ACCESS 2day HEALTH

Today's Date:_____

Patient Information:

Patient's Legal First Name: _____ Middle Initial: ____ Last Name: _____

DOB: _____ SSN: _____Phone: _____

(SSN is required for Access 2 Day Benefits)

Access 2Day Health Employer: _____
(Policy Holder's Employer: Self, Spouse, Parent, etc..)
Pharmacy: _____

Primary Care Physician: _____

What are you being seen for today? (PLEASE LIST ALL SYMPTOMS)

_____

_____

_____

_____

_____

Onset date & time: _____
(When did it start? How many days?)

RESPIRATORY SCREEN

Do you have a fever?	YES	NO
Do you have a cough and/or difficulty breathing?	YES	NO
Have you been in close contact with a family member or friend that is known to be positive for COVID-19?	YES	NO

Thank you for your cooperation.

Patient Information:

Patient Legal First Name: _____ M: ___ Last Name: _____

DOB: _____ Sex: Male/Female SSN: _____-____-_____ Email: _____

Home Address: _____ City: _____ State: ___ Zip:_____

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

Home Phone: _____ Cell: _____ Work: _____ Ext: ____

Primary Care Provider: _____ Phone:_____

Marital Status: ___ M ___ S ___ D ___ W ___ Other Language:_____ Race: _____

Ethnicity: Hispanic / Non Hispanic / Decline to Specify

Access 2Day Health Employee Information:

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: ____ Zip:_____

If Access Health is through a spouse or parent, who is their employer? _____

Responsible Person's or Spouse Information:

Legal First Name: _____ M: ___ Last Name: _____

Relationship to Patient: _____ DOB: _____ SSN : _____-____-_____

Address: _____ City: _____ State: ___ Zip: _____

Home #: _____ Cell:_____ Work:_____

Emergency Contact:

Emergency Contact: _____ Relationship_____ Phone:_____

Preferred Pharmacy:

Name:_____ Street:_____ City:_____Phone:_____

Authorized Contacts:

Please list all persons who can inquire/discuss/relay information pertaining to your personal health information.

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____
3. Name: _____ Relationship: _____ Phone: _____

Cenla Family Medicine Associates, LLC
Central Louisiana Foot and Ankle Specialists
Alexandria Gastroenterology Associates

Patient's Notification and Signature Form

Print Patient Name: _____ Date of Birth: _____

Please initial all:

I have received a copy and have read the HIPPA Notice of Privacy Practices Policy for the clinic.
_____ Patient or Guardian's Initial

I have received a copy and have read the Patient Consent for Use and Disclosure of Protected Health Information Policy for th e clinic.
_____ Patient or Guardian's Initial

I have received a copy and have read the Payment Policy for the clinic. _____ Patient or Guardian's Initial

I have received a copy and have read the No Show Policy for the clinic.
_____ Patient or Guardian's Initial

I have received a copy and have read the Authorization of Care for the clinic.
_____ Patient or Guardian's Initial

I authorize the release of any information necessary to process this claim and authorize payment of benefits to Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists, Cardiac and Vascular Services of Cenla, and/or Alexandria Gastroenterology Associates for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.
_____ Patient or Guardian's Initial

I authorize my insurance company to pay benefits directly to Cenla Family Medicine Associates, LLC and/or Cardiac and Vascular Services of Cenla for charges relating to all services.
_____ Patient or Guardian's Initial

PRESCRIPTION HISTORY CONSENT
I agree that the clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

Yes_____ (please initial) No _____ (please initial)

I recognize my responsibility and my rights as a patient of Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists and/or Cardiac and Vascular Services of Cenla.

_____ _____
Patient or Guardian's Signature Date

New Patient History Questionnaire:

Name: _____DOB: _____ Occupation: _____

Gender: Male Female

Marital Status: Single Married Widowed Separated Divorced

Use of: Alcohol_____ Tobacco_____ Recreational Drugs_____

Family History

Relation	**Age**	**Living**	**Deceased**
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

Sibling History

Number of brothers living _____ Number of brothers deceased_____

Number of sisters living _____ Number of sisters deceased _____

Prescription Medication (that you are currently taking)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

OTC Medications (that you are currently taking – please include any herbs or supplements)

_____ _____ _____

_____ _____ _____

Medication Allergies

_____ _____ _____

_____ _____ _____

Surgeries

_____ _____ _____

Family Illnesses

Check in the **Self** column if any of the following has happened to you. Check the **Blood Relative** if any of the following has happened to a blood relative and state the relationship.

Key- M: mother, F: father, S: sibling, PGF or PGM: paternal grandfather or grandmother, MGF or MGM: maternal grandfather or grandmother, PA or PU: paternal aunt or uncle, MA or MU: maternal aunt or uncle.

Self	Blood Relative	
___	_____	Diabetes (sugar)
___	_____	High Blood Pressure
___	_____	High Cholesterol
___	_____	Stroke
___	_____	Heart Attack
___	_____	Congestive Heart Failure
___	_____	Cancer, type or site
___	_____	Mental Problems
___	_____	Arthritis
___	_____	Gout
___	_____	Alcoholism or drugs
___	_____	Asthma
___	_____	Breathing Problems
___	_____	Tuberculosis (TB)
___	_____	Cystic Fibrosis
___	_____	Allergies
___	_____	Skin Problems
___	_____	Anemia
___	_____	Sickle Cell Disease
___	_____	Bleeding
___	_____	Seizures
___	_____	Glaucoma
___	_____	Blindness before age 50
___	_____	Deafness before age 50
___	_____	Kidney Problems
___	_____	Bladder Problems
___	_____	Thyroid Problems
___	_____	Migraine
___	_____	Stomach Problems
___	_____	Bowel Problems
___	_____	Rectal Polyps
___	_____	Liver Problems
___	_____	Genetic/inherited diseases
___	_____	Other unusual diseases

Thank you for your cooperation.

HIPAA Notice of Privacy Practices

the CLINICS
1587 N. Bolton, Alexandria LA

Cenla Family Medicine Associates, LLC
Central Louisiana Foot and Ankle Specialists
Alexandria Gastroenterology Associates

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that my identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by Law; Public Health issues as required by law. Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceeding: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

1. You have the right to inspect and copy your protected health information. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request for a copy of the medical record. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

2. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members of friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosures of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

3. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

4. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

5. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2021**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.