## Patient Demographics Information (Please Print)

Last Name: _____ Suffix: ____ First Name: _____ MI: ____ Nickname/AKA: _____

SS#: _____ Date of Birth: _____ Gender (at Birth): _____ Gender Identity: _____ Sexual Orientation: _____ Pronouns: _____

Race: _____ Ethnicity: _____ Language: _____Marital Status: ____ Phone: _____ ☐ Mobile ☐ Home

Address (Physical): _____ Address (Mailing): _____

City: _____ State: _____ Zip Code: _____ Email: _____ **Preferred Method of contact:**

Preferred Pharmacy: _____ Pharmacy Phone: _____ ☐ Email ☐ Text ☐ Written

Employer: _____ Job Title: _____ Phone: _____ **By selecting the checkboxes, the patient agrees to received text and email notifications from the practice.*

## Guarantor Information

Name: _____ Date of Birth: _____ SS# _____ Relationship: _____

Phone: _____ ☐ Mobile ☐ Home Email: _____

Address (Physical): _____ City: _____ State: _____ Zip Code: _____

## Emergency Contact: *(You must complete this section)*

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

## Disclosure Consent *(You must complete this section)*

☐ I authorize Rural Health Clinic of Loreauville to communicate any information pertaining to my health to the following individuals.

***This form permits verbal communication only, you may revoke this document at any time by completing a new form.***

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ I do not authorize Rural Health Clinic of Loreauville to communicate any information pertaining to my health to anyone other than myself.

## Insurance Info:

Name of ***Primary*** Insurance Company: _____ Policy Number: _____

Group Number: _____ Policy Holder: _____ Date of Birth: _____

Social Security: _____ Relationship to Patient: _____

Name of ***Secondary*** Insurance Company: _____ Policy Number: _____

Group Number: _____ Policy Holder: _____ Date of Birth: _____

Social Security: _____ Relationship to Patient: _____

## Assignment and Release

I, undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Rural Health Clinic of Loreauville all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorization Rural Health Clinic of Loreauville to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Initial

I certify that the above information is correct to the best of my knowledge. I will not hold Rural Health Clinic of Loreauville or any members of his staff responsible for any errors or emissions that I may have made in the completion of this form.

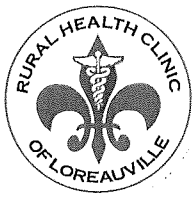
_____ Initial

## No Show Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In order to be respectful of the medical needs of other patients, please be courteous and call Rural Health Clinic of Loreauville promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is need of treatment. If it is necessary to cancel your scheduled appointment, we advise that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. This policy enables us to better utilize available appointments for our patients in need of medical care. A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a schedule appointment will be recorded in your medical records as a "no-show". After the 1st no-show, our office staff will contact you by phone. After the 2nd no show, you, NOT your insurance, will be charged $25.00 for the time slot we were not able to fill when you were a NO SHOW. After the 3rd no show, you *may* be dismissed from the clinic.

_____ _____ _____

Patient or Guardian Signature Date Relationship to Patient




411 South Main Street, Loreauville, LA 70552

Consent for Treatment

The undersigned, as a patient or authorized representative of the patient, hereby consents to any and all medical, behavioral, preventative, and other healthcare related evaluation and management ("healthcare services") as may be deemed by the healthcare provider. I am aware that providing healthcare services is not an exact science. I acknowledge that no guarantees have been made to me by the clinic or healthcare provider as to the results of healthcare services including: diagnosing, examinations, or treatments in any clinic or hospital, or other healthcare organization.

Healthcare Provider

The undersigned, as a patient or authorized representative of a patient, hereby understands, and agrees that healthcare services may be provided by an advanced practice registered nurse (APRN), registered nurse (RN), licensed clinical social worker (LCSW), or a physician. Also, I understand that the APRN has a collaborating physician who may or may not be at the clinic, and I am a patient of the APRN and this clinic, and not the patient of the collaborating physician. I understand that the clinic has a physician as a medical director who has certain administrative and clinical responsibilities. Further, I understand that the collaborating physician owns or operates another clinic and that he or she may or may not be available to provide healthcare services and may or may not accept my insurance or payments.

