PARRIS
CARDIOVASCULAR CENTER

☐ Mr. ☐ Mrs. ☐ Rev. ☐ Doctor

NAME ____

TODAY'S DATE ________________ **DATE OF BIRTH** ____________________ **AGE** ________

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **SEPERATED** ☐ **DIVORCED**

ADDRESS ____ HOME PHONE (___)___________

SOC. SEC. # _________________ **DRIVER'S LIC#** ____________ **OCCUPATION** ________________________

PATIENT'S EMPLOYER _________________________________ **BUS. PHONE (___)**____________

CELL/OTHER PHONE # (___)___________ **EMAIL ADDRESS** __________________________________

SPOUSE INFORMATION

SPOUSE NAME ____ **DATE OF BIRTH**__________________

SOC. SEC. # _________________ **OCCUPATION** _________________________ **WORK# (___)**___________

INSURANCE ____ **ARE YOU THE INSURED** ___ YES ___ NO

INSURED NAME ________________________________ **DATE OF BIRTH** __________ **SS#** _____________

EMERGENCY CONTACT

NAME ___________________________ RELATIONSHIP __________ PHONE # (___)____________

NAME ___________________________ RELATIONSHIP __________ PHONE # (___)____________

REFERRING PHYSICIAN'S NAME **PRIMARY CARE PHYSICIAN**

____ _______________________________________

Do you have Advance Directives to be followed? ___ Yes ___ No

If yes, **what type**? ____

Please provide a copy of your records at Parris Cardiovascular Center

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I am responsible for accrued interest in the amount of 15% of the unpaid principal balance per month, reasonable attorney fees in the amount of 25% of the unpaid principal balance and interest, court cost and any other expenses related collection procedures on my account. If I am the guarantor for a patient. I as guarantor bind myself, in solido, with patient herein for all sums owed Parris Cardiovascular Center.

I authorize the release of any information to process my insurance and to my referring physician(s).

PATIENT/LEGAL GUARDIAN DATE

PATIENT'S NAME ____ **TODAY'S DATE** ______________

PAST MEDICAL HISTORY

Fever or chills __________________ Eyes __________________________ Throat ________________________
Glasses / Surgery **Difficulty Swallowing**

Ears ______________ **Chest Pain**____
Hearing Aid DESCRIBE

Shortness of breath _____________ **Nausea or vomiting** _____________ **Bowel changes** _____________

Urinary frequency _____________ **Aches or pain** _____________ **History of diabetes** _____________
Where

HIV _____________ **Immune issues** _____________ **Hepatitis** _____________

Anemia _____________ **CVA/Stroke** _____________ **Anxiety or depression** ___________

PAST SURGICAL HISTORY ____
LIST DATES / PROCEDURES

FAMILY HISTORY

FATHER ____
ALIVE / IF DECEASED AT WHAT AGE LIST MEDICAL PROBLEMS

MOTHER ____
ALIVE / IF DECEASED AT WHAT AGE LIST MEDICAL PROBLEMS

BROTHERS ____
HOW MANY? LIST MEDICAL PROBLEMS

SISTERS ____
HOW MANY? LIST MEDICAL PROBLEMS

____
OTHER FAMILY MEMBERS WITH HEART PROBLEMS

PAST CARDIAC EXAMS: **NUCLEAR STRESS TESTING** ________________ **HEART CATHS** __________________

GXT'S _________________ **ECHOCARDIOGRAMS** __________________

OPEN HEART SURGERY ____
LIST DATE AND PHYSICIAN

PACEMAKER IMPLANTATION ____
LIST DATE AND PHYSICIAN

SOCIAL HISTORY: Tobacco ______________________ Drugs________________ Alcohol _______________
Cigarettes / How many quit Name How often

Type of Employment _____________________________________ Children ______________________________

MEDICATION SHEET

NAME ____

DATE ____

ALLERGIES ____

	NAME OF MEDICATIONS	DOSE FREQUENCY	DATE ORDERED	DOSE CHANGE DISCHARGE DATE	PRESCRIBING MD
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

Authorization for the Use or Disclosure of Protected Health Information

Parris Cardiovascular Center
236 Wabash Ave
Baton Rouge, LA 70806
Phone: (225) 757-6700 Fax: (225) 757-6711

As required by the Health Insurance Portability and Accountability act of 1996, Parris Cardiovascular Center may not use or disclose your health information except as provided I our Notice of Privacy Practice without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

PATIENT NAME ____ DATE OF BIRTH _______________

SOCIAL SECURITY # ____ CHART _____________________

From (Individual/Facility) ____________________________________ _________To: Parris Cardiovascular Center

Address ____ Address: 236 Wabash Ave

____ Baton Rouge, LA 70806

City State Zip

Phone ( ) _________________ Fax ( ) _________________ Phone (225) 757-6700 Fax (225) 757-6711

I, _______________________ (print name) hereby authorize the use and disclosure of the following heath information that pertains to me for the following treatment dates from _________ to _________

___ Office visit notes ___ Test results ___ Entire chart ___ Laboratory result ___ Copies of EKG's

___ Other specify ___ Hospital Procedure ___ Hospital visit notes ____________________________

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

___ Information regarding the patient's diagnosis and treatment for HIV/AIDS
___ Psychotherapy notes
___ Treatment for alcohol or drug abuse

For the following purposes: ___ Medical ___ Legal ___Insurance ___Personal ___Other

This authorization shall be in force and effect from _________ to _________ at which time this authorization to use or disclose this protected health information expires.

I understand and consent to all of the following:

- This authorization will automatically expire on _______. If not expiration date is specified authorization will expire six months from the date on which it was signed.
- I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not.
- The released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.
- I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. PCC is entitled to receive compensation in accordance with the laws of the State of Louisiana relative to the release of medical records.

____ ______________________

Signature of Patient / Legal Representative Date

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of the **Parris Cardiovascular Center** to disclose general medical information and other protected health information to the following persons and/or entities listed below. If one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of the **Parris Cardiovascular Center**.

Name and relationship of person you wish to allow access – for example, your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:

Name of Person or Entity Relationship

____

____

____

____

____

This authorization to and disclose this protected health information is being submitted by my request and <u>shall be in force and effect until revoked in writing</u> by me, or if the purpose of the disclosed is related to research, at the end of research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the **Parris Cardiovascular Center** and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the **Parris Cardiovascular Center** Privacy Officer at the Health Information Management Department. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Regardless of whether you provide us with this authorization, we will provide you with medical services or conduct payment operations. However, if your treatment is for any of the following purposes, we have the right not to provide you with medical services:

1. If your treatment is related to research.
2. If heath care services are provided to you solely for the purpose of creating protected health information for disclosure to a third party.

____

Signature of Patient or Personal Representative

____

Date

____

Print Name of Patient or Personal Representative

Send Correspondence to:

Parris Cardiovascular Center
A Professional Medical Corporation
236 Wabash Ave
Baton Rouge, LA 70806
Phone: (225) 757-6700
Fax: (225) 757-6711

Notice of Privacy Practices Acknowledgement Form

I have been provided with and read a copy of the Parris Cardiovascular Center Notice of Privacy Practices.

____

Signature of Patient or Legally Authorized Representative   Date

____

Print Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

____

Staff Member Witnessing Signature   Date