Comprehensive Family Care

Indira Gautam, M.D.
502 Lafayette St.
Youngsville, La 70592
Phone: (337) 857-3512 Fax: (337) 857-3513

Appointment Policy

Out of respect for your valuable time and that of our other patients, and our staff, we do our best to keep your wait time at or below 15 minutes. In order to accomplish this we ask that you do your part by not being late for your scheduled appointment.

As much as we dislike having to do so, being late for your scheduled appointment may require you to reschedule. If you foresee that you may be late, please call us immediately to be informed if our schedule will allow for tardiness.

We ask that you contact us in advance if you cannot make your scheduled appointment, In order to ensure all patients a timely appointment. If you fail to show for three consecutive scheduled appointments you may not be allowed to reschedule.

I, hereby, acknowledge that I have received a copy of this letter in return after signing.

____
Patient Name Printed

____
Patient Signature (or Responsible Party)

____
Today's Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	**Birth Date:**	Social Security No. *(optional)*:

PHI Recipient Name: **Dr. Indira Gautam**	**Address/City/State/Zip –** **502 Lafayette St. Youngsville, LA 70592**	**Phone Number: (337) 857-3512** **Fax Number: (337) 857-3513**
PHI Sender Name:	Address/City/State/Zip	Phone Number: (__) ________ Fax Number: (__) ________

Purpose of Disclosure: **CONTINUATION OF CARE**

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization.
☐ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐ All PHI in record ☐ History and Physical ☐ Consult Report ☐ Operative Report ☐ Progress Notes		☐ Physician Orders ☐ Laboratory ☐ Imaging/Radiology ☐ Nursing Notes ☐ Medication Record		☐ Demographics ☐ Rehabilitation Services ☐ Special Test/Therapy ☐ Itemized Bill/Claims ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ________________ (Initial) If not, applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	**Date:**
Print Name of Patient/Guardian/Patient Representative:	**Relationship to Patient**:

COVID-19 Acknowledgement of Risk

COVID-19 poses a significant risk to our patients and staff until there is an effective vaccination of the public. Infection control measures are in place for the protection of your well-being. Nevertheless, in-facility (office/clinic/face-to-face) medical treatment presents an unavoidable risk of exposure to COVID-19 that must be minimized to the extent possible by social distancing (when possible), wearing masks, frequent hand washing, and any other available safety measures.

Patient Name: ______________________________ DOB: ____________

Signature: _________________________________ Date: _____________

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FINANCIAL POLICIES

As your physician, we are committed to giving you the best possible care. To achieve this goal, we need your assistance and understanding our payment policy.

Payments:

- Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes coinsurance and co-payments for participating companies. We accept payments in the form on cash, check, money orders, Visa, MasterCard, Discover, and Debit Cards
- NSF Checks are subject to a $25 check fee in addition to the balance of the check and any fees your bank may charge you. We reserve the right to refuse to accept checks as a payment at any time.

Insurance:

- We bill participating insurance companies on your behalf as a courtesy to you.
- You are **expected to pay your deductible and co-payments at the time of service.**
- If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full.
- If you wish for us to bill your insurance company, your insurance card must be presented at the time of service. If your insurance card or information changes which may be necessary to bill your insurance company, that information must be provided as well at the time of service. Ultimately the patient (or guardian) is responsible for all costs of their healthcare. If your insurance company will not pay for a service or charge which you consent to, you are responsible for the cost associated with those charges.
- We will be glad to discuss your proposed treatment and the costs of those services. We will also attempt to find out if your insurance will cover these services for you. HOWEVER, please be aware that your insurance is a contract between you and your employer (if applicable), and the insurance company. We are not a party to your contract. Unfortunately, not all services are a covered benefit in all contracts. Some insurances companies select certain services that they will not cover (e.g. yearly physicals)
- Insurance companies may request that you release otherwise confidential medical information regarding your condition to them. If you do not authorize the release of this information, we cannot bill your insurance company on your behalf.
- We may refuse to bill an insurance company on your behalf at any time.

Forms/Administrative Time:

- Any form other than the standard insurance forms that you request be completed by our office may be subject to a fee for the time and labor involved. This will be discussed on a case-by-case basis.

****I understand and agree to the financial policy. Furthermore, I understand that intentionally providing false insurance information may constitute insurance fraud and be in violation of federal law.**

____ ____________________

Patient Name **Date**

Social History:

Are you: Single___ Married___

Or in a Relationship___-w/man__ or Woman__

What is your occupation? ___________________

Please (x) if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Health Habits:

Please (x) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Immunizations- Are you up to date with your immunizations?

Tetanus: _______ (Every 10 years)

Influenza: ______(Yearly)

Pneumonia: series 1____ series 2_____

Shingles: _____ (for patients over 60 years)

Allergies: Please list any allergies you may have.