Use of Protected Health Information

The undersigned, as a patient or authorized representative of a patient, hereby understands and agrees that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examinations, test results, diagnoses, treatment, and any plans for future care of treatment, so that my healthcare provider can get paid, and for various uses related to my healthcare provider's clinic administration. I hereby consent to my provider using and disclosing my health information in connection with my treatment in order to get paid for healthcare services provided to me, and as necessary for the administration of the clinic. Further, I understand that medical information and records may be released to other institutions, agencies, healthcare organizations of healthcare providers, who accept me for medical or institutional care. In addition, I understand that my medical information may be released to my insurer(s), managed care organization(s), governmental entities responsible for paying for my care, and/or pharmaceutical manufacturers and their respective agents, for purposes including, but not limited to, payment, utilization review and quality assurance review, and to support applications for patient assistance. I acknowledge receipt of a copy of the clinic's Notice of Privacy Practice.

Electronic Signature on File

The undersigned, as a patient or authorized representative of a patient, hereby understands and agrees that my health records are documented in an Electronic Health Record system and that for the purpose of billing claims to my insurer for services rendered at the clinic, my electronic signature will be stored on file and used for billing purposes.

Payment and Financial Responsibility

The undersigned, as a patient or authorized representative of a patient, hereby understands and agrees that charges for healthcare services must be paid at the time of service, unless they are covered by my insurance. Further, I understand and agree that the clinic will submit these charges to my healthcare insurer and if these charges are not covered by my insurance it is still my personal obligation to pay any and all charges. I assign all rights and causes of action that I might have under Louisiana law, including but not limited to the title to any cause or action or rights of the patient with respect to collection of insurance benefits under the revised statutes of the State of Louisiana. I further authorize any and all insurers that I might have of whatsoever nature, form of description, to pay my healthcare provider, and/or clinic, any and all amounts that may be due me by the said insurer. I further authorize any and all insurance companies that I have, to pay directly my treating provider, and/or clinic, and its agents or third-party providers, any benefits due and payable under the terms of any and all insurance policies that I might have that would be effective and provide coverage and/or benefits to me.

Medication Management

The undersigned, as a patient or authorized representative of a patient, understands and agrees that APRNs do not treat chronic pain or obesity. I understand that as part of regular practice, my healthcare provider will review the Louisiana Prescription Monitoring Program to ensure that healthcare services are provided prudently. I also understand that some providers may choose to not write prescribe controlled or scheduled medications (e g., Lortab. Xanax. or promethazine with codeine) and that I must abide by that decision while remaining a patient at this clinic. In addition, I understand and agree that should my healthcare provider choose, in his or her sole professional judgment within his or her scope of practice, licenses, and/or collaborative practice agreement, to prescribe controlled or scheduled medications that I will be subject to drug screens, with or without notice, to ensure that I am taking the medication as directed and that I am taking no other narcotic medication or illicit substance. I understand and agree that should my drug screen provide results that indicate I am not taking the medication as prescribed or in a manner that is contraindicated and my adversely affect my health, that the healthcare provider may not write any other controlled or scheduled medications to me in the future and that I could also be caused to be discharged from the clinic and the healthcare provider's practice.

Patient Rights

The undersigned, as a patient or authorized representative of a patient, understands that I have certain rights and responsibilities. They include the following:
Every patient, and/or his/her representative, shall whenever possible, be informed of the patient's rights in advance of receiving his or her healthcare services. The rights of the patient and or his/her representative when appropriate include the right to:

