New Patient Questionnaire

Patient Name: _____
Date: _____
Street Address: _____
_____
Mailing Address: (if different from above)
_____
_____
PHONE NUMBERS:
Home: _____
Mobile: _____
Work: _____
Email Address: _____

Social Security Number: _____

Date of Birth: _____

Marital Status: Married Divorced Single Widow (circle one)

Work Status: Full Time/ Part Time/ Unemployed (circle one)

Ethnicity: Hispanic/ Non-Hispanic (circle one)

Race: Asian/ White/ African American/ American Indiana/ Alaska Native (circle one)

What Pharmacy do you prefer? _____

Does anyone have **medical power of attorney** on your behalf? YES / NO

Emergency Contact Information:

Name: _____

Relationship to Patient: _____

Phone Number: (_____)_____

Address: _____

If patient is a minor, parents or guardians fill out next section:

Name of Parent/Guardian: _____

SSN of Parent/Guardian: _____

Date of Birth of Parent/Guardian: _____

If address and phone number are same as listed on pg1, check box ☐

Address: _____

_____

Phone Number: _____

Insurance Information

Do you have health insurance? Yes / No

Name of Insurance: _____

ID #: _____

Policy Holder (if not the patient):_____

Policy Holder's DOB: _____

Name of Secondary Insurance (if applicable):_____

ID # of Secondary Insurance: _____

Policy Holder (if not the patient): _____

Policy Holder's DOB: _____

*****Please have your Driver's License or ID card and insurance card(s) ready to give to the front desk clerk to scan in your chart. *****

I certify that I have read or had read to me the above questionnaire and that all of the information is correct.

I have been provided with a HIPPA privacy and release of information authorization form.

Patient's Signature/Legal Representative:	Date:
_____	_____

HISTORY INTAKE FORM

Montgomery FAMILY CLINIC

NAME: _____
DATE OF BIRTH: _____

1. Personal Medical History: What have you been treated for in the past?

- ADD/ADHD
- AIDS/HIV
- ABUSE/DOMESTIC VIOLENCE
- ALLERGIES/HAYFEVER
- ANEMIA
- ANESTHESIA COMPLICATIONS
- ANXIETY
- ARTHRITIS
- ASTHMA
- AUTISM SPECTRUM DISORDER
- BEDWETTING
- BIRTH DEFECTS OR INHERITED DISEASES
- BLADDER OR KIDNEY PROBLEMS
- BLOOD DISEASES
- BLOOD TRANSFUSION
- BREAST CANCER
- BREAST PROBLEM
- COPD
- CANCER
- CHICKEN POX
- CHRONIC EAR INFECTIONS
- CONGESTIVE HEART FAILURE (CHF)
- CONSTIPATION
- CORONARY ARTERY DISEASE (CAD)
- DEPRESSION
- DEVELOPMENTAL OR BEHAVIORAL DISORDERS
- DIABETES
- DIFFICULTY SWALLOWING
- DIVERTICULITIS
- EAR OR HEARING PROBLEMS
- EATING DISORDERS
- ECZEMA
- ENDOMETRIOSIS
- FIBROMYALGIA
- GI PROBLEMS
- GOUT
- HEADACHES
- HEART DISEASE
- HEART PROBLEMS
- HEPATITIS
- HIGH CHOLESTEROL
- HOSPITALIZATIONS
- HYPERTENSION
- HYPERTHYROIDISM
- HYPOTHYROIDISM
- INFERTILITY
- KIDNEY DISEASE
- KIDNEY STONES
- LIVER DISEASE
- LUNG DISEASE
- MRSA EXPOSURE
- MENIERE'S DISEASE
- MENTAL DISORDER
- MENTAL ILLNESS
- MUSCLE, JOINT, OR BONE PROBLEMS
- OBESITY
- OSTEOPOROSIS
- OVARIAN CANCER
- POLYPS
- PRE-ECLAMPSIA
- PULMONARY EMBOLISM
- REFLUX/GERD
- SEIZURES/EPILEPSY
- SKIN PROBLEMS
- STROKE
- THROMBOPHILIAS
- THYROID PROBLEMS
- VARICOSITIES
- VISION/EYE PROBLEM
- OTHER_____

What specialty physicians do you <u>CURRENTLY</u> see? (Cardiology, ENT, pain management, pulmonology, etc.): _____

Please list any recent hospitalizations. Include hospital(s) name/location, date(s) hospitalized and reason(s) for being hospitalized.