____

Medications: List all the medications you are currently taking.

__________________________ _______________________ ______________________

__________________________ _______________________ ______________________

__________________________ _______________________ ______________________

****I certify that the above information is correct to the best of my knowledge, and I will not hold physician or any member of her staff responsible for any errors or omissions that I have made in the completion of this form.**

PATIENT SIGNATURE__________________________________ DATE __/___/___

Indira Gautam, MD. 502 Lafayette St. Youngsville, LA 70592 P- 337-857-3512 F- 337-857-3513

Indira Gautam, M.D.
502 LAFAYETTE ST.
Youngsville, La 70592
Phone: (337) 857-3512 Fax: (337) 857-3513

Patient Name: ____ **Today's Date:** _______________
Date of Birth:_______________________ **Age:** ___________ **Gender:** _________
Date of last Physical Exam: _____________________ **What is your reason for today's visit?** _______________
____

Past Medical History

Please check (√) if you have ever been diagnosed with any of the following?		If YES, please tell us when you were diagnosed? Year:
	High Blood Pressure	
	Diabetes	
	High Cholesterol	
	Thyroid Problems	
	Depression	
	Anxiety	
	Cancer Type?	
	Heartburn	
	COPD	
	Have Pacemaker?	
	Other:	

*****Please fill out this Medical History Form to the best of your knowledge.**

****Where do you prefer to get your Labs Done?**

____

**Where do you prefer to get your imaging studies done? (ex. Xrays, CT, MRIs)

____

****Pharmacy:** (Please list your Pharmacy Name & Address, & Phone Number)______________________
____
____

Surgeries/Serious Injuries:

Year	Hospital	Type of Surgery of Injury:

Family Medical History:

- **Father: If Living – Age:_____ If Deceased – Cause of Death:** ____

Please list any Medical Problems: ____
- **Mother: If Living – Age: _____ If Deceased – Cause of Death:** ______________________________________

Please list any Medical Problems: ____
- **Do you have and blood relatives with the following: If yes: List Relationship to you.**

  [ ] Diabetes _______________ [ ] Hypertension _______________ [ ] High Cholesterol ______________
  [ ] Heart Disease___________ [ ] Stroke ______________________ [ ] Genetic Disease ______________
  [ ] Blood Disorders_________ [ ] Depression __________________ [ ] Alcoholism/Drug Abuse_________
  [ ] Bipolar Disorder ________ [ ] Cancer: Type _________________ Relationship ____________________
  Type _________________ Relationship ____________________
  Type _________________ Relationship ____________________

- **Please add any other information about your health that you would like us to know:** ____________________

____

Children			Health History (List any illnesses that your children may have)
# of Children	Males	Females:	
	Ages:	Ages:	

PATIENT AGREEMENT FORM

Please refer to attached papers for detailed office policy information. **INITIAL NEXT TO EACH LINE**

- I understand that Comprehensive Family Care is a Private Practice and reserves the right to make independent decisions regarding who we serve excluding decisions that would be posed as discriminatory______.
- I understand that CFC has a zero-tolerance policy for disruptive behavior/ abusive language towards other patients, front office staff, the nurse, the provider, and the Office Manager. Such behavior is grounds for automatic discharge from practice_____.
- I understand that upon completion of ordered tests, if there is no call from the office in 7-10 days, I am responsible for contacting office to follow-up______.
- I understand that repeated appointment No Call/No shows can result in automatic discharge from practice_____.
- I understand that if I don't have active insurance on file the day of the visit I will be considered self-pay and charged at the self-pay rate of the current type of office visit starting at $43.43. If the patient deductible is not met the patient will be responsible for the company's standard rate which is a minimum of $43.43_____.
- I understand that deception of Medical coverage is grounds for automatic discharge from practice_____.
- I understand that a verbal statement to find another physician is an automatic termination of physician/patient relationship_____.
- I understand that under no circumstances will a school/work excuse be issued to a patient who has not been evaluated by the doctor_______.
- I understand that in the event that I relocate out of state, Dr. Gautam is only responsible for a 90-day refill of medications on file in my records____.
- I understand that the office has 24 to 48hrs to return calls and repeat calls are a form of harassment and only delay return calls______.
- I understand that medication refill requests will be completed within 24 to 48hrs _____.

Printed Name_________________________________ Date___/___/____

Patient Signature___________________________________

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Patient HIPAA Acknowledge and Consent Form

Patient Name: ____

Date of Birth: ____

____ (Patient Initials) **Notice of Privacy Practices**. I acknowledge that I have received that practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated to the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practices Notice of Privacy Practices.

_____ (Patient Initials) **Release of Information:** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at any other affiliated facility may be made available to subsequent affiliated admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- if I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDs.