1. *Receive treatment equally, not be discriminated in the provision of services to an individual (i) because the individual is unable to pay; (ii) because payment for those services would be made under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP); or (iii) based upon the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity or inability to pay.*
2. *Be treated with consideration, respect, dignity and recognition of their individuality, including the need for privacy in treatment; and respect for their personal values, beliefs, cultural, psychosocial, spiritual needs and preferences.*
3. *Be informed of the names and functions of all Nurse Practitioners and other health care professionals who are providing direct care to the patient.*
4. *Receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and the clinic's health care personnel or individuals outside the clinic.*
5. *Receive and participate in the development and implementation of his/her plan of care.*
6. *Make informed decisions regarding his or her care, and be informed about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes.*
7. *Be informed of his/her health status, be involved in care planning and treatment, and be able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.*
8. *Be included in experimental research only when he or she gives informed, written consent to such participation, and to refuse to participate in experimental research, including the investigations of new drugs and medical devices.*
9. *Be informed if the clinic has authorized other health care and/or educational institutions to participate in the patient's treatment and to know the identity and functions of these institutions and may refuse to allow their participation in his/her treatment.*
10. *Be informed by the attending physician and other providers of health care services about any continuing health care requirements after his/her services are rendered from clinic and to have clinic staff make arrangements for the required follow-up care after discharge.*
11. *Have his/her medical records, including all computerized medical information, kept confidential; and to access information contained in his/her medical records within a reasonable time frame.*
12. *Be free from all forms of abuse and harassment.*

13. *Receive care in a safe setting.*
14. *Receive assistance in pain management.*
15. *Examine and receive an explanation of the patient's clinic bill regardless of source of payment.*
16. *Be informed in writing about the clinic's policies and procedures for initiation, review and resolution of patient complaints or grievances, including the address and telephone number of where complaints may be filed with the department.*
17. *Be informed of his/her responsibility to comply with clinic's rules, cooperate in the patient's own treatment, provide a complete and accurate medical history, be respectful of other patients, staff and property and provide required information regarding payment of charges.*
18. *Access, request amendment to, and receive an accounting of disclosures regarding his/her own health information as permitted under applicable law.*
19. *Access protective and advocacy services.*

Patient Responsibilities

The undersigned, as a patient or authorized representative of a patient, understands that I have certain responsibilities in order to remain a patient at this clinic and under the care of the healthcare provider. They include the following:

1. *It is the patient's responsibility to treat others with respect. All patients deserve respect, and staff, other patients, and visitors deserve respect. This includes following rules about smoking, noise, number of visitors, conduct and respect of property that belongs to others or the clinic.*
2. *It is the patient's responsibility to give accurate information. There may be a need to answer numerous questions about their health, medical history, etc.*
3. *The patient is responsible for bringing their advance medical directive to the clinic, if available. This may include living wills, durable power of attorney for health care, and other forms of healthcare decisions.*
4. *The patient is responsible for following their healthcare team's treatment plan*
5. *The patient is responsible for asking questions if they do not understand certain aspects of their care.*
6. *The patient is responsible for accepting financial responsibility associated with his/her care.*
7. *The patient is responsible for following the clinic's rules and regulations.*
8. *It is the patient's responsibility to advise the nurse, nurse practitioner, and/or patient advocate of any dissatisfaction they may have regarding their care or safety.*

Complaints and Grievances

The undersigned, as a patient or authorized representative of a patient, understands should I have a complaint or grievance that I should ask for the practice administrator to be called at any time or location or by calling the main clinic at (337) 229-4212. I understand and agree that if the practice administrator can immediately resolve my complaint, that the matter will be deemed resolved, but that if the complaint cannot be resolved to my satisfaction, that the complaint will be considered a grievance and be subject to those policies and procedures. I understand and agree that the practice administrator will respond to all grievances, in writing, within ten (10) days. The response will include the nature of the grievance, the investigation into that grievance, findings, if any, of the investigation, and the resolution of the grievance. I also understand that I may call the Louisiana Department of Health and Hospitals to make a complaint at (866) 280-7737. Further, I understand that I may call my insurer to make a complaint and the insurer's phone number is usually found on the back of the insurance card.

In the event your complaint remains unsolved with Rural Health Clinic of Loreauville, you may file a complaint with our Accreditor, The Compliance Team, Inc. via their website (www.thecomplianceteam.org) or via phone 1-800-291-5353. Complaints can be filed with the Louisiana Department of Health via their website (www.ldh.la.gov/page/3768) or via phone (225) 342-0138.

Treatment of Minors

The undersigned, as a patient or authorized representative of a patient, understands and agrees that the parent or legal guardian must consent to the treatment of the child (for the purposes of this agreement a minor or child is defined as any person under the age of majority [17 or younger] in Louisiana) prior to the provision of healthcare services. The consent and authorization may be amended or revoked at any time by the parent or legal guardian.

