Crowley Primary Care, LLC
1325 Wright Avenue Suite A
Crowley, LA 70526
PH: 337 788-3032

Thank you very much for entrusting us with your medical care!
We look forward to seeing you, and want your visit here to be a pleasant experience for you.

Enclosed is our medical information packet. If you would help us by completing the packet and returning it to us along with a copy of your insurance card prior to your appointment, it would assist us tremendously. This will allow the doctor to have your current medical information, and will allow our office staff to set up your insurance information correctly.

Our office is located in the Tower One building behind the Acadia General Hospital in Crowley. We are located on the first floor in Suite A.

Should you have any questions or concerns, please feel free to call us at any time.

Sincerely,

Kellie Lege

KellieLege
Office Manager

Enclosure

REGISTRATION INFORMATION
(please print)

Date____________________ Home Phone _________________________ Cell_________

Patient ____
Last Name First Name Initial

Patient's Social Security Number:____

Street Address____

City__________________________ State______________ Zip______________________
Email Address ________________
Sex □M □F Age____________ Birthdate _____________________________________
□ Full-Time Student □ Part-Time Student Patient's School Name __________________
□ Employed
Patient employed By____

Occupation____________________ Employer Phone Number_______________________

Employer Address ____

Spouse (or responsible party) Name ______________________ Birthdate_______________

Social Security Number of Spouse (or responsible party) __________________________

Spouse's Employer______________________________________ Employer's Phone ________

Address of Spouse's Employer ____________________________

Who is responsible for this account? (please specify relationship)____________________

In an emergency, whom should we notify? (other than spouse) ______________________

Phone _________________________________ Relationship to patient ____________________

(other than your own)

Do you have Medical Insurance □No □Yes If yes, please complete below:

Name of Primary Insurance Company ____

Member ID#_______________________________ Group #_____________________________

Secondary Insurance Company (if any) ____

Member ID# _______________________________ Group#_____________________________

Is your condition related to employment? (current or previous) □No □ Yes

Is your condition related to an auto accident? □No □ Yes

Other accident? □No □Yes Please describe ______________________________________

Please list other doctors that you have seen within the past five years:
1\. ____ City/State __________________________
(General Practitioner, Specialist or other)

Reason for seeing ____

2. ______________________________ City/State ____________________
(General Practitioner, Specialist or other)

Reason for seeing ____

How did you learn of our practice? ________________________________

Whom may we thank for referring you? ____________________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with ______________________________
Name of Insuring Company

and assign directly to Crowley Primary Care, LLC all medical 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 insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

______________________________ ______________________________
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Crowley Primary Care, LLC, for any services furnished me by those physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA - 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________________________
Beneficiary Signature Date

MEDICAL CHART REVIEW PATIENT RELEASE FORM

Insurers and managed care companies occasionally review medical charts to insure compliance with company procedures. I understand that my chart may be selected for such review and that the confidentiality of the information in my chart will be preserved and I hereby consent to such review and release these physicians and any such insurer or managed care company for liability for any reasonable review of my chart.

____
Signature of Patient or Parent, if Minor

Patient Name:_______________________________ Date of Birth: ________________________

MEDICAL HISTORY QUESTIONNAIRE

1. Are you allergic to anything? **Yes or No.** If yes; please list allergies here:____
____
____
____

2. List any other current/past medical problems (example: high blood pressure, diabetes, high cholesterol, cancer, etc.)

Current Medical Problems:

____
____
____
____
____
____

3. List any surgeries you have had in the past:

Past Surgeries:

____
____
____
____
____

4. Do you currently smoke? **Yes or No.** If Yes, how much do you smoke per day?____________

If no, have you ever smoked? ____________ How long ago?________________

How long did you smoke for (number of years)?_____________________________

How many packs/day during that time?______________________________________

5. Do you drink alcohol? **Yes or No.** If yes, how often do you drink?___________

If yes, what type of alcohol do you drink?_____________________________________

FAMILY HISTORY:

