MEDXCEL
OCCUPATIONAL MEDICINE & WALK-IN CLINIC
121 Tivoli Street; Abbeville, LA 70510
Phone: 337-893-0788 Fax: 337-893-0787

REGISTRATION AND CONSENT FORM

Today's Date: _____

Patient's Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ Cell/Alt phone #: _____ Marital Status: S M W D

Date of Birth: _____ Sex: _____ S.S.N: _____

Legal Guardian's Name (if patient is a minor): _____

Patient's Place of Employment: _____ Work Phone #: _____

Spouse's Place of Employment: _____ Work Phone #: _____

Emergency Contact (friend/family member NOT living with you whom we can contact in the event of an emergency)

Name: _____ Relation: _____ Phone #: _____

Authorization to Release Information

I hereby authorize MedXcel, or any holder of medical information about me, to be released to the Health Care Financial Administration and its agents or Insurance Companies or Third Parties, any information needed to determine these benefits or the benefits payable to related services. I understand I am financially responsible for all charges whether or not paid by insurance.

Consent for Services

I hereby consent to medical treatment provided to me by the staff of MedXcel. I authorize MedXcel to disclose to my insurance carrier any information concerning my condition including the history and physical and any and all X-ray and lab work.

I hereby release MedXcel and its employees from any liability arising from such disclosure. This authorization and assignment may be revoked by me at any time by a written notice. I agree that a photocopy of this form may be used in lieu of the original.

Signature: _____ Date: _____

Insurance information:

Person responsible for bill: _____ Covered by Insurance?: _____ Yes _____ No

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's SS# _____ Subscriber's DOB: _____

Group #: _____ Policy #: _____ Co-payment: _____

Patient relationship to subscriber: _____Spouse _____Child _____ Self _____ Other

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Name: _____ DOB: _____ Age: _____ Race: _____

Phone: _____ Marital Status: S M W D Separated Name of Spouse: _____

Chief Complaint (Reason for visit, please include symptoms):

_____

_____

Circle all that applies to you:

HIGH BLOOD PRESSURE
DIABETES
HEART ATTACK
STROKE
CANCER: _____
OTHER HEART DISEASE
ANGINA—HEART FAILURE
SERIOUS ACCIDENT OR TRAUMA
LUNG DISEASE (Emphysema/Bronchitis/Asthma)
LIVER DISEASE (Jaundice/Hepatitis/Cirrhosis)
KIDNEY DISEASE (Other than bladder infection)
PHLEBITIS (Blood clots in the legs)
BLEEDING PROBLEMS (Free bleeder)
ALCOHOLISM OR HISTORY OF DRUG ABUSE
OTHER: _____
OTHER: _____

Surgeries and years performed: _____

_____

_____

Are you currently pregnant? Yes or No

Number of pregnancies: _____ Number of living children: _____

Current Medications: _____

_____

List any allergies to food or drugs: _____

_____

Do you smoke? Y or N Have you ever smoked? Y or N How much per day? _____ For how many years? _____
If not current, how long ago did you stop? _____ Do you drink alcohol? Y or N How much? _____

Living arrangements: Alone W/Spouse W/Parents Retirement home W/Friend W/Children

Handicaps: _____

Please circle all that apply to your **immediate family** members:

Heart Disease Stroke High Blood Pressure Bleeding Problems Diabetes
Cancer-type and location _____ Problems with anesthesia Hearing loss
Circulatory Problems Other: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAFEFULLY.

Your health information is private. Keeping the privacy of your health information is important to us. This notice describes how we use your personal health information, what your rights are, and what our responsibilities are.

