NEW PATIENT REGISTRATION FORM

Montgomery FAMILY CLINIC

PATIENT INFORMATION

Patient Name_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Mailing Address ☐ check if same

_____ City_____State_____ Zip_____

Phone #: Home_____Cell_____Work_____

Email Address _____ Social Security #_____

Date of Birth_____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow

Work Status: ☐ Full Time ☐ Part Time ☐ Unemployed

Race: ☐ Asian ☐ White ☐ African American ☐ American Indian ☐ Alaska Natvie

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#_____ Address_____

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

Name of Parent/Guardian _____ Date of Birth of Parent/Guardian _____

SSN of Parent/Guardian _____ Phone #_____

Address ☐ check if same as listed above _____

INSURANCE INFORMATION

Do you have health insurance? ☐ Yes ☐ No

1. Name of Insurance_____ ID #_____

Policy Holder (if not the patient)_____ Policy Holder's DOB_____

2. Name of Secondary Insurance (if applicable)_____ ID #_____

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 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

Montgomery FAMILY CLINIC

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 CURRENTLY 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:_____

_____

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)

SOCIAL HISTORY

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 If so, how many packs_____for how many years_____

Former: quit _____ year/mo. ago

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)

FAMILY HISTORY

What has your family been diagnosed with?

Mother: ☐ Living ☐ Deceased (age of death) ____ Father: ☐ Living ☐ Deceased (age of death) ____

_____ _____

_____ _____

Siblings(s): ☐ Living ☐ Deceased (age of death) ____ Other significant family history (list relationship):

_____ _____

_____ _____

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: _____

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.

_____ _____

Patient's Signature/Legal Representative Date

MEDICAL INFORMATION RELEASE

Name_____

Date of Birth_____

_____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.

_____ _____

Patient's Signature/Legal Representative Date

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

LEGAL MATTERS

BJC Healthcare, LLC/ Dry Prong 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/ Dry Prong Family Clinic.

BJC Healthcare, LLC/ Dry Prong 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/ Dry Prong 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/ DRY PRONG FAMILY CLINIC."

ACKNOWLEDGED AND AGREED TO THIS DATE _____

Signature_____ Witnessed By (Office Staff)_____

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

Montgomery FAMILY CLINIC

1. 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. Dry Prong 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.
2. 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.
3. REMAINING BALANCES AFTER INSURANCE HAS PAID: Dry Prong 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.
4. 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.
5. *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, Dry Prong 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 Dry Prong 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.

Print Patient Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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 the following Pharmacy for filling prescriptions for all my medicine/controlled substances:

Name of Pharmacy_____

Address_____

Phone #_____

_____ (legal guardian if under age 17

Signature