Disclosure to Friends and/or Family Members:

I give permission for my protected health information to be disclosed for purposes of communications results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

PATIENT REGISTRATION

LAST NAME: ___________________ FIRST NAME: ___________________ MIDDLE NAME: __________________

ADDRESS: ______________________________________ CITY: ___________ STATE: ____ ZIP: ____________

HOME PHONE: _____-_____-_____ MOBILE PHONE: _____-_____-_____ WORK PHONE: _____-_____-_____ EMAIL: ________________ (PLEASE CIRCLE) CONSENT TO EMAIL: Y/N CONSENT TO TEXT: Y/N

CONTACT PREFERENCE: HOME PHONE/ WORK PHONE/ MOBILE PHONE/ EMAIL/ PORTAL

SEX: ___ DATE OF BIRTH: ___/___/___ SSN#______-______-______

REQUIRED BY GOVERNMENT MANDATE [ALTHOUGH YOU MY REFUSE]

LANGUAGE: __________________ RACE: _________________ ETHNICITY (CIRCLE ONE): NOT HISPANIC/ HISPANIC

MARITAL STATUS (CIRCLE ONE): MARRIED SINGLE DIVORCED SEPARATED WIDOWED PARTNER

INSURANCE (GUARANTOR INFORMATION TO BE FILLED OUT IF YOU ARE NOT THE POLICY HOLDER)

RESPONSIBLE PARTY (LAST) ____________________ (FIRST) ________________________ (MIDDLE INITIAL) _____

SSN#______-______-______ D.O.B:_____/_____/______ GENDER: F/M CONTACT NUMBER: _______-______-______

RELATIONSHIP TO PATIENT: ______________________

EMPLOYMENT

EMPLOYER NAME: ______________________________ OCCUPATION: __________________

EMERGENCY CONTACT

FIRST NAME: _______________________ MI: _____ LAST NAME: __________________ RELATIONSHIP: _______________

PHONE: HOME: ______-_____-_____ MOBILE: _____-_____-_____

NEXT OF KIN

FIRST NAME: ____________________ LAST: _____________________MI:____ RELATIONSHIP: _________________

PHONE: HOME: ____-____-_____ MOBILE: ____-____-____

PREFERRED PHARMACY: ________________________________ PHONE: ____-____-____ LOCATION: ________________

MAIL-ORDER PHARMACY: ________________________________ PHONE: ____-____-____

HOW DID YOU HEAR ABOUT US? ________________________

***TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.**

PATIENT (OR RESPONSIBLE PARTY) **SIGNATURE____________________________________ DATE: ____/_____/_____**

POLICIES

OFFICE POLICIES

APPOINTMENTS: Comprehensive Family Care is an appointment-based Practice. Broken appointments represent a cost to us, you and other patients who could have been seen in the time set aside for you. Cancellations should be requested at least 24 business hours prior to appointment. Excessive abuse of broken appointments may result in discharge from our Practice. If you have a child under the age of 18 years, a parent must be present at the time of appointment.

ETHICS: We value you as a human being and always strive to treat you with respect and dignity. In return, we expect you to treat us similarly. Verbal or Physical abuse of any employee will not be tolerated and is grounds for dismissal from our practice.

PAIN MANAGEMENT: We DO NOT prescribe narcotic medication for pain management of long-term pain(s), under ANY circumstances. We are more than pleased to refer you to a pain management specialist if you require narcotic pain medication as part of your treatment plan.

SCHOOL/WORK EXCUSES: Under no circumstances will school/work excuses be issued to the child/parent who has not been seen by the doctor or under extremely limited circumstances.

WORKER'S COMPENSATION AND AUTO INSURANCE: We do not participate in the treatment of illness in Worker's Compensation claims nor do we handle the initial Emergency Care from automobile accidents.

POLICY ON NARCOTICS

PRESCRIPTIONS: Narcotic Pain-Relieving Medications all have the potential to be harmful and addictive. For that reason, this office has a strict policy on such prescriptions. **NO EXCEPTIONS**.

1. WE WILL NOT REFILL NARCOTICS PRESCRIBED BY ANOTHER PHYSICIAN
2. WE WILL ONLY PRESCRIBE NARCOTICS UNDER EXTREME CIRCUMSTANCES, AND ONLY AFTER EVALUATING THAT PATIENT IN THE OFFICE AND NOT OVER THE PHONE.
3. WE WILL NOT REFILL LOST NARCOTIC PRESCRIPTIONS.
4. WE WILL PROVIDE ALTERNATIVE NON-NARCOTIC PAIN-RELIEVING MEDICATIONS, RATHER THAN NARCOTICS.
5. WE WILL NOT TREAT CHRONIC, LONG STANDING PAIN PROBLEMS AS EMERGENCIES REQUIRING NARCOTIC PAIN-RELIEVING MEDICATIONS.

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