***Mom** – Living? ____________________ If so, list Mom's medical problems here: ____

____

Deceased? __________ Age at time of death: ______ Cause of Death: ________

***Dad** – Living? ____________________ If so, list Dad's medical problems here: ____

____

Deceased? __________ Age at time of death: ______ Cause of Death: ________

*Does anyone in your immediate family have cancer? **Yes or No**. If yes, please list relationship and type of cancer:

____

____

____

********PLEASE BRING ALL MEDICATIONS WITH YOU********

And fill in your medications below:

____

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Crowley Primary Care, LLC
1325 Wright Avenue Suite A
Crowley, LA 70526
PH: 337 783-4043

FINANCIAL POLICY

Thank you for choosing us as your healthcare providers. We value your trust in us and look forward to accommodating your medical needs. In order to devote our full attention to your health, we would like to clarify our financial policy prior to your treatment.

We would appreciate your reading and signing (all places indicated) the following. Please feel free to speak to our office staff or office manager regarding any questions that you may have.

Our office operates on a cash basis. Payment is due at the time of service unless:

1. You possess a valid Medicaid card
2. You are insured through a contracted care agreement in which we participate and under which we have been able to establish/verify the benefits **prior to your treatment**.

For your convenience, we accept cash, checks, Care Credit, or Visa/Mastercard/Discover/American Express. We are also able to do an automated payment to your checking account.

With regard to Insurance: (Private, Non-contracted care):
As a convenience to you, our patient, we are happy to file insurance claims on your behalf with certain insurance companies. Although we are happy to provide this service whenever possible, please be aware that health insurance is a contract between you and your insurance company. Please notify us of any changes in your coverage.

With Regard to Insurance: (Contracted care):
We are pleased to be included as participating providers in many contracted care plans.
We are legally required to collect co-pays *at the time of each visit* as established under these plans.
Also, as with private insurance, we do need you to furnish us with current information on your insurance company (such as company name, address and phone number) and a copy (front and back) of your insurance card. We must be able to establish these items as well as to verify the benefits under your particular plan prior to your visit. Please notify us as well of any changes in your coverage.

Credit Card Authorization for Outstanding Balances

We ask that you provide us with an authorization for outstanding balances determined by your healthplan to be *your* responsibility. After filing your insurance, we will charge your credit card or checking account for any amounts deemed to be your responsibility for one of the following reasons:

- Deductible not met
- Your insurance has a copayment amount for which you are personally responsible
- There is no coverage for the medical service under your policy

- Your insurer voids or retrospectively terminates the benefits under your policy

Or

- There is a shift in payment responsibility from your insurer to you, the patient.

Billing patients for remainder balances is one of the highest expenses in our office overhead. This credit/debit card authorization is meant to reduce these billing costs, and thus avoid having to pass this cost on to you, our valued patient. It is our intent to provide the most cost-efficient care possible to our community, and to only increase our charges when absolutely necessary:

An easily identifiable example of this charge authorization practice is that of a hotel requesting your credit card when checking in. This authorization covers any incidental charges that the hotel may incur such as food, beverages, internet, or whatever else may not be included in the hotel's initial price. Likewise, medical practices run the same risk in many instances. It has been our experience that on numerous occasions, our medical practice has not been reimbursed for medical services and/or supplies (such as vaccines) rendered to the patient or insured.

Please rest assured that the information you provide us with us is secure. Your credit card information is not stored in our system – only your authorization is. Your credit card information is encrypted and stored in a manner that is inaccessible to any of our staff. It is stored in its encrypted form with our contracted processing service, which provides the highest level of service.

Acknowledgment of Payment Responsibility and Authorization to Charge Credit or Debit Card:

I hereby state that I am personally responsible for the payment of my own and/or my dependent's medical care. I authorize Crowley Primary Care, LLC to charge my credit or debit card for any medical services rendered to me and/or my dependent named herein for charges that are not covered by my own and/or my dependent's health insurance policy. I hereby provide my credit or debit card information to Crowley Primary Care, LLC as set forth herein.

