- Use is for **non-emergency** communication and requests only. If you are having a medical emergency, please go to your nearest Emergency Room or call 911.
- The Portal is used for communication between appointments. The Portal does not replace your scheduled appointments.
- The Portal is not checked on weekends. It is only checked during regular business hours, which are Monday through Thursday 8:00 a.m. to 5:00 p.m. and Friday 8:00 a.m. to 12:00 p.m.
- Please allow up to 24-48 hours for us to respond. For prescription refills please allow 48-72 hours.
- We will not send any private health information to your e-mail.
- We will send you an e-mail only when necessary, to request that you access the secure Patient Portal to review private healthcare information that we have posted on your Patient Portal.
- Documents and forms cannot be attached to the Portal messages.

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PARENT INFORMATION

Child's Name(Patient) _____ **Child's DOB (Patient)** _____

MOTHER'S INFORMATION: E-Mail Address: _____

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Home Phone: _____Work Phone: _____Cell Phone: _____

If different from patient:

Mailing Address: _____ City: _____ State: _____ Zip: _____

FATHER'S INFORMATION: E-Mail Address: _____

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Home Phone: _____Work Phone: _____Cell Phone: _____

If different from patient:

Mailing Address: _____ City: _____ State: _____ Zip: _____

GUARDIAN INFORMATION: E-Mail Address: _____

Name of Legal Guardian: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

OTHER THAN PARENTS, PLEASE LIST THOSE ADULTS (OVER 18) WHO ARE ABLE TO ACCOMPANY THE PATIENT TO THE PHYSICIAN'S OFFICE.

(Include Person's Name, Relationship to Patient and Contact Number.)

PARENTS OR LEGAL GUARDIAN MUST BE PRESENT FOR IMMUNIZATIONS

Contact Name: _____ Contact Phone Number: _____

Relationship to Patient: ☐ Parent ☐ Step Parent ☐ Legal Guardian ☐ Grandparent ☐ Other _____

Contact Name: _____ Contact Phone Number: _____

Relationship to Patient: ☐ Parent ☐ Step Parent ☐ Legal Guardian ☐Grandparent ☐ Other _____

Contact Name: _____ Contact Phone Number: _____

Relationship to Patient: ☐ Parent ☐ Step Parent ☐ Legal Guardian ☐Grandparent ☐ Other _____

I,_____, parent or guardian, hereby give authorization to Surgical Associates to treat minor child who presents here without adult without being accompanied by parent or guardian.

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627 E Prudhomme St, Opelousas, LA 70570
337-594-3446 Office 337-942-5940 Fax

Authorization to Release or Obtain Health Information

Name: _____ Date of Birth: _____ SSN#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of Insurance: _____

I authorize: Surgical Associates of Opelousas □ **Release Information To** **OR** □ **Obtain Information From**

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

The **Purpose of this Authorization** is indicated below: (Please place a check in the box that applies)
__ Changing Physicians __ Legal Purposes __ Further Medical Care __ Other: _____

Preferred Provider: ____ Dr. Eric Amy ____ Dr. M. Andrew Sicard ____ Dr. Salvador Vazquez

Records to Include:
This authorization pertains to the disclosure of the record types indicated below between the following dates of service:
from _____ to _____ OR select one of the following options:
_____ All records retained by facility/office
_____ Progress notes _____ Hospital records _____ Laboratory notes _____ Immunization records
_____ Operative reports _____ Imaging reports _____ Other specified information: _____

Terms and conditions:

- I have the right to revoke this Authorization, in writing, at any time by notifying the Privacy Office at Opelousas General Health System and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that already had been disclosed in reliance on this Authorization.
- I have the right to not sign this Authorization. Surgical Associates of Opelousas will not condition treatments, payment for services or enrollment or eligibility for benefits on whether I sign this Authorization.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
- I have read and understand this Authorization, have had an opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
- Please note, this Authorization expires one (1) year after the date of signature unless otherwise specified: _____.

I understand that the information to be released is considered confidential and is to be utilized by the recipient only for the purpose of medical treatment.

Signature: _____ Date: _____ Phone Number: _____

Printed Name: _____ Relationship: _____