_____
_____
_____

Please list any known allergies:

_____
_____

2. **Surgical History**: What surgeries have you had in the past? (include endoscopy studies – colonoscopy, upper GI study, and performing physician if known)

Procedure Date (year, month if known)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

3. Social History. Please answer or circle appropriately.

Highest Level Education grade/degree completed: _____

Occupation _____

Live alone or with others? Alone With Others

Exercise Level None Little Moderate Heavy

Do you smoke? Current Never Former: quit ____ year/mo. ago
If so, how many packs_____ how many years_____

Do you use smokeless tobacco? No Yes (how much) _____

Do you consume alcohol? None Occasional Moderate Heavy

Illicit drug use? Never
Current (list substance) _____
Former (list substance) _____

Do you follow a diet?
No (Regular)
Yes (choose one) Cardiac Diabetic Vegetarian Other_____

Caffeine intake: None Occasional Moderate Heavy

Sexually Active? No Yes (protected) Yes (unprotected)

4. Family History. What has your family been diagnosed with?

Mother Living Deceased (age of death) _____
_____
_____

Father Living Deceased (age of death) _____
_____
_____

Sibling(s) Living Deceased (age of death) _____
_____
_____

Other significant family history (list relationship):

Living Deceased (age of death) _____
_____
_____

*********FEMALES ONLY**********
(Answer only those that apply)

Date of last Pap smear _____
Ever had abnormal Pap smear Yes No

Most recent mammogram _____
If post-menopausal, age at menopause_____

HPV (*(human papilloma virus)* Vaccine Yes No

Sexually Active Yes No
Sexual Problems Yes No
STIs/STDs Yes No

Age at first child _____

On Birth Control Pills at conception? Yes No

Current Birth Control Method _____

Desired Birth Control Method _____

Date of LMP _____

Duration of flow (days) _____

Frequency of cycle _____

Menses monthly? Yes No

Age of first menstrual cycle _____

Other significant history: _____

MONTGOMERY FAMILY CLINIC

RELEASE OF PROTECTED HEALTH INFORMATION AUTHORIZATION

PATIENT INFORMATION

PATIENT NAME	DOB	AGE
PHYSICAL ADDRESS	CITY	STATE / ZIP
MAILING ADDRESS	CITY	STATE / ZIP
HOME PHONE	CELL PHONE	SSN

INDIVIDUAL/ORGANIZATION *REQUESTING* MEDICAL RECORDS

INDIVIDUAL/ORGANIZATION			
ADDRESS	CITY	STATE	ZIP
CONTACT PERSON	PHONE	FAX	EMAIL

INDIVIDUAL/ORGANIZATION *RELEASING* MEDICAL RECORDS

INDIVIDUAL/ORGANIZATION			
ADDRESS	CITY	STATE	ZIP
CONTACT PERSON	PHONE	FAX	EMAIL

PROTECTED HEALTH INFORMATION TO BE RELEASED

- ☐ **Entire Health Record**
- ☐ Operative Report(s)
- ☐ History & Physical(s)
- ☐ Behavioral Health Record
- ☐ Consultation Report(s)
- ☐ Radiological Report(s)
- ☐ Progress Note(s)
- ☐ Behavioral Health Testing Results
- ☐ Lab Report (s)
- ☐ ED Record(s)
- ☐ Vaccination Record(s)
- ☐ Behavioral Health Hospital Stay information
- ☐ Hospital Stay Information
- ☐ EKG (s)
- ☐ Billing Records
- ☐ OTHER (*please specify*)_____

The following information will be released when included in the above unless you indicate otherwise:

- ☐ **DO NOT** release any AIDS/HIV test results.
- ☐ **DO NOT** release any records pertaining to alcohol/substance abuse treatment.
- ☐ OTHER (*please specify*)_____

I, the undersigned patient or legal patient custodian, hereby authorizes the above named *releasing* individual or organization to provide the information requested above to the above named *requesting* individual or organization. This authorization is only for this purpose and only for this occasion. Any other protected health information not requested is not authorized for release or distribution. Further, should other information be requested, I will provide a new authorization delineating the information to be released or distributed. I may revoke this authorization at any time, except to the extent that it has already relied upon it in making use or disclosure. I understand that a written request to revoke an authorization may be sent to the clinic in writing. I have the right to refuse to sign this authorization and was not coerced or manipulated to do so. I understand that my healthcare provider cannot provide healthcare services, receive payment, inquire about my insurance enrollment or eligibility for benefits on the me without providing this signed authorization. I understand that if healthcare services are being provided to me for the purpose of providing information to a third party (e.g. insurance company), that services may be denied if I do not authorize the release of information related to such healthcare services to the third party. I understand that I maintain the right to inspect or copy the protected health information to be used or disclosed in accordance with RS 40:1299.96. When my health information is used or disclosed pursuant to this authorization, I understand that it may be subject to re-disclosure by the recipient or any of its agents and/or employees. Further, I agree that a photocopy/facsimile of this authorization may serve as the original.