I further understand that the payments for which I may be personally responsible include, but are not limited to, co-payment(s) deductible(s) and/or any outstanding balances or fees that are not covered by my own and/or my dependent's health insurance policy.

I, ______________________________, hereby authorize Crowley Primary Care to charge my credit or debit card for the balance of charges not paid by my insurer in the event that there is an outstanding balance due after the bills submitted to my insurance company for reimbursement were reviewed by my insurance company. I agree to keep Crowley Primary Care notified of my current address and/or email address so that the appropriate receipt for payment will be sent to me.

I am aware that if my insurer pays Crowley Primary Care after my credit or debit card has been charged, my card will be reimbursed in the amount paid by my insurance company. In the alternative, if I so desire, I can request that Crowley Primary Care retain all or some part of that amount, as a credit on my account for my next visit. If I have any questions, I can contact Crowley Primary Care at 337 783-4043.

I affirm that the statements contained herein are true to the best of my knowledge: that I am authorized to incur this charge to my credit or debit card, and that I hereby authorize future credit card charges necessary to pay outstanding balances as stated above.

Patient name:______________________________

Signature of Patient and/or Legal Guardian: ______________________________

Date:

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Due to the complexity and differences in individual cases, prices for office visits and procedures may vary. Should you wish to obtain a cost estimate, please feel free to ask our office staff.

Treatment of Minor Patients
The adult accompanying a minor patient is responsible for payment. Rather than becoming involved in custody disputes, we simply require that arrangement for payment be made *prior* to the minor's visit so that the *accompanying adult* furnishes payment.

Thank you for your understanding of our Financial Policy. We ask that you please let us know if you have any questions or concerns.

I have read the Financial Policy of Crowley Primary Care. I understand and agree to the terms of this policy.

X______________________________ Date: ______________
Patient or responsible party

Designation of Personal Representative (PHI) and Consent for Medical Care

Crowley Primary Care, LLC
1325 Wright Avenue Suite A
Crowley, LA 70526
PH: 337-783-4043

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with regard to Protected Health Information (PHI), you have a right to nominate one or more persons to act on your behalf with respect to your health information. By completing this form, you are informing us of your wish to designate the named person as your personal representative(s). You may revoke this designation at any time by signing and dating the revocation statement included at the bottom of this form and sending a copy to us.

I, ________________________________(print name) with ________________(date of birth), hereby give consent to the physicians, practitioners, and other qualified medical personnel of Crowley Primary Care to treat me, recommend and/or order tests as indicated for diagnosis of my medical condition, and obtain my medical and medication history from other providers and facilities. I nominate the following person(s) to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

Name of Personal Representative	Phone Number	Relationship
Name of Personal Representative	Phone Number	Relationship
Name of Personal Representative	Phone Number	Relationship
Name of Personal Representative	Phone Number	Relationship
Name of Personal Representative	Phone Number	Relationship
Name of Personal Representative	Phone Number	Relationship

This/these persons is/are to be afforded all the privileges that would be afforded to me with respect to my heath information.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to the office of Crowley Primary Care, LLC at 1325 Wright Ave. Suite A, Crowley, LA 70526. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

____ ______________________
Patient's signature Date

____ ______________________
Parent or Guardian Print name/Signature Date

Revocation Section

I hereby revoke this designation of the following personal representative:

____
Personal Representative being Revoked

_______________________________________ ______________________
Signature Date

Crowley Primary Care, LLC
1325 Wright Avenue Suite A
Crowley, LA 70526
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POLICY ON PAIN MANAGEMENT

It is the policy of Crowley Primary Care. LLC that any patient being seen by a pain management doctor will not have his or her pain management medications filled in this clinic. If you should discontinue your relationship with your pain management doctor. Crowley Primary Care, LLC WILL NOT under any circumstances or any time refill any pain management medications or assume responsibility for your pain management needs.

If it is necessary, in the opinion, of one of the physicians of Primary Care, LLC, to prescribe pain medication or other controlled substance to you for a condition he or she is treating, please be aware that you should safeguard your script. If the script for pain medication or controlled substance is lost, it will not be replaced.

