ATCHAFALAYA
Gynecology & Obstetrics
1216 Victor II Blvd, Suite 100
Morgan City, La 70380
Phone 985-702-BABY Fax 985-384-0329

We Welcome Our Patients

Thank you for choosing our practice for your obstetric and gynecologic care. On behalf of the entire staff, we are delighted you have placed your confidence in us. We are committed to providing the best possible medical care. A doctor/patient relationship is a very special arrangement, one that requires the sharing of information. That is why we have prepared this letter. Please take a moment to read it carefully. It is designed to let you know how our office operates and what to expect when you visit.

Scheduling Your Appointments

Our office is open from Monday through Thursday 7:45am to 5:00pm. We are closed for lunch from 12:00 p.m. to 1:00 p.m. Patient appointments are scheduled Monday through Friday. We start seeing patients at 7:45am with the last appointment being at 4:00pm. When your condition requires urgent attention, we will make every effort to meet your needs. In return, we would appreciate your being on time for appointments and letting us know when you can't keep an appointment. If you need to cancel, please let us know as far in advance as possible to allow the substitution of others who would like to schedule an appointment. **For the consideration of other patients, you will be rescheduled if you are 15 or more minutes late for your appointment.**

Telephone Consultations

If you need to talk to the doctor, please make non-emergency calls during regular office hours when your records are available. Our receptionist will take some preliminary information and let you know when to expect a return call. If you call to request a prescription to be refilled, please be sure to call during office hours and be prepared to give the receptionist your pharmacy's telephone number. Our answering service will answer when the office is closed. Non-emergency messages can also be left with this service. All calls will be returned. Please let us know if your phone call has not been returned.

Emergency Situations After Office Hours

Dr. Natchez Morice, Dr. Andrew Suire, and Dr. Jessica Bell will provide care after hours. Our answering service will immediately forward messages concerning your needs to the doctor on call. In a major emergency when there is not time to call, you should go directly to the nearest emergency room. We prefer that you go to Thibodaux Regional Medical Center. The hospital will notify the physician on call immediately.

Filing Insurance Claims

Payment for medical care is expected at the time of service. Our office will file insurance claims for you. Should you prefer to file your insurance yourself, you may do so with itemized bill provided. Please understand that coverage varies significantly among the many insurance carriers, therefore, it is your responsibility to thoroughly understand the coverage and exceptions of our particular policy. Awareness of the unique provisions of your policy will aid in meeting your deductible and limiting complicated paperwork for you. Please notify our receptionist of any changes to your insurance coverage.

Confidentiality of Your Medical Records

All your medical records and any information you give any staff member are confidential. No information about you or your medical history will be released unless we have a written authorization from you to do so.

Your Suggestions Are Welcome

Again, we appreciate you selecting our practice. The entire staff is committed to providing the highest quality medical care. Our goal is to do this in a pleasant environment with courtesy and attention to your individual needs. Please feel free to share your comments with any member of our staff. Your suggestions are most welcome.

Paying the Bill

1. Atchafalaya Gynecology & Obstetrics will submit claims to insurance plans according to the terms of the individual agreements with the insurance company when they exist. The patient's co pay is due at the time of service and is payable by cash, check, or credit card.

2. Balances that are "patient responsibility" include non-covered services, 30 day aged accounts, deductibles, denied services and self pay (self- pay is defined as patient without insurance, motor vehicle accidents, and "other liability accidents) is payable in full, unless other arrangement have been made prior to services.

3. Secondary insurance claims will be submitted one time as a courtesy to the patient, however, the patient will remain responsible for the balance except in the instances where Atchafalaya Gynecology & Obstetrics is in contractual arrangement with the secondary insurance. The above "patient responsibility" rule will apply.

ATCHAFALAYA GYNECOLOGY & OBSTETRICS
MORGAN CITY, LA

PRIVACY NOTICE

Starting April 14, 2003, the Health Insurance Portability and Accountability Act (HIPPA) became law. In an effort to simplify this for our patients, we offer this brief overview as an explanation.