Children of Divorced Parents

The undersigned, as a patient or authorized representative of a patient, understands and agrees that the clinic or healthcare provider will not be party to a dispute related to a divorce except to provide medical records, duly authorized for release, or professional opinions legally compelled by a court. I agree and understand should either parent have a dispute regarding the consent to treat, consent to treat minors, financial responsibilities or any other agreement with the clinic or healthcare provider, the parent should provide the clinic or healthcare provider with documentation of custodial care. I agree and understand that the clinic or healthcare provider will then comply with the decree of the court.

Treatment for the Purposes of Litigation

The undersigned, as a patient or authorized representative of a patient, understands and agrees that this clinic does not deliver healthcare services for the direct purpose of engaging in litigation (e.g. accident or injury evaluation and/or management for the purposes of litigation). I understand that this does not mean that the clinic and/or healthcare provider will not provide emergency stabilization or healthcare services immediately following an accident, injury, or other trauma, but that the clinic and/or healthcare provider will not provide healthcare services post-accident, injury, or other trauma for the sole purpose for intent to engage in litigation.

Workers Compensation

The undersigned, as a patient or authorized representative of a patient, understands and agrees that this clinic does not provide healthcare services to patients participating in a workers compensation claim. I understand that this does not mean that the clinic and/or healthcare provider will not provide emergency stabilization or healthcare services immediately following an accident, injury, or other trauma, but that the clinic and/or healthcare provider will not provide healthcare services post-accident, injury, or other trauma as directed by or under an employer's workers compensation insurance, program, payment system.

Reproduction of Medical Records

The undersigned, as a patient or authorized representative of a patient, understands and agrees that upon each visit the patient has an opportunity to receive a printed summary of their visit, a copy of any diagnostic tests or procedures, and any pertinent health education. I also understand that there is certain information about my health and healthcare services received at the clinic available online at (Clinic Website). I agree and understand that should I, or other party I designate in writing on a properly executed Consent to Release Protected Health Information form to receive my medical record, want a printed copy of my entire medical record that I will be required to pay the Louisiana mandated medical record reproduction fees as described in RS 40:1299.96 "If the original treatment records are generated, maintained, or stored in paper form, copies shall be provided upon payment of a reasonable copying charge, not to exceed one dollar ($1.00) per page for the first twenty-five (25) pages, fifty cents ($.50) per page for twenty-six (26) to three hundred fifty (350) pages, and twenty-five cents ($.25) per page thereafter, a handling charge not to exceed twenty-five dollars ($25.00) for hospitals, nursing homes, and other health care providers, and actual postage." "If treatment records are generated, maintained, or stored in digital format, copies may be requested to be provided in digital format and charged at the rate provided by this item: however, the charges for providing digital copies shall not exceed one hundred dollars ($100.00), including all postage and handling charges actually incurred. If requested, the healthcare provider shall provide the requester, at no extra charge, a certification page setting forth the extent of the completeness of records on file."

Rural Health Clinic

The undersigned, as a patient or authorized representative of a patient, understands that the patient is receiving healthcare services at a rural health clinic, or a clinic that is endeavoring to become a rural health clinic, that is licensed by the Louisiana Department of Health and Hospitals, certified by the Centers for Medicare and Medicaid Services, and accredited by The Compliance Team. I understand that the clinic has certain regulatory obligations and responsibilities, and that I consent that my healthcare information may be used to comply with any and all regulations therewith.

Receipt of Information

The undersigned, as a patient or authorized representative of a patient, attests that they have received the following documents, the clinic's Privacy Practices, The Clinics complaint/grievance policy, a copy of the patient rights and responsibilities, the clinic's hours of operation, and contact numbers, the name of my individual healthcare provider, and the professional role of my healthcare provider (e.g., APRN or nurse practitioner, RN, LCSW, or physician).

Accuracy of Information

The undersigned, as a patient or authorized representative of a patient, certify that all information given to the clinic and my healthcare provider related to my healthcare services, financial obligations, and other consents and authorizations, is both true and correct. Further, I understand and agree that any such time this information changes, I must notify the clinic and/or healthcare provider as soon as practical.