Signing this document indicates that you understand and will comply with this policy. This document will be part of your medical record. Your cooperation is appreciated.

____
Print Patient Name

____
Date of Birth

____
Patient Signature

____
Date

Crowley Primary Care, LLC
1325 Wright Avenue Suite A
Crowley, LA 70526
Phone: (337) 783-4043
Fax: (337) 783-4053

Policy Regarding "No Show, Rescheduled, and Cancelled" Appointments

It is our goal to treat our patients in a caring, timely, and efficient manner. "No show" appointments prevent us from seeing and scheduling patients in a timely manner, and also pose a health risk to patients.

In an effort to discourage "no show" appointments, the following policy has been implemented. In the event that a patient **does not show up for an appointment, cancels or reschedules an appointment on short notice**, a note will be made in his/her medical record. Not showing up for three appointments can result in a patient's discharge from this practice.

Failure to give **24 hour notice** of cancellation or rescheduling of an appointment or not showing up for an appointment will result in a **charge of $25** to your account. This charge is not covered by your insurance company and it is your responsibility. Failure to pay a no-show fee will be treated the same as our policy regarding any other unpaid balances and will be subject to reporting to a collection agency if unpaid.

Please sign acknowledging your understanding of the above policy:

______________________________ ______________________________

Signature Printed Name and Date

NOTICE OF PRIVACY PRACTICES

Crowley Primary Care, LLC
1325 Wright Avenue Suite A
Crowley, LA 70526
PH: 337 783-4043

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose: *The following privacy practices are adopted to ensure that Crowley Primary Care, LLC and the office staff of Crowley Primary Care, LLC comply fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is very important to our organization. Violations of any of these provisions will result in severe disciplinary action.*

Effective Date: *These practices are in effect as of April 4, 2003*

Expiration Date: *These practices remain in effect until amended or cancelled.*

Should you have any additional questions regarding these practices, please contact Dr. Nancy Briley Walker at 337 788-3032

Crowley Primary Care, LLC collects health information from you and store it in a chart and on a computer. The information compiled by Crowley Primary Care, LLC during the course of your treatment is your medical report (your "chart"). This medical report is the property of Crowley Primary Care, LLC, but the information in the report belongs to you. Crowley Primary Care LLC and her staff protect the privacy of your health information. The law permits Crowley Primary Care LLC to use or disclose your health information for the following purposes.

Treatment: Crowley Primary Care, LLC will use your information sheet, your health history sheet, and any notes that his nurse or he takes during his examination of you to make a diagnosis of your condition. He may then prescribe medicine, do diagnostic testing such as x-rays, laboratory tests, etc. The information that Crowley Primary Care, LLC obtain in the course of their treatment of you may need to be shared with a pharmacy for authorization of filling prescriptions for you, or with another physician whom he feels you need to see. It is possible that your medical records may need to be mailed or faxed to another physician who is going to participate in your care, or to an insurance company or outside source such as a hospital or treatment facility that we may be sending you to. We may also need to discuss these records and your treatment with the physician or authorized representative at that outside source.

Payment: We may use and disclose health information about you so that the treatment and services you receive from us can be billed to and payment collected from you, an insurance company or a third party. *For example,* we may need to give your health plan information about your office visit so that your health plan will pay us or reimburse you for a visit. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover this treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and to make sure that all of our patients receive quality care. For *example,* we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for our patients. Also, there are times when we may be monitored or audited by various insurance companies. At such times, representatives from those companies may come in and randomly pull charts in order to monitor such things as quality of care, record keeping, etc.

Health-related Services and Treatment Alternatives: We may use and disclose health information to tell you about health-related services or recommend possible treatment options that may be of interest to you.

Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Health and Safety: We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Notification and Communication With Family: We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location or your general condition. If you are available to agree or object, our health professionals will use their best judgment in communication with your family and others. Please understand that this office will not violate your privacy rights if at all possible. Normally, we will have a signed consent before disclosing your information, but there are circumstances that are beyond our control and times where we may need to contact others regarding your health care.