Patient/Authorized Person	Relationship to Patient	Today's Date
Witness	Title	Today's Date

FOR CLINIC USE ONLY

IF REQUESTING FROM ANOTHER PROVIDER

DATE OF REQUEST	TIME OF REQUEST	METHOD OFREQUEST ☐ FAX ☐ US MAIL ☐ UPS/FEDEX ☐ EMAIL ☐ HAND DELIVERY *Tracking Number:*	STAFF WHO REQUESTED
DATE OF RECEIPT	TIME OF RECEIPT	METHOD OFRECEIPT ☐ FAX ☐ US MAIL ☐ UPS/FEDEX ☐ EMAIL ☐ HAND DELIVERY *Tracking Number:*	STAFF WHO RECEIVED

IF SENDING TO ANOTHER PROVIDER

DATE OF REQUEST	TIME OF REQUEST	METHOD OFREQUEST ☐ FAX ☐ US MAIL ☐ UPS/FEDEX ☐ EMAIL ☐ HAND DELIVERY *Tracking Number:*	STAFF WHO REQUESTED
DATE OF SEND	TIME OF SEND	METHOD OFSEND ☐ FAX ☐ US MAIL ☐ UPS/FEDEX ☐ EMAIL ☐ HAND DELIVERY *Tracking Number:*	STAFF WHO SENT

Medical Information Release Form

Montgomery FAMILY CLINIC

Name:

Date of Birth:

Release of Information

_____I authorize the release of information including the diagnosis, records, (for example: lab results, medication/prescription information, pathology reports, etc.), examination rendered to me and claims information. This information may be released to:

____ Spouse_____

____ Child(ren)_____

____ Parent(s)_____

____ Other_____

____ Information is not to be released to anyone.

Signature: _____

Date:_____

This ***Release of Information*** will remain in effect until terminated by me in writing.

CONSENT FOR TREATMENT

The undersigned, as a patient or authorized representative of a patient, hereby consents to any and all medical, behavioral, preventative, and other healthcare related evaluation and management and diagnostic testing ("healthcare services") as may be deemed advisable by my 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 the healthcare provider as to the results of healthcare services including: diagnosis, examinations, or treatments in any Clinic, or in a hospital, or other healthcare organization.

Signature: _____ Date: _____

HIPPA Privacy & Release of Information Authorization

Montgomery FAMILY CLINIC

Patient Name:

Patient DOB:

Patient ID:

I, _____ hereby authorize Montgomery Family Clinic and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information release to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to Montgomery Family Clinic. However, this authorization may not be revoked if; Montgomery Family Clinics' employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authorization.

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am a legal representative of the member identified above and will provide written proof (e.g. , Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the member's behalf with respect to this authorization form.

_____

Patient Printed Name Date

_____

Patient Signature

FINANCIAL POLICY

I. **ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE:** Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes all applicable deductibles, coinsurances, and copayments for participating insurance companies. **Montgomery Family Clinic/ BJC Healthcare, LLC** accepts payment via cash, personal checks, VISA or MasterCard. Please be advised there is a $25.00 service charge for returned checks.

II. **INSURANCE:** We will bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, coinsurance and copayments at the time of service. It is your responsibility to be sure all charges are paid whether by you or by your insurance carrier. We will bill secondary insurance companies.

III. **REMAINING BALANCES AFTER INSURANCE HAS PAID:** Montgomery Family Clinic/BJC Healthcare, LLC will submit a claim to your primary health insurance company for your services rendered. We will bill secondary insurance company, if applicable. Once your insurance(s) has/have processed your claim, we will post any payment we receive to your account. If there is a remaining balance, this is now your responsibility. This balance may be due to your deductible, coinsurance and any all non-covered charges. Payment for this balance is due within 30 days of you receiving your statement. Payment Plans are available.

