

## Cardiac and Vascular Services of Cenla

My Primary Care Provider (PCP) is: \_\_\_\_\_

Do you have a Medical Power of Attorney?  Yes  No

Do you have a Living Will?  Yes  No

### Patient Information

Patient Legal First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

Home Address : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

How do you want us to contact you: Home  Cell  Work  Marital Status: \_\_\_M\_\_\_S\_\_\_D\_\_\_W\_\_\_Other

Language Preference:  English  Other: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: Hispanic/Non-Hispanic/Decline

Employer: \_\_\_\_\_  Retired

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Responsible Person's or Spouse Information

Legal First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

Address : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

### Authorized Contacts:

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

1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

3) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Insurance Information

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Social Security #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Social Security #: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Preferred Pharmacy

Name: \_\_\_\_\_ Street: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Cenla Family Medicine Associates, LLC  
Central Louisiana Foot and Ankle Specialists  
Cardiac and Vascular Services of Cenla  
Alexandria Gastroenterology Associates**

**Patient's Notification and Signature Form**

Print Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please initial all:

I have received a copy and have read the HIPPA Notice of Privacy Practices Policy for the clinic.

\_\_\_\_\_ Patient or Guardian's Initial

I have received a copy and have read the Patient Consent for Use and Disclosure of Protected Health Information Policy for the clinic.

\_\_\_\_\_ Patient or Guardian's Initial

I have received a copy and have read the Payment Policy for the clinic. \_\_\_\_\_

\_\_\_\_\_ Patient or Guardian's Initial

I have received a copy and have read the No Show Policy for the clinic.

\_\_\_\_\_ Patient or Guardian's Initial

I have received a copy and have read the Authorization of Care for the clinic.

\_\_\_\_\_ Patient or Guardian's Initial

I authorize the release of any information necessary to process this claim and authorize payment of benefits to Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists, Cardiac and Vascular Services of Cenla, and/or Alexandria Gastroenterology Associates for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

\_\_\_\_\_ Patient or Guardian's Initial

I authorize my insurance company to pay benefits directly to Cenla Family Medicine Associates, LLC and/or Cardiac and Vascular Services of Cenla for charges relating to all services.

\_\_\_\_\_ Patient or Guardian's Initial

**PRESCRIPTION HISTORY CONSENT**

**I agree that the clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.**

**Yes \_\_\_\_\_ (please initial)**

**No \_\_\_\_\_ (please initial)**

I recognize my responsibility and my rights as a patient of Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists and/or Cardiac and Vascular Services of Cenla.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

## CENLA FAMILY MEDICINE ASSOCIATES PATIENT/PROVIDER AGREEMENT

Good communication between patients and physicians/providers is the key to better outcomes. The staff at Cenla Family Medicine Associates, offices of Dr. Screpetis, Dr. McBride, Dr. Buck, Dr. Michelle Beurlot, Dr. Jonathan Hunter, Dr. Maria Saucier, Dr. Paul Sunderhaus, Dr. Joseph Hollier, Kim Sills, FNP, Frances Turregano, FNP, Dana Homer, FNP, Amy Langston, FNP and Tina Billberry, FNP are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.DM

### Our Responsibilities to You:

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

### Your Responsibilities to Us:

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

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

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

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider or Representative Signature

\_\_\_\_\_  
Date



### Family Illnesses

Check in the **Self** column if any of the following has happened to you. Check the **Blood Relative** if any of the following has happened to a blood relative and state the relationship.

**Key- M: mother, F: father, S: sibling, PGF or PGM: paternal grandfather or grandmother, MGF or MGM: maternal grandfather or grandmother, PA or PU: paternal aunt or uncle, MA or MU: maternal aunt or uncle.**

Self	Blood Relative		Prescription Medication (you are taking currently)
_____	_____	Diabetes (sugar)	_____
_____	_____	High Blood Pressure	_____
_____	_____	High Cholesterol	_____
_____	_____	Stroke	_____
_____	_____	Heart Attack	_____
_____	_____	Congestive Heart Failure	_____
_____	_____	Cancer, type or site	_____
_____	_____	Mental Problems	_____
_____	_____	Arthritis	_____
_____	_____	Gout	_____
_____	_____	Alcoholism or drugs	_____
_____	_____	Asthma	_____
_____	_____	Breathing Problems	_____
_____	_____	Tuberculosis (TB)	_____
_____	_____	Cystic Fibrosis	_____
_____	_____	Allergies	<b>Medication Allergies</b>
_____	_____	Skin Problems	_____
_____	_____	Anemia	_____
_____	_____	Sickle Cell Disease	_____
_____	_____	Bleeding	_____
_____	_____	Seizures	<b>Surgeries</b>
_____	_____	Glaucoma	_____
_____	_____	Blindness before age 50	_____
_____	_____	Deafness before age 50	_____
_____	_____	Kidney Problems	_____
_____	_____	Bladder Problems	_____
_____	_____	Thyroid Problems	_____
_____	_____	Migraine	_____
_____	_____	Stomach Problems	<b>OTC (over the counter) Medication</b>
_____	_____	Bowel Problems	(you are currently regularly,
_____	_____	Rectal Polyps	please include any herbs or
_____	_____	Liver Problems	supplements)
_____	_____	Genetic/inherited diseases	_____
_____	_____	Other unusual diseases	_____

**Thank you for your cooperation.**