BY LAW, we are required to give you, the patient, a Notice of Privacy Practices disclosure and have you, the patient, sign an Acknowledgment of Receipt.

WHAT THIS MEANS IN OUR PRACTICE IS that we agree to show good faith and good effort to keep your medical records private. With your signed acknowledgment, we will have your permission to provide necessary information to your family physician and to your insurance company or give this information to an institution that we deem necessary for payment of your account. If you have any questions, feel free to ask us.

The NOTICE OF PRIVACY PRACTICES describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Keeping the medical and health information we have about you secure is one of out most important responsibilities. We value your trust, and we will handle your information with care. Our employees access information about you only when necessary, to provide treatment, verify eligibility, obtain authorization, process claims, and otherwise meet your needs. We may also access information when considering a request from you or when exercising our rights under the law or any agreement with you.

PROTECTION & STORAGE OF YOUR HEALTH INFORMATION: YOUR PERSONAL HEALTH INFORMATION IS STORED ON OUR SECURE SERVER AT Atchafalaya Gynecology & Obstetrics. We have a firewall to prevent individuals from accessing information without authorization. Physical access to our server requires individual authorization and authentication.

KEEPING YOUR HEALTH INFORMATION ACCURATE AND UP-TO-DATE IS VERY IMPORTANT. If you believe the health information we have about you is incomplete, inaccurate, or not current, please call, write us, or come by our facility. We will take the appropriate action to correct any erroneous information as quickly as possible through a standard of practices and procedures.

HOW AND WHY INFORMATION IS SHARED: we limit who receives information and what type of information is shared. Sharing information within the office: we share information within our office to deliver your health care services. We share information with the doctors who referred you to our facility. Sharing information with companies that work for us: we share information with companies that work for us, such as reference labs. But these companies are obligated contractually to keep your information that we provide to them confidential. If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with parties, including government agencies. This office does not share any patient information with third-party marketers who offer their products to our patients.

COUNT ON OUR COMMITMENT TO YOUR PRIVACY: you can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us, whether it is at our office, over the phone, or by mail.

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Patient/Client Information: **Date of Birth** _____

Last Name _____ **First Name** _____ M.I. _____ Age _____

Mailing Address _____**City**_____ **State** _____ **Zip code**_____

Physical Address _____City_____ State_____ Zip Code _____

Phone # _____**Cell phone #** _____ **Social Security#**_____

Ethnicity / Race _____ Employer_____ Phone #_____

Pt. Email Address _____ **Marital Status** Single, Married, Divorced, Widowed

Spouse's Name _____ Spouse's DOB _____ Spouse's SS# _____

Spouse's Phone _____ Spouse's Employee _____

Emergency Contact (nearest relative not living with you)

Name _____ Relationship _____Phone # _____

Primary Insurance: (please give picture ID and insurance card to receptionist)

Carrier _____ ID# _____ Group#:_____

Secondary Insurance: (please give insurance card to receptionist)

Carrier _____ ID# _____ Group# _____

Guarantee of Account: FEES ARE DUE AND PAYABLE AT TIME OF SERVICE. I understand that my fees are due in full at the time of service. I agree to pay a $25.00 service charge for each NSF check issued. If my insurances and physicians are under contract, I agree to pay applicable co-payments as required. I further understand that I am fully responsible for services not covered under my policy benefits. In the event my overdue account is place for collection, I agree to pay ALL costs, including reasonable attorney fees, court costs and service charges up to fifty percent (50%) of the amount owed.

Patient's Signature: _____Date:_____

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Which provider are you scheduled to see today? (Please circle one)

Natchez "Trey" Morice, MD, FACOG Andrew Suire, MD, BEACOG
Jessica Bell, MD, BEACOG Celina Hargenrader, FNP-C, IBCLC
Kristin Plaisance, FNP-C Casey Pech, FNP-C Lauren Hymel, FNP-C

How did you hear about us? _____

_____

_____

What is the reason for your visit today? (Please give brief description.)