IV. **COLLECTIONS ACCOUNTS:** Our office will make every effort to communicate with you about your account and will present reasonable options for payment. Outstanding balances that have not been paid after 6 months will be turned over to collections.

V. ***MEDICAID/BAYOU HEALTH PATIENTS WAIVER*:** You are responsible for keeping your records with Medicaid and your Bayou Health Plan current. If you have other insurance coverage besides your Medicaid, it is important for you to report this to your Bayou Health Plan. If your claim is denied due to outdated primary insurance information on your Bayou Health or Medicaid records, **Montgomery Family Clinic/BJC Healthcare, LLC will bill you for the charges directly.** The Bayou Health Plans will not pay without and Explanation of Benefits from the primary Carrier. If you have a Primary insurance listed on your records and this insurance is no longer in effect, we cannot get payments for the services rendered if you do not update your information and have this insurance removed from your Bayou Health Records. By signing this policy you acknowledge you are aware of this policy.

If you have questions, please contact our Insurance/Billing Department **between 8:00 a.m. and 5:00 p.m. on Monday through Thursday and between 8:00 a.m. and 12:00 noon on Friday at 318-646-3000.**

I have read and agree to the above financial policy, and hereby authorize my insurance carrier to make payment to Montgomery Family Clinic/BJC Healthcare, LLC on my behalf for any and all of my services rendered. I also agree that if it becomes necessary to forward my account to a collection agency for any overdue balances.

Signature: _____ Date: _____

Witness: _____ Date: _____

641 Rowena Street
P.O. Box 37
Montgomery, LA 71454
Tel 318-646-3000
Fax 318-646-3003

Montgomery
FAMILY CLINIC

TO PROSPECTIVE PATIENTS:

BJC Healthcare, LLC/ Montgomery Family Clinic welcomes the opportunity to provide the highest quality medical assistance and treatment to you.

However, due to high patient volume of involvement in personal liability claims and/or lawsuits against third parties this has caused great administrative cost and burden to **BJC Healthcare, LLC/ Montgomery Family Clinic.**

BJC Healthcare, LLC/ Montgomery Family Clinic does not evaluate and/or treat patients who are involved in any actual or potential ligation and/or liability claims.

BJC Healthcare, LLC/ Montgomery Family Clinic respectfully requests that you acknowledge the following statement in the space provided below.

"THERE IS NO PENDING OR PROSPECTIVE LIABILITY CLAIM AND/OR LAWSUIT ASSOCIATED WITH MY MEDICAL CONDITION(S) THAT WILL BE EVALUATED TODAY BY BJC HEALTHCARE, LLC/ MONTGOMERY FAMILY CLINIC."

ACKNOWLEDGED AND AGREED TO THIS DATE: _____

_____
Signature

_____
Witnessed By: (Office Staff)

PAIN MANAGEMENT/CONTROLLED SUBSTANCES AGREEMENT

Montgomery FAMILY CLINIC

_____ Pt. Initials **The purpose of this Agreement is to prevent misunderstandings** about certain medicines you will be taking for pain management or controlled substances such as anti-anxiety medication (Examples-Valium, Xanax) or ADD/ADHD medications. This is to help both you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ Pt. Initials **I understand that this Agreement is essential to the trust and confidence** necessary in a provider/patient relationship and that my doctor undertakes to treat me based on this Agreement.

_____ Pt. Initials **Because these medicines have the potential for abuse or diversion, strict accountability is necessary.**

_____ Pt. Initials **I understand that if I break this Agreement,** my provider will stop prescribing these pain-controlled medications/controlled substances.

_____ Pt. Initials **I agree to notify my provider of any and all pain medications or prescriptions that I receive from other providers** (effective from date of this agreement and ongoing). Such notification should occur by next business day following receipt of prescription. **If I fail to alert my provider I understand I may be discharged from the practice.**

_____ Pt. Initials **I understand that someday my provider may wean me partially or totally from narcotics** if he/she determines that, in the long run, this is likely to be in my best interests. In such situations other meds or therapies will likely be suggested as part of my new treatment plan, I agree to respect my provider's opinion in such circumstances and comply with the new treatment plan.

_____ Pt. Initials **I understand that if I am suspected of diverting or distributing my pain medications/controlled substances, my provider will immediately cease prescribing** these medications. In this case, my provider will be required to comply with local stat and/or federal reporting requirements and investigation.

