PLEASE PRINT AND BRING WITH YOU TO YOUR VISIT.

NORTHSHORE FAMILY MEDICAL CENTER

PATIENT INFORMATION

PATIENT'S NAME | DATE OF BIRTH | SOCIAL SECURITY #

STREET ADDRESS | CITY, STATE, ZIP

HOME PHONE # | CELL PHONE # | WORK PHONE #

Emergency Contact & relationship: Phone #:

Pharmacies local and mail-order:

PATIENT ALLERGIES:

COMMUNICATION PREFERENCES

1. May we leave messages on your answering machine? YES ☐ NO ☐
2. Would you like to receive TEXT messages? YES ☐ NO ☐
3. May we call you at work? YES ☐ NO ☐
4. May we leave messages with any other person? YES ☐ NO ☐ Specify who _____
5. Are we authorized to release your medical information to your spouse? YES ☐ NO ☐

PATIENT PORTAL AND EMAIL

*By giving us your email address you are agreeing to allow us to **email appointment reminders, lab letters, visit summaries and test reminders.** We will use your email address to grant access to the NORTHSHORE FAMILY PATIENT PORTAL.*

EMAIL ADDRESS: (please print):_____

The patient portal allows you to securely communicate with our staff. You can:

- Send Messages to your nurse
- View Health information as it becomes available
- Request appointments

PATIENT CONSENT FOR TREATMENT

1. I consent to the use and disclosure of my/the patient's protected health information for the purposes of obtaining payment for services rendered to me/the patient.
2. I authorize payments to Northshore Family Medical Center/Family Medicine Billing of SMH for services rendered.
3. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.
4. I also give permission for sharing and obtaining my health information via the Carequality Network which connects to local hospitals.
5. Co pays and deductibles are due at the time of the visit.
6. There is a $ 25.00 charge for late cancellations and No show appointments.

PATIENT OR AUTHORIZED PERSONS SIGNATURE **TODAY'S DATE**

NORTHSHORE FAMILY MEDICAL CENTER

PATIENT NAME:

DATE OF BIRTH:

Lab of choice: LabCorp ☐ Quest ☐ *Quest is in our office- It is important to use ONE of these Labs!*

Language:

Race: ☐ Asian ☐ Black ☐ Hispanic/Latino ☐ White ☐ Do not wish to report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Do not wish to report

Do you have a living will? ☐ YES ☐ NO *If yes -please provide us a copy at your convenience.*

(A living will tells your doctor what kind of care you would like to have if you are unable to make medical decisions.)

THIS IS A COPY OF OUR HEALTH INFORMATION AND DISCLOSURE –WE HAVE CAPTURED YOUR SIGNATURE ELECTRONICALLY

Northshore Family Medical Center generates and maintains paper and electronic health records, to describe your health history, symptoms, examinations, test results, diagnoses, treatments and as a record of your medications and medication history.

How we use your medical records:

* A means of sharing information among your doctors, nurses and pharmacists.
* **This includes sharing LAB RESULTS and TEST RESULTS with other providers.
* We will also request information from other providers in your circle of care.
* A source of information for paying for treatment.
* A means to verify that services billed were actually provided.
* Your Prescription history updated and accessed from centralized database.
* A tool for routine evaluation of healthcare professionals.

I understand that I have the following rights and privileges under federal regulations.

* * The right to review the complete notice before signing this consent.
* * A copy is at the front desk or our website. www.northshorefamily.net
* * The right to limit how my health information may be used.
* * The right to limit my health plans access to certain information.
* * The right to a copy of my electronic health record.

I understand that Northshore Family Medical Center is not required to agree to the restrictions requested, and that I may take back this consent in writing.

I also understand that by refusing to sign this consent or taking back this consent Northshore Family Medical Center may refuse to treat me- as permitted by Section 164.506 of the Code of Federal Regulation.

