An Affiliate of Opelousas General Health System

1371 I-49 S Service Rd, Sunset, LA 70584
(337) 678-4160 Office (877) 278-8499 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 Collins Family Clinic 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 Collins Family Clinic.

Evaluation and Treatment: I hereby authorize any of the providers of Collins Family Clinic 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 Collins Family Clinic 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 Collins Family Clinic 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

An Affiliate of Opelousas General Health System

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 Collins Family Clinic to release ALL of my health information to the following people:

____ Relationship to patient: ____________

____ Relationship to patient: ____________

_______________________________________ _______________________________
Signature **Date**

_______________________________________ _______________________________
Relationship to Patient **Date**