Health Oversight Activities: We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Person Information: We may disclose your health information to coroners, medical examiners and funeral directors.

Organ Donation: We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Uses and Disclosures of Protected Health Information

It is the policy of Crowley Primary Care, LLC that protected health information may not be used or disclosed except when at least one of the following conditions is true:

1. The individual who is the subject of the information (i.e. the "subject individual") has authorized the use or disclosure.
2. The individual who is the subject of the information has consented to the use or disclosure and the use or disclosure is for treatment, payment or health care operations.
3. The individual who is the subject of the information does not object to the disclosure and the disclosure is to persons involved in the health care of the individual or for facility directory purposes.
4. The disclosure is to the individual who is the subject of the information or to HHS for compliance-related purposes.
5. The use or disclosure is for one of the HIPAA "public purposes" (i.e. required by law, etc.)

Deceased Individuals

It is the policy of Crowley Primary Care, LLC that privacy protections extend to information concerning deceased individuals.

Notice of Privacy Practices

It is the policy of Crowley Primary Care, LLC that a notice of privacy practices must be published, that this notice and any revisions to it be provided to all subject individuals at the earliest practicable time, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices.

Restriction Requests

It is the policy of Crowley Primary Care, LLC that serious consideration must be given to all requests for restrictions on uses and disclosures of protected health information as published in this organization's notice of privacy practices. It is furthermore the policy of this organization that if a particular restriction is agreed to, then this organization is bound by that restriction.

Minimum Necessary Disclosure of Protected Health Information

It is the policy of Crowley Primary Care LLC that (except for disclosures made for treatment purposes) all disclosures of protected health information must be limited to the minimum amount of information needed to accomplish the purpose of the disclosure. It is also the policy of this organization that all requests for protected health information (except requests made for treatment purposes) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

Access to Protected Health Information

It is the policy of Crowley Primary Care, LLC that access to protected health information must be granted to each employee or contractor based on the assigned job functions of the employee or contractor. It is also the policy of this organization that such access privileges should not exceed those necessary to accomplish the assigned job function.

Access to Protected Health Information by the Subject Individual

It is the policy of Crowley Primary Care, LLC that access to protected health information must be granted to the person who is the subject of such information when such access is requested.

Amendment of Incomplete or Incorrect Protected Health Information

It is the policy of Crowley Primary Care, LLC that incorrect protected health information maintained by this organization will be corrected in a timely fashion. It is also the policy of this organization that notice of such corrections will be given to any organization with which the incorrect information has been shared.

Access by Personal Representatives

It is the policy of Crowley Primary Care, LLC that access to protected health information must be granted to personal representatives of subject individuals as specified by subject individuals.

Confidential Communications Channels

It is the policy of Crowley Primary Care, LLC that confidential communications channels be used, as requested by subject individuals, to the extent possible.

Disclosure Accounting

It is the policy of Crowley Primary Care, LLC that an accounting of all disclosures of protected health information be given to subject individuals whenever such an accounting is requested.

Complaints

It is the policy of Crowley Primary Care, LLC that all complaints relating to the protection of health information be investigated and resolved in a timely fashion.

Prohibited Activities

It is the policy of Crowley Primary Care, LLC that no employee or contractor may engage in any intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA regulations. It is also the policy of this organization that no employee or contractor may condition treatment, payment, enrollment or eligibility for benefits on the provision of an authorization to disclose protected health information.

Responsibility

It is the policy of Crowley Primary Care, LLC that the responsibility for designing and implementing procedures to implement this policy lies with the chief privacy officer (i.e. "CPO").

Verification of Identity

It is the policy of Crowley Primary Care, LLC that the identity of all persons who request access to protected health information be verified before such access is granted.

Mitigation

It is the policy of Crowley Primary Care, LLC that the effects of any unauthorized use or disclosure of protected health information be mitigated to the extent possible.

Business Associates

It is the policy of Crowley Primary Care, LLC nat business associates must be contractually bound to protect health information to the same degree as set forth in this policy.