_____ Pt. Initials **I would also be amenable** to seeking psychiatric treatment, psychotherapy and/or psychological treatment if my provider deems necessary.

_____ Pt. Initials **I agree to communicate fully and honestly with my provider** about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping relieve the pain.

_____ Pt. Initials If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy. I also understand that my state may have regulations concerning driving while under the influence of drugs and accept responsibility for adhering to those regulations.

_____ Pt. Initials **I understand the use of opiates or pain medications in combination with anti-anxiety medications such as Valium or Xanax may cause me to stop breathing and abnormal heart rhythms resulting in injury or death.**

_____ Pt. Initials **I understand that strong medications, which may include opiates and other controlled substances, which I may be prescribed, have potential risks and side effects, including the risk of addiction.** An over-dosage with an opiate medication may cause injury or death. Other possible complications include, but are not limited to, constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function.

_____ Pt. Initials **I will not use any illegal controlled substances, including marijuana, cocaine, etc., not will I misuse or self-prescribe/medicate with legal controlled substances**. Use of alcohol will be limited to a time when I am not driving, operating machinery and will be infrequent.

_____ Pt. Initials **I will not share, sell or trade my medication with anyone.**

_____ Pt. Initials **I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider**.

_____ Pt. Initials **I will inform my provider of ALL current medications** including herbs, vitamins, supplements, and over-the-counter medications. I will provide an updated medication list during every visit.

_____ Pt. Initials **I will not alter my medicine in any way or use any other administrative method other than what has been prescribed.** Long-term agents (MS Contin, Oxycontin, etc.) must be taken whole and are not allowed to be broken, chewed, crushed, injected and/or snorted. Potential toxicity could occur due to rapid absorption if taken inappropriately, which may lead to death.

_____ Pt. Initials **I understand that suddenly stopping some medications** (including opioids and sedatives) can cause substantial discomfort over and above any increase in my chronic pain causing psychological distress, extreme achiness and fatigue, nausea, trembling, etc.

_____ Pt. Initials **I will avoid withdrawal symptoms by budgeting my pills, not taking more medications than prescribes, and keeping my appointments for refills. I understand that 'running out' of itself is not grounds for insisting an 'emergency or urgent appointment'.**

_____ Pt. Initials **I will safeguard my pain medicine/controlled substances from loss or theft.** Lost or stolen medicines will not be replaced.

_____ Pt. Initials **I agree that refills of my prescriptions for pain medicine/controlled substance will be made only at the time of an office visit or during regular office hours.** No refills will be available during evenings or on weekends.

_____ Pt. Initials **I agree that prescriptions for pain medicine/controlled substances will not be refilled earlier than the agreed upon renewal date.**

_____ Pt. Initials **(Males Only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance.** I understand that my prescriber/provider may check my blood or request that my primary care provider do routine testing to see if my testosterone level is normal. Please be aware your insurance may not cover these tests, therefore if deemed medically necessary you agree to be responsible for any costs not covered by your insurance.

_____ Pt. Initials **(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately call my obstetric doctor and prescribing prescriber/provider to inform them.** I am aware that should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids, infant drug withdrawal can be life threatening. As a female of childbearing age, I certify that I am not pregnant and will use appropriate contraceptive measures during the course of treatment with opioids/controlled substances.

_____ Pt. Initials I understand that any serious misbehavior such as yelling, threatening, cursing, etc. will likely be the cause for dismissal from the practice.

_____ Pt. Initials **I understand that changing date, quantity, or strength of medicines or altering a prescription in any way is against the law.** Forged prescriptions and/or forged provider's signatures are also against the law, if any of these instances occur, it will result in an immediate termination from this practice.

_____ Pt. Initials **I authorize the doctor and my pharmacy to cooperate fully with any city, state of federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine or other controlled substances.** I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ Pt. Initials I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medicine/controlled substance. Tests may include screens for illegal substances, and your cooperation is required. **Refusal of such testing may subject you to an abrupt/rapid wean schedule in order for the medication to be discontinued or prompt termination from care.**

_____ Pt. Initials **I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.**

_____ Pt. Initials If I chose to have my medications filled by a new pharmacy not listed below, I will be required to sign an amendment to this agreement with my updated pharmacy information.

I agree to use _____ Pharmacy,

Located at _____,

Telephone # _____, for filling prescriptions for all of my medicine/controlled substances.

(Signature) _____ (legal guardian if under age 17)