NORTHSHORE
FAMILY MEDICAL CENTER

Please print and bring with you to your visit.

Today's Date

PATIENT INFORMATION

Patient's Name:

Social Security #:

Date of Birth:

Home Phone #:

Cell Phone #:

Work Phone #:

Street Address:

City, State Zip:

Account Guarantor Name:

Guarantor Address:

Guarantor Date of Birth:

Guarantor SS #

Marital Status:

Spouse's Name

ALLERGIES

Medication Allergies:

Environmental or Food Allergies:

Tobacco Use:

Packs per day?

How many years?

Alcohol Use:

Drinks per day?

Other Drug Use:

PAST MEDICAL HISTORY

Previous Diagnosis(es):

Previous Surgeries:

Family History:

PREVIOUS MEDICAL TESTS

Bone Density Year?:

Colonoscopy Year?:

Eye Exam Year?:

Mammogram Year?:

Pap Smear Year?:

PSA Year?:

IMMUNIZATION HISTORY

Pneumonia Vaccine Year?:

Shingles Vaccine Year?:

Tetanus Vaccine Year?

Other Doctors You See ?

NORTHSHORE
FAMILY MEDICAL CENTER

HEALTH INFORMATION USE AND DISCLOSURE

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I also understand that by refusing to sign this consent or taking back this consent Northshore Family Medical Center may refuse to treat me- as permitted by Section 164.506 of the Code of Federal Regulation.

I have reviewed this copy of NSFMC's Patient Privacy Rights and give my permission to Northshore Family Medical Center to use and disclose my health information as needed.

SIGNATURE: _____

(patient or guardian) Date

NORTHSHORE
FAMILY MEDICAL CENTER

1150 Robert Blvd. Suite 100 Slidell, LA 70458 985-646-1122 Fax 888-865-7591

Authorization for Release of Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I understand that my health care will not be affected if I do not sign this form. I understand that I may revoke this request in writing.

Patient Name	Date of Birth
Street Address	City, State and Zip
Organization Providing the information Provider Name: Name of Clinic: Phone: Fax #:_____	Person or organization receiving the information Northshore Family Medical Center 1150 Robert Blvd. Suite 100 Slidell, LA 70458 985-646-1122 Fax 888-865-7591

Specific description of information

☐ ***** Please send ONLY information from the last 2 years.**
(Preferred- unless deemed medically necessary.)

☐ Other (please specify)_____

☐ Exclude drug, alcohol or psychiatric information

What is the purpose of the use or disclosure?	I understand this authorization expires on_____ Or in 6 months, whichever occurs first.
Signature	Todayôs Date
NSFMC office staff use: Date request was faxed_____ Records received_____	

NORTHSHORE
FAMILY MEDICAL CENTER
1150 Robert Blvd. Suite 100 Slidell, LA 70458 985-646-1122

Patient Name: _____

Date of Birth: _____ Phone #: _____

I give my permission for Northshore Family Medical Center to request and share my medical information with these providers. Medical Information including:

- OFFICE NOTES
- LABORATORY RESULTS
- APPOINTMENT INFORMATION
- EYE Examinations
- TEST RESULTS Imaging and Lab
- MEDICAL OPINIONS
- TREATMENT PLANS
- HOSPITAL including DC summary

My Doctors Names

• **Eye Doctor:**	**Last Visit**
• **GI (Gastroenterology)Doctor:**	**Last Visit**
• **Gynecologist:**	**Last Visit**
• **Cardiologist:**	**Last Visit**
• **Pulmonologist:**	**Last Visit**
• **Rheumatologist:**	**Last Visit**
• **Neurologist:**	**Last Visit**
• **Home Health/Hospital:**	**Last Visit**
• **Endocrinologist or OTHER:**	

PATIENT SIGNATURE_____TODAY'S DATE: _____

I understand that I may revoke this consent at any time. It expires 365 days from date, unless sooner is specified.

Please fax records to 888-865-7591