*The undersigned, as a patient or authorized representative of the patient, attests that they have reviewed, understand, and agree to all information included within the authorization and consent document.*

| *Patient Full Name (Printed)* | *Date of Birth* | *Patient/Legal Representative Name (Printed)* | *Relationship to Patient* |
|---|---|---|---|

| *Patient/Legal Representative Sign* | *Date* |
|---|---|

# 411 South Main Street, Loreauville LA, 70552

## This notice describes how your medical information may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

This Facility is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact (337) 229-4214.

## UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are admitted to our Facility, a record of your stay is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- *plan your care and treatment*
- *communicate with other health professionals involved in your care*
- *document the care you receive*
- *educate health professionals*
- *provide information for medical research*
- *provide information to public health officials*
- *evaluate and improve the care we provide*
- *obtain payment for the care we provide*

Understanding what is in your record and how your health information is used helps you to:

- *ensure it is accurate*
- *better understand who may access your health information*
- *make more informed decisions when authorizing disclosure to others*

## HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

- For Treatment. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other Facility personnel who are involved in taking care of you at a Facility. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can plan your meals. Different departments of a Facility also may share health information about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose health information about you to people outside the Facility who may be involved in your medical care after you leave a Facility. This may include family members, or visiting nurses to provide care in your home.
- For Payment. We may use and disclose health information about you so that the treatment and services you receive at a Facility may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- For Health Care Operations. We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all residents receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many residents to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our corporate office for business development and planning, cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the Facility including resolution of internal grievances, customer service and due diligence in connection with the sale or transfer of the Facility. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of residents. We may disclose your age, birth date and general information about you in the Facility newsletter, on activities calendars, and to entities in the community that wish to acknowledge your birthday or commemorate your achievements on special occasions. If you are receiving therapy services, we may post your photograph and general information about your progress.

## OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- Business Associates. There are some services provided in our Facility through contracts with business associates. Examples include medical directors, outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- Providers. Many services provided to you, as part of your care at our Facility, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g., MD, DO, Podiatrist, Dentist, Optometrist), therapists (e.g., Physical therapist, Occupational therapist, Speech therapist), portable radiology units, clinical labs, hospice caregivers, pharmacies, psychologists, LCSWs, and suppliers (e.g., prosthetic, orthotics).
- Treatment Alternatives. We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
- Health-Related Benefits and Services and Reminders. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Fundraising Activities. We may use health information about you to contact you in an effort to raise money as part of a fundraising effort. We may disclose health information to a foundation related to the Facility so that the foundation may contact you to raise money for the Facility. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services at the Facility.
- Facility Directory. We may include information about you in the Facility directory while you are a resident. This information may include your name, location in the Facility, your general condition (e.g., fair, stable, etc.) and your religion. The directory information, except for your religion, may be disclosed to people who ask for you by name. Your religion may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the Facility and generally know how you are doing.
- Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- As Required By Law. We will disclose health information about you when required to do so by federal, state or local law.
  - To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
  - Organ and Tissue Donation. If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.
- Military and Veterans. If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- Research. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all residents who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with residents' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave a Facility.

- Workers' Compensation. We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- Reporting Federal and state laws may require or permit the Facility to disclose certain health information related to the following:
  - *Public Health Risks.* We may disclose health information about you for public health purposes, including:
    - *Prevention or control of disease, injury or disability*
    - *Reporting births and deaths;*
    - *Reporting child abuse or neglect;*
    - *Reporting reactions to medications or problems with products;*
    - *Notifying people of recalls of products;*
    - *Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;*
    - *Notifying the appropriate government authority if we believe a resident has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.*
  - *Health Oversight Activities.* We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
  - *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
  - *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a resident has been the victim of abuse, neglect or domestic violence.

Law Enforcement. We may disclose health information when requested by a law enforcement official:
In response to a court order, subpoena, warrant, summons or similar process;
To identify or locate a suspect, fugitive, material witness, or missing person;
About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
About a death we believe may be the result of criminal conduct;
About criminal conduct at the Facility; and
In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

- National Security and Intelligence Activities. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or its agent's health information necessary for your health and the health and safety of others.

## OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of the Facility, the information belongs to you. You have the following rights regarding your health information:

- Right to Inspect and Copy. With some exceptions, you have the right to review and copy your health information.
  *You must submit your request in writing to P.O. Box 278 Loreauville LA, 70552. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.*
- Right to Amend. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for the Facility.
  *You must submit your request in writing to P.O. Box 278 Loreauville LA, 70552. In addition, you must provide a reason for your request.*
  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  Is not part of the health information kept by or for the Facility; or
  Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.
*You must submit your request in writing to P.O. Box 278 Loreauville LA, 70552. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.*

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.
We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
*You must submit your request in writing to P.O. Box 278 Loreauville LA, 70552. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.*

Right to Request Alternate Communications. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.
*You must submit your request in writing to P.O. Box 278 Loreauville LA, 70552. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.*

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact (337) 229-4214.

## CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Facility and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the Facility administrator.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility or with the Secretary of the Department of Health and Human Services. To file a complaint with the Facility, contact the administrator at (337) 229-4214. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
In the event your complaint remains unsolved with Rural Health Clinic of Loreauville, complaints can be filed with the Louisiana Department of Health via their website (https://ldh.la.gov/page/3768) or by phone (225) 342-0138.

The undersigned, as a patient or authorized representative of the patient, attests that they have reviewed, understand, and agree to all information included within the HIPAA Privacy Practices Consent document.

Patient/Legal Representative Name (Printed) _____ Relationship to Patient _____

Patient/Legal Representative Signature _____ Date _____

# Rural Health Clinic of Loreauville

Phone (337) 229-4212♦ Fax (337) 229-4065

I, _____ DOB _____, understand that in order to continue to receive care with Rural Health Clinic of Loreauville, I must comply with the following rules:

1. Patients who are more than 15 minutes late for their scheduled appointment may be rescheduled.
2. 24-hour notice is required for all cancellations; later notice is considered a missed/ no show appointment and the patient will be charged accordingly.
3. After 3 missed/ no show appointments, I understand that I will be discharged/ terminated.

_____ (initial)

4. I realize that all medications have potential side effects, and I agree to have the recommended laboratory studies required to keep the regimen as safe as possible.
5. I understand that office visits are required for the renewal of all prescriptions.
   a. I understand that I will attend my follow-up appointments as scheduled, or I will not be able to receive a new prescription.
6. I agree to take medications at the dose and frequency prescribed by my provider.
   a. I understand that my medication prescriptions will ONLY be refilled as scheduled by my provider; early renewal of prescriptions is NOT permitted.
   b. I understand that lost, stolen, or damaged prescriptions or medications will NOT be replaced.
   c. I will NOT use any illegal controlled substances including marijuana, cocaine, heroin, etc. during and after my treatment.
   d. I will NOT share, sell, or trade my prescribed medications.
   e. I will NOT change medication dosages on my own without permission from or without consulting my provider.

_____ (initial)

7. I understand that I cannot request or accept controlled substances or medications from any other provider/ provider without consulting my provider, or my treatment will be discontinued/ terminated.
   a. I will use one pharmacy to obtain my prescriptions; failure to comply with this policy will result in discontinued/ terminated treatment.
   b. I understand that the Prescription Drug Monitoring Program will be checked periodically throughout my treatment.
   c. I understand that urine drug screens can be scheduled or randomly unannounced and I must submit to testing at the provider's discretion. Failure to comply with drug screens; abnormal drug screens will result in discontinued/ terminated treatment.
   d. I understand that I must bring ALL medications to EVERY appointment for unannounced periodic pill counts. Failure to comply with this policy will result in denial of refills or discontinued/terminated treatment.

_____ (initial)

8) I understand that this signed agreement is valid throughout my continuous care with my provider, and failure to comply with the terms of this agreement will result in the withdrawal of ALL prescribed medication(s) by my provider and the termination of the provider/patient relationship.

