

## 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 \_\_\_\_\_

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### **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](http://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 health information exchange programs listed below: CommonWell Health Alliance, "CWA", and Carequality Interoperability Framework, "CIF", secure computer networks, collect the electronically available medical records you have with any health care provider who participates in "CWA" (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 CWA 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

\_\_\_\_ CWA  
\_\_\_\_ CIF

I **DO NOT** APPROVE SENDING DATA TO THE FOLLOWING EXCHANGES

\_\_\_\_ CWA  
\_\_\_\_ CIF

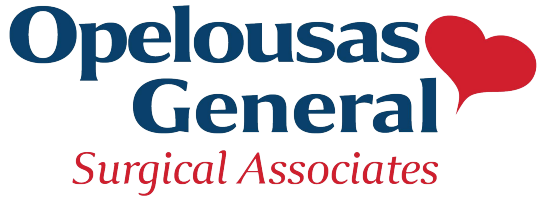
If you opt out of CWA and CIF, your electronically available medical records will not be shared through CWA and CIF for any purpose, including in an emergency. However, OGHS may still share your medical records with other health care providers through means other than CWA and CIF to the extent permitted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



**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: \_\_\_\_\_

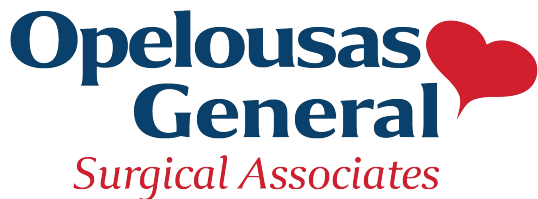
\_\_\_\_\_ Relationship to patient: \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Date**



## 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.**

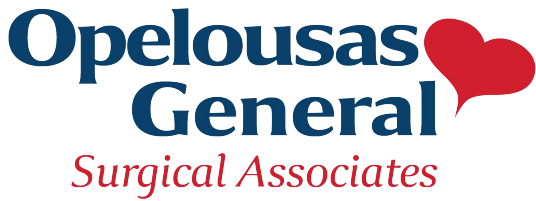
When you connect to the portal, you are NOT connecting to our actual office computer system, but a secure website hosted elsewhere. Only the limited information you see is stored on the portal, the actual records are maintained in our office.

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.



**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 \_\_\_\_\_

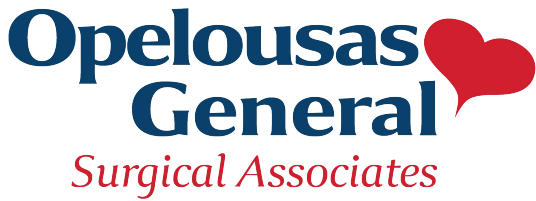
Contact Name: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

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.



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: \_\_\_\_\_