Green Clinic TECH CARE

STOP Please **NOTIFY US** immediately if you have an emergency such as: Chest Pain, Head Injury, Shortness of Breath, Severe Abdominal Pain, or the Worst Headache of Your Life before continuing. STOP

Patient's Full Name (Last, First, Middle): _____

Sex: _____ Date of Birth: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

I authorize Green Clinic TechCare to communicate with me (in addition to phone and mail) via: ☐ Text Message ☐ Email

Street Address / P.O. Box: _____ Apt. / Lot #: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Email Address: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Preferred Pharmacy: _____

GUARANTOR (This is where your bill will be sent.) ☐Same as Person Above

Guarantor's Full Name (Last, First, Middle): _____

Street Address / P.O. Box: _____ Apt. / Lot #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN: _____ Phone: _____

PRIMARY INSURANCE INFORMATION Name of Insurance Carrier: _____

Patient's Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other: _____

Policy Holder's Full Name (Last, First, Middle): _____

Policy #: _____ Date of Birth: _____ SSN: _____

SECONDARY INSURANCE INFORMATION Name of Insurance Carrier: _____

Patient's Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other: _____

Policy Holder's Full Name (Last, First, Middle): _____

Policy #: _____ Date of Birth: _____ SSN: _____

AUTHORIZATION FOR ACCESS TO LOUISIANA TECH UNIVERSITY ADMISSION RECORDS

☐ I am a Tech Student. I authorize the release of my Louisiana Tech University admission records including demographic information, health history form, and immunization records to Green Clinic. _____ Initials

I certify that the information I have provided is true and correct to the best of my knowledge.

_____ _____

Patient Signature (if minor, signature of Parent/Guardian) Date

Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Name of Practice: Green Clinic

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

_____

Name of Personal Representative Phone

_____

Address

_____

City, State, Zip

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Officer. This can be done in-person or by mailing a request to:

  Green Clinic

  Attn: Privacy Officer

  1200 South Farmerville St

  Ruston, LA 71270

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the HIPAA Privacy Rule and will no longer be the responsibility of this practice.

_____ _____

patient signature date

Copies of signed authorizations are available upon request.

921 Tech Drive, PO Box 2134 | Ruston, LA 71273-2134 | Telephone: (318)251-4866

PATIENT AUTHORIZATION FORM

Patient's Full Name: _____

Patient's Date of Birth: _____

Assignment of Benefits / Payment Authorization:

I request that payment of authorized Medicare or other Health Insurance benefits be made to me or on my behalf to Green Clinic for any services furnished to me by that provider. The employees and agents of Green Clinic and copy services under contract with Green Clinic are authorized to release the Health Care Financing Administration and its agents or other insurance carrier and its agents any information about me needed to determine these benefits or the benefits payable for related services. This authorization will include verbal or photostatic release of medical information for the purpose of continuity of care, processing of insurance claims, performing precertification, determining benefits and payment.

Financial Agreement

I agree to pay Green Clinic for services/care rendered by Green Clinic physicians, lab services, x-ray services and any other services provided to me by the Green Clinic at the time service is provided.

Consent to Treatment

I hereby authorize Green Clinic physicians to administer such treatment or care deemed necessary or advisable in the diagnosis or treatment of this condition provided to myself or my dependents.

I hereby authorize Green Clinic to obtain electronic pharmacy records.

Notice of Privacy Practices

I have received the Green Clinic "Notice of Privacy Practices". _____

Initials

A photostatic copy of this assignment and release shall be considered as effective and valid as the original. This consent may be revoked by me at any time in writing, except to the extent that action has already been taken in reliance thereon. This authorization shall be valid for any current and future treatment that the provider may furnish and unless revoked earlier, is valid for the length of time necessary to process claims made on my account.

The undersigned certifies that he/she has read the foregoing, is the patient or legal representative of the patient, and hereby consents to this agreement.

_____ _____

Patient or Legal Representative ***Date***

NOTICE OF PRIVACY PRACTICES

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

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

- **You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask at the time of your next appointment. This Notice is also posted on the Green Clinic website.
- **You have the right to authorize other use and disclosure** - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.
- **You have the right to request an alternative means of confidential communication** – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.
- **You have the right to inspect and copy your PHI** - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines
- **You have the right to request a restriction of your PHI** - This means you may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.
- **You may have the right to request an amendment to your PHI** - This means you may request an amendment to your PHI for as long as we maintain this information. In certain cases, we may deny your request.
- **You have the right to request a disclosure accountability** – This means you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

- **You have the right to receive a privacy breach notice** - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required. If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Officer. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

- **Treatment** - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.
- **Special Notices** – We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt-out of such special notices, and each such notice will include instructions for opting out.
- **Payment** - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services that we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.
- **Healthcare Operations** - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.
- **Health Information Organization** - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.
- **To Others Involved in Your Healthcare** - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.
- **Other Permitted and Required Uses and Disclosures** - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the HIPAA Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Officer at:

Green Clinic, 1200 South Farmerville St, Ruston, LA 71270, or by phone at 318-251-6306

We will not retaliate against you for filing a complaint.

Effective Date: 8/05/2013 Publication Date: 8/05/2013