Minden Family Care Center

208 Morris Drive Minden, LA 71055 Phone 318.377.8260 Fax 318.377.9053

Patient information

Fill in ALL information below

Patient First Name ______________________ Last Name ______________________

E-mail address ____

Mailing Address: ______________________ City ____________ State _____ Zip ________

Physical Address: ______________________ City ____________ State _____ Zip ________

Sex M / F Date of Birth ____________ Social Security Number ________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Primary Language Other than English: ______________________ Race: ______________

Marital Status of Patient: ________________ Preferred Pharmacy: ______________________

Patient Employer: ______________________ Occupation: ____________ Phone ____________

Guardian Name: ______________________ DOB ____________ Phone # ______________

Emergency Contact Not Living with you: ______________________________ Phone # ____________

Next of Kin ______________________ Relationship ______________ Phone ______________

Insurance Information

Who is your primary care provider? Dr. Nida Karen L. Rhodes NP Ray Brown NP Beau Burton NP Dr. Fleming

Insurance Company: ______________________ Policy Number ______________________

Insured Person: ____________________ DOB ____________ Group Number ______________

Social Security Number ________________ Employer ______________________________

Please have your insurance identification card ready to present to the receptionist

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I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information and have completed the above answer. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

______________________________________ ______________

Signature of Patient Date

______________________________________ ______________

Signature of Parent if patient is a minor Date

Minden Family Care Center - MEDICAL HISTORY

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Name: ______________________________ DOB: ______________

Pharmacy: ______________________________

Allergies/Reactions: ______________________________

Current Medications

Medication	Dosage	Prescribing Doctor

Any Family Medical Problems: ______________________________

____

____

Social History

Smoking Status ____ Never a Smoker ____Former Smoker ____Current Smoker How much ______________

Advanced Directive ____No ____ Yes

Education Level: ______________________________

Are you currently employed ___ No ___ Yes

Exercise Level: ____None ____ Occasional ___Moderate ____ Heavy

General Stress Level: ____Low ____ Medium ____High

Caffeine intake: ____None ____ Occasional ___Moderate ____ Heavy

Alcohol Intake: ____None ____ Occasional ___Moderate ____ Heavy

Chewing Tobacco: ____No ____Yes How Much ______________________

Illicit Drugs: ____ No ____Yes

GYN History:

Date of Last Menstrual Period: ______________

Current form of Birth Control: ______________

Date of Last Mammogram ______________

Date of last Pap Smear ______________

______________________________ ______________________________

Patient/Guardian Signature Date

Minden Family Care Center - MEDICAL HISTORY CONT'D

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Name: ____ DOB: ____________________

Past Surgeries: Please list Surgery and date. ___ None

	Yes	No	Date	Comments
Appendectomy				
Bariatric Surgery				
Cataract surgery				
Colectomy				
Colonoscopy				
Gallbladder				
Heart surgery				
Hemorrhoids				
Hernia				
Hysterectomy				
Mastectomy				
Tonsil/adenoids				
Tubal Ligation				
Other Surgeries/Procedures:				

Past Medical History

	Yes	No
ADD or ADHD		
Acne		
Allergies		
Anemia		
Anxiety Disorder		
Arthritis		
Asthma		
BPH (Men only)		
Bed wetting		
Bladder/kidney problem		
Blood Diseases		
Breast Cancer		
Breast problem		
Bronchitis		
CHF		
COPD		
Cancer		
Chest Pain		
Chicken Pox		
Constipation		
Dementia		
Depression		

	Yes	No
Diabetes		
Diverticulitis		
Ear Infections		
Eczema		
GERD/Reflux		
Glaucoma		
HTN		
Headaches		
Heart Attack		
Heart Disease		
High cholesterol		
Hyperthyroidism		
Hypothyroidism		
Kidney Disease		
Liver Disease		
Lung Disease		
Memory Problems		
Muscle/joint or Bone problems		
PVD		
Seizures/Epilepsy		
Stroke		
Vision Problems		

______________________________________ ______________________

Patient/Guardian Signature Date

Minden Family Care Center - CONSENT FORM

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1. **Individuals Authorized to Discuss My Medical Information**: the individuals listed below have my permission to obtain and/or discuss my personal medical condition for all encounters until I change the information below.

   Name ______________________ Relationship ____________ Phone No. ____________

   Name ______________________ Relationship ____________ Phone No. ____________

   Name ______________________ Relationship ____________ Phone No. ____________

2. **Permission to Leave/Send Appointment Messages:** My signature below indicates my permission for Minden Family Care Center to leave recorded messages regarding the date, time and location of my scheduled appointment. My signature below also gives permission for text messages and emails to be sent to me.

3. **Financial Responsibility:** As a courtesy to you, we will bill your insurance company for services provided. ALL co-payments and unsatisfied deductibles must be paid at the time of service. I understand that I am ultimately responsible for all fees regardless of insurance coverage. I agree to pay the amount due in full at the time of service, and collection and/or attorney fees that are added to the unpaid balance. **Interest may also be added to any lien or account past due 120 day & over.**

4. **Authorization to Release Information Needed to Process Insurance Claim:** I authorize Minden Family Care Center to release any medical information necessary to process my insurance claims. I am fully aware my health information can be transmitted by electronic transmission, by fax transmittal, by internet or by e-mail. If another party in error receives them, I absolve Minden Family Care Center of any and all liability.

