Cenla Family Medicine Associates

My Primary Care Provider (PCP) is: (Please check one)

___ Dr. McBride **___ Dr. Beurlot** **___ Dr. Screpetis** **___ J. Townley, FNP** **___ I. Kendrick, FNP**

___ F. Turregano, FNP **___ Dr. Buck** **___ Dr. Hunter** **___ J. Lombard, FNP** **___ J. Ponthier, FNP**

___ D. Fontenot, FNP **___ T. Billberry, FNP** **___ Dr. Miller**

Please check Yes or No

Do you have a Medical Power of Attorney? **□ Yes** **□ No**

Do you have a Living Will? **□ Yes** **□ No**

Patient Information

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

Date of Birth: _____ Sex: Male/Female Social Security #: _____ Email: _____

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

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

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

How do you want us to contact you: Home □ Cell □ Work □ Marital Status: _____M _____S _____D _____W _____Other

Language Preference: □ English □ Other: _____ Race: _____ Ethnicity: Hispanic/Non-Hispanic/Decline

Employer: _____□ Retired

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

Responsible Person's or Spouse Information

Legal First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Sex: Male/Female Social Security #: _____ Email: _____

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

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Employer: _____

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

Emergency Contact

Name: _____ Relationship: _____ Phone #: _____

Mother's Name/Legal Guardian if Patient is a Minor: _____

Authorized Contacts:

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

1) Name: _____ Relationship: _____ Phone #: _____
2) Name: _____ Relationship: _____ Phone #: _____
3) Name: _____ Relationship: _____ Phone #: _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Group #: _____ Policy Holder DOB: _____

Policy Holder Name: _____ Policy Holder Social Security #: _____ Relationship: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____ Policy Holder DOB: _____

Policy Holder Name: _____ Policy Holder Social Security #: _____ Relationship: _____

Preferred Pharmacy

Name: _____ Street: _____ City: _____ 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, 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 Central Louisiana Foot and Ankle Specialists for charges relating to all services.
_____ Patient or Guardian's Initial

I authorize **Cenla Family Medicine Associates, LLC** to disclose information related to my visit to the CommonWell network with this consent. I understand that the purpose of this disclosure is for continuity of care. Furthermore, I understand that this authorization is revocable by me at any time if I provide a written, signed notice except to the extent that action has been taken on this release.

___ (Please check if this applies.) I want to participate in the CommonWell/Care Quality Program.

___ (Please check if this applies.) I choose **not** to participate in the CommonWell/Care Quality Program.

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 , and/or Central Louisiana Foot and Ankle Specialists

_____ _____
Patient or Guardian's Signature Date

CENLA FAMILY MEDICINE ASSOCIATES PATIENT/PROVIDER AGREEMENT

Good communication between patients and physicians/providers is the key to better outcomes. The staff at Cenla Family Medicine Associates, offices of Dr. Michael J. Screpetis, Dr. William M. McBride, Dr. Michael G. Buck, Dr. Michelle R. Beurlot, Dr. Jonathan D. Hunter, Dr. Noah L. Miller, Dr. Maria N. Saucier, Dr. Paul T. Sunderhaus, Dr. Joseph D. Hollier, Kim Sills, FNP, Frances Turregano, FNP, Dana Fontenot, FNP, Tina Billberry, FNP, Jessica Townley, FNP, Jeannie Ponthier, FNP, Indria Kendrick, FNP, and John Lombard, FNP are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.

Our Responsibilities to You:

- Respect you as an individual – we will not make judgments based on race, ethnicity, national origin, religion, gender, age, physical disability, sexual orientation, or genetic information.
- Respect your privacy – your medical information will not be shared with anyone else unless you give permission or as required by law.
- Provide "whole person" care based on the best possible treatment and advice based on current medical evidence – we respect your right to information and will discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage.
- Manage your health status, including well person/preventive care as well as treatment for acute and chronic diseases.
- Coordinate your care and services with other healthcare providers and settings.
- Provide you timely access to care in our practice, as well as facilitate timely access to specialists, diagnostic services, and other care as needed.

Your Responsibilities to Us:

- Ask questions, share your feelings and be part of your care.
- Be honest about your history, symptoms, and other important information about your health.
- Tell your provider about any changes in your health and well-being, including visits to other medical providers and/or facilities and providing any associated medical records.
- Take your medicine as ordered and follow your provider's advice – if you are unwilling or unable to do so, be honest with your provider.
- Make healthy decisions about your daily habits and lifestyle.
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible.
- Call your provider first with all problems unless you have a medical emergency.
- End every visit with a clear understanding of your provider's expectations, treatment goals and future plans.

PLEASE NOTE: Cenla Family Medicine is open Monday through Thursday, 7:45am to 5:00 pm and Friday 745 to 12:00 pm. There is a provider available to see you or consult with you during these hours. When the office is closed, there is an on-call provider available for urgent issues which cannot wait until regular office hours. To access the on-call provider, call the regular office phone number and you will be automatically connected for immediate assistance.

By signing below, you indicate that you have read this document, and that it is your wish to join our medical home and to do your best to abide by the statements listed above. This is not a legally binding contract but is intended to provide a framework upon which we can build a relationship that will allow you to maximize your health status in a comfortable and welcoming environment.

_____ _____ _____

Patient Name Patient Signature Date

_____ _____

Provider or Representative Signature Date

New Patient History Questionnaire

It is fair to ask why we feel it is important that you complete this questionnaire as thoroughly as you can. We believe in, and attempt to provide you with, personal and thorough health care. Whereas this requires knowledge of medicine on our part, it also requires your participation and help. Please answer the questions as best you can as it helps you give us the needed information about your medical condition(s).

Thanks in advance,
William M. McBride, MD
Michael J. Screpetis, MD
Michael G Buck, MD
Jonathan D. Hunter, MD
Michelle R. Beurlot, MD
Noah L. Miller, MD
Dana Fontenot, FNP-C
Frances Turregano, FNP-C
Tina Billberry, FNP-C
Jessica Townley, FNP-C
Jeannie Ponthier, FNP-C
Indria Kendrick, FNP-C
John Lombard, FNP-C

Date: _____

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 _____

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		Prescription Medication **(you are taking currently)**
___	_____	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	**Medication Allergies**
___	_____	Skin Problems	_____
___	_____	Anemia	_____
___	_____	Sickle Cell Disease	_____
___	_____	Bleeding	_____
___	_____	Seizures	**Surgeries**
___	_____	Glaucoma	_____
___	_____	Blindness before age 50	_____
___	_____	Deafness before age 50	_____
___	_____	Kidney Problems	_____
___	_____	Bladder Problems	_____
___	_____	Thyroid Problems	_____
___	_____	Migraine	_____
___	_____	Stomach Problems	**OTC (over the counter) Medication**
___	_____	Bowel Problems	(you are currently regularly,
___	_____	Rectal Polyps	please include any herbs or
___	_____	Liver Problems	supplements)
___	_____	Genetic/inherited diseases	_____
___	_____	Other unusual diseases	_____

Thank you for your cooperation.