FCIM
FREEDMAN CLINIC INTERNAL MEDICINE

176 Versailles Blvd., Alexandria, LA 71303
Phone: (318) 445-9331 Fax: (318) 619-6899

PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

PATIENT information	Mr. Mrs. Miss/Ms.	First Name	Middle Name	Last Name
Patient's Date of Birth		Social Security Number		Marital Status: ☐ Married ☐ Partner ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Sex: Male ☐ Female ☐ Transgender ☐	Race: ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Native Hawaiian/ other Pacific Islander ☐ Other	Ethnicity: ☐ Hispanic ☐ Non-Hispanic		Primary Language:
E-mail address:				Does patient want to receive e-mail: yes ☐ no ☐
Home phone		Cell phone		Alternate Phone
Address	Street or P.O. Box	City	State	Zip Code
Patient's Employer	Name of Company	Address		Phone
Guardian or Spouse information	First Name	Middle Name	Last Name	
Phone number		Spouse's Date of Birth		Spouse's Social Security Number
Address if different from above				
Guardian or Spouse Employer	Name of Company	Address		Phone Number
Emergency Contact	Name	Relationship to patient		Phone Number (s)
Street or P.O. Box		City	State	Zip Code

IF YOU ARE LISTED AS THE DEPENDENT ON SOMEONE ELSE'S INSURANCE,
We need their name, address, date of birth and Social security number and phone number.

Policy Holders Name	Relationship to patient	Policy Holders date of birthdate	Policy Holders Social Security Number
Policy Holders Address			Policy Holders Phone number

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE.

METHODS OF PAYMENT ACCEPTED: CASH / CHECK / MONEY ORDER / CREDIT CARD

Signature _____ Date _____

Spouse or Guardian _____ Date _____

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176 Versailles Blvd.
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MEDICAL BENEFITS & HIPAA PRIVACY PRACTICES

PLEASE PUT YOUR INITIALS NEXT TO EACH STATEMENT TO SHOW THAT YOU HAVE READ THE FOLLOWING.

_____ I, the undersigned patient of Freedman Clinic of Internal Medicine, LLP, do hereby acknowledge that I have received a copy of the Notice of Privacy Practice of this office & it is my responsibility to read its contents. I understand that a copy will always be available to me. Furthermore, I understand that any questions that I may have can be directed to the Privacy Officer and/or my physician.

_____ I directly assign all Medical & Surgical Benefits provided by Freedman Clinic of Internal Medicine, LLP & understand that I am financially responsible for all charges whether or not paid by my insurance. In the event collection action becomes necessary, I agree to pay reasonable collection costs of the unpaid balance should my account be forwarded to a collection agency. I hereby authorize the provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

_____ I understand that my provider may require in the course of my treatment that I have lab work, radiology, diagnostics, and/or other procedures and etc. that will be performed by offices other than FCIM and that they will send me statements from their offices and FCIM is in no way responsible for their billing practices.

_____ I acknowledge that the office of FCIM has notified me of the option to access my medical records through the eClinical Works Patient Portal &/or HEALOW application and its benefits, by providing my personal email address should I choose to participate. I am aware that my health information can be transmitted by electronic transmission, fax transmittal, internet, or by email.

PLEASE CHECK ONE OF THE FOLLOWING:

_____I am satisfied to read and consult the office copies of the NOTICE OF PRIVACY PRACTICIES that are always available to me.
_____ I would like a personal copy to take home with me.

PRESCRIPTION HISTORY CONSENT: **PLEASE INITIAL TO SHOW THAT YOU HAVE READ THE FOLLOWING**

_____ 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.

I AUTHORIZE Freedman Clinic of Internal Medicine, LLP to release my protected medical information, including prescriptions, x-rays, orders, doctors excuse, etc. and billing information as described in our Notice of Privacy Practices as well as I authorize Freedman Clinic of Internal Medicine, LLP to release my medical information to the below listed. (*THIS IS NOT A MEDICAL RECORDS RELEASE*)

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Authorization to release ***APPOINTMENT INFORMATION ONLY*** with a person, voicemail or email: **YES or NO**

Signature: _____ Date: _____

Freedman Clinic of Internal Medicine, L.L.P.

Authorization to Release or Obtain Health Information (including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip	Social Security #

I authorize:

Freedman Clinic of Internal Medicine, L.L.P.
Attention: Medical Records
176 Versailles Blvd
P.O. Box 13030
Alexandria, LA 71315-3030
(318) 445-9331, Fax (318) 619-6899

☐ **RELEASE Information TO or ☐ OBTAIN Information FROM**
(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____ Fax: _____

The Purpose of this Authorization is indicated in the box (es) below. *(Place an "X" in the box (es) that apply)*

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action
☐ Changing Physicians ☐ Research related treatment
☐ Creating health information for disclosure to a third party.
☐ Other: (Specify) _____

I authorize the release of the following protected health information.
(Place an "x" in the box (es) that apply to the information you want released or you want to obtain.)

☐Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests
☐Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports
☐X-ray Reports ☐ Other: _____

In compliance with state and/or federal laws, which require special permission to release otherwise privileged information, please release the following records.
☐ Alcoholism ☐ Drug Abuse ☐ Mental Health ☐ Vocational Rehabilitation ☐HIV (AIDS) ☐ Genetics
☐ Sexually Transmitted Diseases ☐ Psychotherapy Notes
☐ Other _____

This authorization shall expire on _____(date or event).

I understand that if I do not specify an expiration date, this authorization will expire six (6) months for the date on which it was signed.

_____ _____
Signature of Individual or Personal Representative authorized by law Date

For FCIM Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the above Personal Representative has been obtained.

_____ _____
Signature of FCIM Representative Date

Freedman Clinic of Internal Medicine, L.L.P.

Important Information about Authorization

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form.

A separate signed authorization form is required for the use and disclosure of health information for:

- ✓ Psychotherapy notes
- ✓ Employment-related determinations by an employer
- ✓ Research purposes unrelated to your treatment

When required by law or policy, FCIM may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

- ✓ An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, FCIM will use and disclose your health information as you have authorized on the signed authorization form.

- ✓ You may be required to sign an authorization before receiving research-related treatment.

- ✓ You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to FCIM.

- ✓ You may cancel an authorization in writing at any time. FCIM can not take back any uses or disclosures already made before an authorization was cancelled.

- ✓ Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by FCIM privacy policies.

Your right to file a privacy complaint.

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how FCIM has used or disclosed information about you. Your benefits will not be affected by any complaints you make. FCIM cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is:

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