REASONS THAT YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED

- **For treatment:** MedXcel is allowed to use and disclose your protected health information in order to treat you. For example, doctors, nurses, medical technicians and other staff may discuss your case with other health care providers in order to treat you.
- **For payment:** MedXcel is allowed to use and disclose your protected health information in order to get payment for your treatment. For example, MedXcel may disclose the type of treatment provided to you in order to get payment from an insurance company. Your information may also be shared with other government programs such as Medicaid and Medicare to coordinate benefits.
- **For health care operations:** MedXcel is allowed to use and disclose your protected health information in order to continue its health care operations. For example, your information may be used or disclosed by a nurse to a social worker for case management purposes and care coordination with other providers of service who may be involved in your case. Your information may be used to review and evaluate our performance in providing services.
- **Appointment reminders:** MedXcel may use your protected health information to contact you to remind you about your appointments, to give you information on treatment alternatives and to provide you with information on other health related benefits and services.
- **Business Associates:** There are some services provided by MedXcel through contracts with businesses. Examples include health care providers and consultants. When these services are agreed upon, we may share your health information with these businesses so that they can perform the job we have asked them to do. To protect your health information we require the business associates to keep your information private.
- **Research:** Anyone that would like to use personal health information to conduct research studies must have approval of the institutional review board unless restricted by other federal and state laws. Only after approval MedXcel may disclose your information.
- **The County Administrator:** MedXcel is permitted to share your personal health information with the County Administrator, who is responsible for overseeing mental health services and must receive information regarding MedXcel's mental health operations as required in certain circumstances as permitted by law.
- **Commitment proceedings:** During the course of an involuntary commitment proceeding, the judge may direct that the court, or mental health review officer, as allowed under the Mental Health Procedures Act, have access to your personal health information for purposes of conduction the hearing. If you are the subject of an involuntary commitment proceeding, information will be shared with attorneys assigned to represent you.
- **Food and Drug Administration (FDA):** MedXcel may disclose health information to the FDA about problems with food, supplements, product and product defects, or post marketing surveillance information so that the FDA may call for product recalls, repairs, or replacements.
- **Workers Compensation:** MedXcel may disclose health information as authorized by law to comply with laws relating to workers compensation or other similar programs established by law.

- **Public Health:** As required by law, MedXcel may disclose your health information without your consent to public health or legal authorities whose job is preventing or controlling disease, injury or disability.
- **Correctional Institutions:** Should you be an inmate of a correctional institution, MedXcel may share your health information with the health care professionals at the institution so you can continue your health treatment. MedXcel may disclose the protected health information of anyone we reasonably believe that is a victim of abuse, neglect, or domestic violence to the appropriate authorities when authorized by the law.
- **Health oversight activities:** MedXcel may disclose your protected information to a health oversight agency when necessary for the oversight of the health care system, government benefit programs, & to determine compliance with civil rights laws.
- **Judicial and Administrative proceedings:** MedXcel may disclose protected health information in response to a court order, subpoena or other lawful request.
- **Law Enforcement:** In certain circumstances MedXcel may disclose protected health information to law enforcement officials.
- **Decedents:** Your health information may be used and disclosed to coroners, medical examiners, and funeral directors if it is needed to carry out their duties.
- **Military:** MedXcel may use and disclose protected health information to the appropriate authorities for military and veterans activities.
- **Reports:** Federal law allows your health information to be given to an appropriate health oversight agency, public health authority or attorney, provided that an employee or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially hurting individuals, workers or the public.
- **Required by law:** MedXcel may use or disclose your protected health information for purposes required by law.

When the situation is not an emergency and you have not objected, MedXcel may disclose your protected health information:

- To a relative or someone who you have agreed to be involved in your care or health care payment;
- To notify, or assist in notifying, a family member or personal representative of your location and general condition;
- To legally authorize disaster relief agencies to coordinate with such agencies.

Authorizations: Other uses and disclosures of your personal health information will be made only with your authorization. You have a right to change your mind at any time in writing before we have shared your information.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION

You have the right to:

- Receive private communications of protected health information;
- View and copy your protected health information;
- Amend your protected health information;
- Receive a paper copy of this notice upon request;
- Ask that your protected health information not be shared in certain circumstances.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this notice of our privacy practices.

Print Name: _____

Signature: _____

Date: _____