5. **Assignment of Insurance Benefits:** I hereby authorize payment for medical and surgical benefits to Minden Family Care Center. I authorize use of this signed form for all my insurance submissions.

6. **Medication History:** I grant the authority to Minden Family Care Center to download my medication history automatically from the pharmacy benefit managers (PBMs).

7. **Acknowledgement of Receipt of Privacy Notice:** I have been presented with a copy of Minden Family Care Center's Notice of Privacy Policies, detailing how my private health information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice. I request the following restriction(s) concerning my personal health information.

   ____

   ____

9. **Consent of Treatment:** I do hereby authorize Minden Family Care Center to provide medical care as may be deemed necessary in the judgment of the physician and/or Nurse Practitioner. This treatment may include but is not limited to: laboratory procedures, medication screening, non-invasive diagnostic and therapeutic procedures/treatments, injection of medication, and minor surgical procedures, such as wound suturing.

Patient Signature ________________________________ Date ______________

(Guardian if under age 18 years)

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Minden Family Care Center Office Guidelines

A Rural Health Clinic

Thank you for choosing Minden Family Care Center for your healthcare needs. We strive to provide the best possible service to our patients. To make your visit as pleasant as possible and prevent future misunderstandings regarding appointments and billing, please read and familiarize yourself with the following guidelines.

- Office hours are Monday-Friday 7:45am-5pm.
- For emergencies go to the closest emergency room.
- We ask that all patients complete necessary paperwork prior to their scheduled appointment. If you are unable to obtain the paperwork prior to your appointment, please plan on arriving 15 minutes early to complete needed forms. If you do not arrive early to complete paperwork, your appointment may be rescheduled. Paperwork can be found on the Minden Family Care Center website: www.mindenfamilycarecenter.com/patient-information/.
- If your Medicaid insurance plan is not "linked" to our clinic or a provider in our clinic, please call the number on your Medicaid card to do so prior to your scheduled appointment. Failure to do this may result in your appointment being rescheduled.
- Please bring all medical records from other providers which you have available.
- Please bring all medication bottles that you are currently taking.
- Please bring your most current insurance card to **every** visit.
- We update our patient demographics continually, including address, phone number, insurance, etc. Please be patient during this time.
- Please notify us if you are unable to keep your appointment as soon as possible. Failure to provide notification will be considered a "No-show." Three "No-shows" in a 6-month period will result in being on a walk-in only status.
- If you are more than 30 minutes late for your appointment we will make every effort to work you in if the schedule permits, however you may be asked to reschedule for a later date.
- Please be considerate if there is a wait time during your scheduled appointment. Emergencies occur and each patient will be treated with the time and care it takes to address their problem, including you.
- Children under the age of 18 will require a parent or guardian present for treatment.
- Prescription refills will be provided at scheduled appointments in quantities sufficient to last until your next scheduled appointment. Please remind us at your appointment if you will need refills.
- This clinic does not provide prescriptions for chronic narcotic medication. Please see our Drug Policy.
- Termination of the physician-patient relationship can occur at the request of the patient or the physician when the relationship is no longer proceeding in a mutually productive manner. If you are

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dismissed from the practice, emergency care only will be provided for 30 days to allow appropriate time to find further providers. Circumstances that may result in dismissal from the practice include:
  - Noncompliance with treatment
  - Failure to keep appointments
  - Threatening, demanding or abusive behavior directed toward our staff, physicians, other healthcare providers or patients
  - Deceptive behavior
  - Medication abuse
  - The patient leaves the practice
  - Failure to pay consistent with policy listed below
- Please be aware that you are responsible for any portion of your bill that is not paid by your insurance company.
- Patients will be responsible for any unpaid balance and notified of the balance monthly. At the end of 90 days unpaid balances may be turned over to a collection agency and the patient will be responsible for agency fees. Failure to remit payment on a past due account will result in possible dismissal from the practice.
- If you have a co-pay or co-insurance or are un-insured, payment is due at time of service.

I have read and understand the above policies, procedures and financial responsibilities, and agree to abide by this policy in exchange for quality medical care.

____
Patient's Name

____
Legal Guardian's Name

____________________________________ ________________
Signature of Patient or Legal Guardian Date

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Minden Family Care Center Drug Policy

Minden Family Care Center does not provide narcotic medications for long-term use. Patients with chronic pain (pain lasting greater than 3 months) will be referred to a Pain Management Specialist. Our office WILL NOT prescribe these medications in a chronic nature.

NARCOTIC PAIN MEDICATIONS:

Examples:

Hydrocodone (Norco)

Oxycodone (Percocet)

Hydromorphine (Dilaudid)

Demerol

Tramadol

____

Patient's Name

____

Legal Guardian's Name

____________________________________ ________________

Signature of Patient or Legal Guardian Date