9) I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my medications and I authorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including La. Board of Pharmacy, in the investigation of any possible misuse, sale, or diversion of my medication(s). I authorize my provider to provide a copy of this agreement to my pharmacy and any other provider involved in my care.

10) I am aware that the medication(s) I am being prescribed may have the ability to be addictive and/or may cause impairment of my ability to safely perform any activity. I agree that I will NOT attempt to perform the activity until my ability to perform that activity has been evaluated by my provider.

*This agreement will be placed in my medical record, and I will be provided with a copy upon request.

Patient Signature: _____ Date: _____

# PAST MEDICAL HISTORY

Do you have now, or have you had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Heart Disease | Yes | No | Hyperthyroid | Yes | No |
| Heart Attack | Yes | No | Kidney Stones | Yes | No |
| Heart Arrhythmia | Yes | No | Stroke | Yes | No |
| Atrial Fibrillation | Yes | No | Gallbladder Disease | Yes | No |
| Congestive Heart Failure | Yes | No | Anemia | Yes | No |
| Hypertension | Yes | No | Chronic Back Pain | Yes | No |
| Vascular Disease | Yes | No | Rheumatoid Arthritis | Yes | No |
| Diabetes | Yes | No | Lyme Disease | Yes | No |
| Insulin Dependent | Yes | No | Psoriasis | Yes | No |
| Non-insulin Dependent | Yes | No | Depression | Yes | No |
| High Cholesterol | Yes | No | Osteoporosis | Yes | No |
| Lung Disease | Yes | No | Neuropathy | Yes | No |
| Asthma | Yes | No | Hypothyroidism | Yes | No |
| Reflux Disease (GERD) | Yes | No | Fibromyalgia | Yes | No |
| Ulcers | Yes | No | Colitis | Yes | No |
| Cancer (location)_____ | Yes | No | | | |
| Blood Clots (DVT or PE) | Yes | No | | | |

Other:_____

# PAST SURGICAL HISTORY

Please list any operations you have had:

_____

_____

_____

_____

_____

_____

_____

# FAMILY/SOCIAL HISTORY

| Your personal habits: | Do you? | | Do you have a Family History of: | | | Relationship |
|---|---|---|---|---|---|---|
| Exercise Regularly | Yes | No | Heart Disease | Yes | No | _____ |
| Smoke or use Tobacco | Yes | No | High Blood Pressure | Yes | No | _____ |
| • How much daily _____ | | | Diabetes | Yes | No | _____ |
| • For how many years _____ | | | Stroke | Yes | No | _____ |
| Used tobacco in the past | Yes | No | Cancer | Yes | No | _____ |
| • How long have you quit _____ | | | Thyroid Disease | Yes | No | _____ |
| Drink Alcohol | Yes | No | Depression | Yes | No | _____ |
| • How much _____ | | | Blood Clots | Yes | No | _____ |

# REVIEW OF SYSTEMS

Have you recently been troubled with any of the following symptoms?

| | | | | | | |
|---|---|---|---|---|---|---|
| Backache | Yes | No | | Blood Sputum | Yes | No |
| Leg Pain | Yes | No | | Indigestion | Yes | No |
| Painful Joints | Yes | No | | Abdominal Pain | Yes | No |
| Headaches | Yes | No | | Diarrhea | Yes | No |
| Double Vision | Yes | No | | Constipation | Yes | No |
| Difficulty Swallowing | Yes | No | | Change in Bowel Habits | Yes | No |
| Hoarseness | Yes | No | | Slow Urine Stream | Yes | No |
| Nosebleeds | Yes | No | | Abnormal Bleeding | Yes | No |
| Shortness of Breath | Yes | No | | Blood in Stool | Yes | No |
| Dizziness | Yes | No | | Pus in Urine | Yes | No |
| Chest Pain/Pressure | Yes | No | | Yellow Jaundice | Yes | No |
| Irregular Heartbeat | Yes | No | | Depression/Anxiety | Yes | No |
| Swelling of Feet | Yes | No | | Weight Gain | Yes | No |
| Cough | Yes | No | | • How many pounds _____ | | |
| Sneezing | Yes | No | | Weight Loss | Yes | No |
| Vomited Blood | Yes | No | | • How many pounds _____ | | |
| | | | | • | | |
| | | | | • | | |