_____

_____

_____

_____

_____

_____

Thank you for selecting us as your health care provider

Consent to Use and Disclosure of Protected Health Information for Purposes of Treatment, Payment and Health Care Operations

As a condition of providing treatment to you, Atchafalaya Gyn/Ob must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and the healthcare operations of Atchafalaya Gyn/Ob.

You may revoke this consent at any time by notifying Atchafalaya Gyn/Ob in writing, except to the extent Atchafalaya Gyn/Ob has taken action and reliance on your consent.

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice" on page 3) for a more complete description of the uses and disclosures that office/staff may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

Atchafalaya Gyn/Ob has reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request Atchafalaya Gyn/Ob to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Atchafalaya Gyn/Ob is not required, however, to agree to such requested restrictions. If, however, Atchafalaya Gyn/Ob agrees to the requested restriction, office/hospital will honor the request and it will be binding to Atchafalaya Gyn/Ob.

I hereby consent to the use and disclosure by Atchafalaya Gyn/Ob, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

_____
Signature

_____
Signature of Personal Representative of Patient

_____
Description of Representative's Authority to Act for Patient

Date: _____

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Request for Confidential Communication of Protected Health Information

Patient's Name _____ DOB _____ Date _____

As the above referenced patient, I am requesting that any and all communications with me regarding my Protected Health Information be handled in the following confidential manner.

____ leaving a message to call the doctor's office on my answering machine at home

____ leaving a message to call the doctor's office with whoever answers the phone at home

____ leaving a message to call the doctor's office on my cell phone

____ leaving a reminder of a scheduled appointment on my answering machine at home

____ leaving a reminder of a scheduled appointment with whoever answers the phone at home

____ no restrictions on communicating with me regarding Protected Health Information

____ permission to text me regarding appointments and results Cell#: _____

____ permission to email me regarding appointments and results Email:_____

____ other restrictions (please describe below)

_____

_____

_____

The following person(s) may have information (example: lab results, appointment times) about me:

_____

_____

Please be advised that we may be unable to comply with certain requests for confidential communication of your Protected Health Information. In such an event, we will notify you.

_____

Patient or Responsible Person's Signature Date

PLEASE READ AND SIGN ONLY STATEMENTS YOU AGREE TO

Patient's Name	DOB	Social Security #

PATIENT'S, INSURED'S, OR AUTHORIZED PERSON'S SIGNATURE: I authorize my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other providers. I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or the party who accepts assignments as a contracted provider. I authorize payment of medical benefits to the physician or supplier for services billed from the contracted provider.

Signature	Date

SPECIALIZED LABORATORY REQUEST: I realize the physician regardless of my insurance will order studies that will be sent to a specialized certified laboratory to process for my specific treatment. I agree to assume responsibility for payment of charges for lab tests not covered by my healthcare insurer.

Signature	Date

NOTICE OF PRIVACY ACT: By signing, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

I have received a copy of this office's Notice of Privacy Practices.

Signature	Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notices of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please specify)

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Authorization to Release Medical Records

I, _____ who resides at_____
In the city of _____in the state of _____ hereby authorizes:

Physicians Name _____ What year? _____ Phone _____ Fax _____
Address _____City _____St _____Zip _____ Date Faxed _____

Physicians Name _____ What year? _____ Phone _____ Fax _____
Address _____City _____St _____Zip _____ Date Faxed _____

Physicians Name _____ What year? _____ Phone _____ Fax _____
Address _____City _____St _____Zip _____ Date Faxed _____

To disclose the following specific medical information by mail and / or fax to:

Name: Atchafalaya Gynecology & Obstetrics
Address: 1216 Victor II Blvd, Suite 100
City, St., Zip: Morgan City, La, 70380

Phone: 985-702-2229 **Fax: 985-384-0329**

For the purpose of: Continuing Care Transferring Care Consultation 2nd Opinion **(circle one)**

My authorization extends only to those data elements/documents marked below:

_____ **Prenatal Records and Deliveries**
_____ Copies of records or reports provided to the above named (**hospital, lab, and clinic. Etc**)
_____ Progress notes
_____ Photographs, videotapes, digital or other images **Other (must be specific)**
_____ **Operative Notes & Discharge Summary** _____
_____ History and physical examination _____
_____ **Last 5 years of pap smear results**
_____ All of the above
_____ Mental Health and or alcohol and drug abuse treatment
_____ AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) information
_____ Hepatitis information

This authorization is given freely with the understanding that:

1. **Any and all record, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.**
2. **A photocopy or fax of this authorization is as valid as the original.**
3. **I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.**
4. **Atchafalaya Ob/Gyn, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.**
5. **Treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon obtaining this authorization.**
6. **Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.**

_____ _____ _____
Patient's Signature (or guardian, if a minor) **D.O.B.** **Patient's Printed Name**

Date: _____ Exp Date: _____ Social Security #_____
(If other than 1 year)

_____ _____
Patient's Personal Representative **Witness**

Please fax this sheet back with the records. Thanks

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Date _____ Name _____ Birth date _____

Have you ever been hospitalized for a major illness or had surgery?
Date _____ Reason/Surgery _____
Date _____ Reason/Surgery _____
Date _____ Reason/Surgery _____

Are you allergic to any medicines or foods? If yes, please list them and the reaction you had to each one.

_____

Medical History (Please circle any conditions you currently have or have had in the past.)

Abdominal pain	Hair Loss	Psoriasis/Eczema
Allergies/Hay fever	Headaches-Frequent	Rashes/Hives
Appetite-Loss of	Heart Murmur	Sexual/Menstrual Problems
Arthritis/Rheumatism	Hemorrhoids	Sinus Trouble
Asthma/Wheezing	Hernia	Stools-Bloody/Tarry
Back Pain-Recurrent	High Blood Pressure	Stroke
Bronchitis	Indigestion/Heartburn	Thyroid Disease
Cancer	Jaundice/Hepatitis	Urethral Discharge
Cancer-Colon	Kidney Stones	**Urinary Problems:**
Chest Pain	Leg Pain	loss of control
Convulsions/Seizures	Memory Loss	more than twice per night
Diabetes	Moodiness-Excessive	painful
Diarrhea/Constipation	Mumps	Varicose veins
Dizziness/Fainting	Muscle Weakness	Venereal disease
Fatigue-(recurrent)	Nausea/Vomiting (recurrent)	Weight loss-recent
Gall Bladder Trouble	Osteoporosis	

Are you pregnant? _____How many times have you been pregnant? (include any miscarriages/abortions) _____
Number of Miscarriages _____ Abortions _____ Live Births _____

Date of last mammogram: _____ Normal / Abnormal
Approximate date of last pap test: _____ Normal / Abnormal
Have you ever had an abnormal pap smear?_____, If yes, when _____
Are you currently using any type of birth control? _____Birth control method: _____

Family History:

	Father	Mother	Siblings	Father's Parents	Mother's Parents	
Bleeding Disorder	□	□	□	□	□	
Breast Cancer	□	□	□	□	□	**age @ diagnosis** _____
Colon Cancer	□	□	□	□	□	**age @ diagnosis** _____
Diabetes	□	□	□	□	□	
Endometrial Cancer	□	□	□	□	□	**age @ diagnosis**_____
Epilepsy	□	□	□	□	□	
Heart Disease	□	□	□	□	□	
High Blood Pressure	□	□	□	□	□	
Kidney Disease	□	□	□	□	□	
Ovarian Cancer	□	□	□	□	□	**age @ diagnosis**_____
Stroke	□	□	□	□	□	
Thyroid disorder	□	□	□	□	□	

Are you married?_____ If yes, how long have you been married?_____

Do you drink alcohol? _____ If yes, how often _____

Do you smoke _____ If yes, how much per day? _____ How long have you been a smoker? _____ years

Do you use drugs?_____ If yes, which ones_____ How often_____

Have you ever had a blood transfusion? _____ If yes, when_____