Cooperation with Privacy Oversight Authorities

It is the policy of Crowley Primary Care LLC that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of health information within this organization. It is also the policy of this organization that all personnel must cooperate fully with all privacy compliance reviews and investigations.

I hereby acknowledge receipt of a copy of the above Notice of Privacy Policy

____

Signature & Date

LOUISIANA DEPARTMENT OF HEALTH

Authorization to Release or Obtain Health Information

(including paper, oral and electronic information)

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Medicaid # or Social Security #

I authorize:

Name: Crowley Primary Care (Drs. Robert Aertker, Stephen Cannon, Claire Ronkartz, Nancy Walker, and Megan Chachere, FNP-C)

Mailing Address: 1325 Wright Ave, Suite A

City, State, Zip Code: Crowley, LA 70526

Relationship: Provider Telephone Number: 337-783-4043 (Fax: 337-783-4053)

☐ **TO RELEASE Information TO** OR ☐ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: ____________________

Mailing Address: ____________________

City, State, Zip Code: ____________________

Relationship: ____________________ Telephone Number: ____________________

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Physicians
☐ Research related treatment ☐ Creating health information for disclosure to a third party.
☐ Other: (Specify)____________________

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests
☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports
☐ X-ray Reports ☐ MR/DD Records ☐ Other: ____________________

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

☐ Alcoholism † ☐ Drug Abuse † ☐ Mental Health ☐ Vocational Rehabilitation ☐ HIV (AIDS)
☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes
☐ Other____________________

This authorization shall expire on ____________________ (date or event) and is needed for the period beginning ______________ and ending ______________.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

____________________ ____________
Signature of Individual or Personal Representative Authorized by Law Date

____________________ ____________
Signature of Witness *(If signed with an "X" or mark)* Date

For LDH Use When Requesting Records

I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

____________________ ____________
Signature and Title of Agency Representative Date

† **Provider shall be given a copy of signed document that acknowledges their receipt of Federal Rule 42 CFR § 2.32 - Prohibition on redisclosure.**

Important Information about Authorization

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form.

A separate signed authorization form is required for the use and disclosure of health information for:

- Psychotherapy notes
- Employment-related determinations by an employer
- Research purposes unrelated to your treatment
- Substance Use (Alcohol and Drug Use)

When required by law or policy, LDH may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, LDH will use and disclose your health information as you have authorized on the signed authorization form.

You may be required to sign an authorization before receiving research-related treatment.

You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by LDH, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to LDH.

You may cancel an authorization in writing at any time. LDH can not take back any uses or disclosures already made before an authorization was cancelled.

Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by LDH privacy policies.

YOUR RIGHT TO FILE A PRIVACY COMPLAINT

You may contact the privacy office listed below if you want to file a complaint or to report a problem about how LDH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. LDH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful.

Your Privacy office contact is:

State of Louisiana - Louisiana Department of Health
Office of Secretary - Privacy Office
Post Office Box 629
Baton Rouge LA 70821-0629
Email: privacy-LDH@la.gov

Crowley Primary Care, LLC

1325 Wright Avenue Suite A
Crowley, LA 70526
PH: 337-783-4043
Website: www.crowleyprimarycare.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Revised on
July 18, 2019

This Notice of Privacy Practices applies to the following organizations.
Crowley Primary Care, LLC

_______________________________ ________________

Patient Signature (Acknowledgment) *Date*

____

Claudette Bihm, Office Manager
PH: 337-783-4043

Medicare Shared Savings Program
Accountable Care Organizations

Crowley Primary Care is participating in Aledade Louisiana ACO, LLC, an Accountable Care Organization (ACO). An ACO is a group of doctors, hospitals, and/or other health care providers that work together to improve the quality and experience of care you receive. ACOs receive a portion of any savings that result from reducing costs and meeting quality requirements.