# LIST OF CURRENT MEDICIATIONS

Pharmacy: _____ Location: _____ Ph #: _____

| Medication (Generic & Brand Name) | Dose | How often do you take medication? | Prescriber |
|---|---|---|---|
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411 South Main Street
Loreauville, LA 70552

# TELEHEALTH CONSENT FORM

I, _____ (Patient Name) hereby consent to engage in Telehealth with Rural Health Clinic of Loreauville.
I understand that Telehealth is a mode of delivering health care services, including psychotherapy and medication management, via communication technologies (e.g., Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

***By signing this form, I understand and agree to the following:***

1.____I have a right to confidentiality regarding my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy and medication management. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my Mental Health Provider also apply to my Telehealth services.

2. ____I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my Mental Health Provider, that my psychotherapy and medication management sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. ____I understand that miscommunication between myself and my Mental Health Provider may occur via Telehealth.

4. ____I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. ____I understand that at the beginning of each Telehealth session, my Mental Health Provider is required to verify my full name and current location.

6. ____I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my Mental Health Provider believes I would be better served by in-person therapy, my Mental Health Provider will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other Mental Health Providers who can provide such services.

7. ____I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. ____I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my Mental Health Provider may record the sessions without the other party's written permission.

9. ____I have discussed the fees charged for Telehealth with my Mental Health Provider and agree to them [or for insurance patients: I have discussed with my Mental Health Provider and agree that my Mental Health Provider will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g., co-payments)], and I have been provided with this information in the Informed Consent to Treat.

10. ____I understand that my Mental Health Provider will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my Mental Health Provider may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

**I have read and understand the information provided above, have discussed it with my Mental Health Provider, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.**

*[For conjoint or family therapy, patients may sign individual consent forms or sign the same form.]*

_____ _____
Patient's Signature Date

_____
Patient's Printed Name

## Verbal Consent Obtained

The Mental Health Provider reviewed the Telehealth Consent Form with the Patient, the Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving psychotherapy and medication management services from the Mental Health Provider via Telehealth.

_____ _____
Mental Health Provider's Signature Date


411 South Main Street
Loreauville, LA 70552

1. I authorize the Rural Health Clinic of Loreauville, to use appropriate telecommunication technologies to evaluate and diagnose my medical condition and any health complaints.
2. I understand that technical issues may arise before or during telehealth sessions and, on occasion, my appointments may not start or end at agreed-upon times.
3. I accept that medical professionals will attempt to contact me using video conferencing software. However, I also understand that other communication channels, such as telephone calls may be used in case of internet connectivity or other issues.
4. I understand that my insurance plan may not cover telehealth services. In cases where my insurance plan does not cover any expenses which have been incurred. I will be personally liable to cover these expenses.
5. I give the Rural Health Clinic of Loreauville permission to access my medical records for ongoing documentation, evaluation, and analysis. I understand that all confidential information will be kept private.

☐ *I agree to the terms and conditions listed above.*

---

Name: _____ DOB: _____

Relationship to Patient: _____ Date: _____

Signature: _____

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Verbal Consent Obtained

The Provider has reviewed the Telehealth Consent Form with the Patient, the Patient understands and agrees to the terms and conditions listed above, and Patient has verbally consented to receiving telehealth services from the Provider via Telehealth.

_____ _____

Provider's Signature Date


411 South Main Street
Loreauville, LA 70552

## Advance Directive
## (Living Will)

I understand that it is my responsibility to furnish Rural Health Clinic of Loreauville with a copy of my advance directive, if any, for placement in my medical record.

*(patient/representative to INITIAL appropriate section below.)*

I DO have a living will and/or power of attorney for medical decisions and:
____ copy was furnished to place in my chart.
____ copy will be obtained from the prior provider and placed in the chart.
____ did not bring, will restate my wishes, or have been instructed to bring.

I DO NOT have an advance directive/living will and:
____ am not interested in any information.

Patient Signature:_____ Date:_____

Patient Representative:_____ Date:_____

Relationship to patient_____

Witness: _____

Date/Time Signed _____ / _____ a.m. p.m.