- Medicare evaluates how well each ACO meets these goals every year. Those ACOs that do a good job can earn a financial bonus. ACOs that earn a bonus may use the payment to invest more in your care or share a portion directly with your providers. ACOs may owe a penalty if their care increases costs.
- Our participation in Aledade Louisiana ACO, LLC doesn't limit your choice of health care providers. Your Medicare benefits are not changing. You still have the right to visit any doctor, hospital, or other provider that accepts Medicare at any time, just like you do now.
- To help us coordinate your health care better, Medicare shares information about your care with your providers. If you don't want Medicare to share your health care information, call 1-800-MEDICARE (1-800-633-4227).

How do ACOs work?

- An ACO **isn't** a Medicare Advantage plan which is an "all in one" alternative to Original Medicare, offered by private companies approved by Medicare. An ACO **isn't** an HMO plan, or an insurance plan of any kind.

Important!

- ACOs have agreements with Medicare to be financially accountable for the quality, cost, and experience of care you receive.
- Coordinated care can avoid wasted time and costs for repeated tests and unneeded appointments. It may make it easier to spot potential problems before they become more serious – like drug interactions that can happen if one doctor isn't aware of what another has prescribed.
- ACOs may use electronic health records, case managers, and electronic prescriptions to help you stay healthy. Some ACOs have special programs to encourage you to have a primary care visit or use their care management team. Participation in these programs is optional.

What information will be shared about me?

- Medicare shares information about your care with your health care providers; like dates and times you visited a health care provider, your medical conditions, and a list of past and current prescriptions. This information helps Aledade Louisiana ACO, LLC track the care and tests that you've already had.
- Sharing your data helps make sure all the providers involved in your care have access to your health information when and where they need it.
- **We value your privacy**. ACOs must put important safeguards in place to make sure all your health care information is safe. We respect your choice on how your health care information is used for care coordination and quality improvement. If you want Medicare to share your health care information with Aledade Louisiana ACO, LLC or other ACOs in which your health care providers participate, there's nothing more you need to do.
- If you **don't** want Medicare to share your health care information, **call 1-800-MEDICARE** (1-800-633-4227). Tell the representative that your health care provider is part of an ACO and you don't want Medicare to share your health care information. TTY users should call 1-877-486-2048.

MEDICARE
SHARED SAVINGS
PROGRAM

- If you change your mind and want to let Medicare share your health information again, call 1-800-MEDICARE to let Medicare know. We aren't allowed to tell Medicare for you.
- Even if you decline to share your health care information, Medicare will still use your information for some purposes, like assessing the financial and quality of care performance of the health care providers participating in ACOs. Also, Medicare may share some of your health care information with ACOs when measuring the quality of care given by health care providers participating in those ACOs.

How can I make the most of getting care from an ACO?

- Ask your clinician if they have a secure online portal that gives you 24-hour access to your personal health information, including lab results and provider recommendations. This will help you make informed decisions about your health care, track your treatment, and monitor your health outcomes.
- As a Medicare beneficiary, you can choose or change your primary clinician or "main doctor" at any time. Your primary clinician is the health care provider that you believe is responsible for coordinating your overall care. If you choose a primary clinician, that clinician may have more tools or services to help with your care. You can learn more in the Voluntary Alignment Beneficiary Fact Sheet.

For step-by-step instructions on how to select or change your "main doctor," refer to the Choosing a Primary Clinician video (https://youtu.be/HgRe4VCH2_I).

What if I have concerns about being part of an ACO?

- If you have concerns about the quality of care or other services you receive from your ACO or provider, you can contact your Medicare Beneficiary Ombudsman who can assist you with Medicare-related questions, concerns, and challenges. The Medicare Beneficiary Ombudsman works closely with the Medicare program, including Medicare.gov, 1-800-MEDICARE, and State Health Insurance Assistance Program (SHIPs), to help make sure information and assistance are available for you. Visit Medicare.gov for information on how the Medicare Beneficiary Ombudsman can help you.
- If you suspect Medicare fraud or abuse from your ACO or any Medicare provider, we encourage you to make a report by contacting the HHS Office of Inspector General (1-800-HHS-TIPS) or your local Senior Medicare Patrol (SMP).