Southeast Community Health Systems
Patient Registration

PATIENT INFORMATION

Last Name | First Name | MI | DOB | SS#

Street Address | **City** | **State** | **Zip** | **County**

CONTACT INFORMATION

Primary Phone Number □ Home □ Cell □ Work

Secondary Phone Number □ Home □ Cell □ Work

Do you need transportation? □ **Yes** □ **No**

Email:

PATIENT DEMOGRAPHICS

Primary Language Spoken
□ English □ Spanish□ Other_____

Would you like an interpreter?
□ Yes □ No

Race (Check all that apply)
□ Black/African American □White □Asian
□ Unreported/Refused to Report
□ American Indian/Native Alaskan
□ Eng □ Other Pacific Islander
Nativ □ Native Hawaiian
□□Pa □ Other
□ _____

Ethnicity
□ Hispanic/Latino
□ Non-Hispanic/ Latino
□ Cuban
□ Puerto Rican
□ Another Hispanic, Latino or Spanish Origin
□ Unreported/Refused to Report

Gender Identity:
Do you think of yourself as:
□ Male
□ Female
□ Female-to-Male/Transgender Male/Trans Man
□ Male-to-Female/Transgender Female/Trans Woman
□ Genderqueer, neither exclusively male nor female
□ Refused to Report
□ Other, please specify:

Sexual Orientation:
Do you think of yourself as: □ Straight or heterosexual
□ Lesbian, gay, or homosexual □ Bisexual
□ Unknown
□ Other, please specify:
□ Refused to Report
_____

Marital Status
□ Single
□ Married □ Divorced
□Widowed
□Separated
□Life Partner

Student
□ Full-Time
□ Part-time
□ Not a student
Highest grade completed?
_____

Employment Status
□ Full-Time
□ Part Time
□ Not Employed □ Retired
□Disabled
□Student
□None

Employer **Phone No.**

Housing Status: □ Not Homeless □ Homeless
□ Other _____

Primary Care Provider _____

Pharmacy_____

Phone No. _____

Military Veteran?
□ Yes
□ No

Agriculture Status
□ Migrant Worker
□ Seasonal
□ Dependent of Migrant
□ Dependent of Seasonal
□ Not Agricultural Worker

GUARANTOR (Person To Be Billed, Check here if same as patient □)

Last Name | **First Name** | **MI** | **DOB** | **SS#**

Street Address | **City** | **State** | **Zip** | **Home Phone** | **Cell Phone**

EMERGENCY CONTACT (Someone outside of your home that we may contact in an emergency)

Last Name | **First Name** | **Relationship**

Street Address | **City** | **State** | **Zip** | **Home Phone** | **Cell Phone**

Last Name | **First Name** | **Relationship**

Street Address | **City** | **State** | **Zip** | **Home Phone** | **Cell Phone**

Southeast Community Health Systems

INSURANCE INFORMATION

Insurance Name: _____ Policy #: _____ Phone # _____

Mailing Address:

(Street/P.O Box) (City) (State) (Zip Code)

Subscriber's Name (name on card): **Date of Birth:**

Patient's relationship to Insured: _____ Self_____ Spouse _____Child _____Other:

INSURANCE ASSIGNMENT: I assign directly to Southeast Community Health Systems (SCHS) all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize SCHS to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions and for a copy for this statement and my signature to be kept on file and used in place of this original.

Insured or Patient's Signature: Date:_____

INCOME VERIFICATION FORM

Date: **Expiration Date:**

Head of Household: _____ **Account #**: _____

Total gross annual household income: $ _____

Household Member's Legal Name	Sex	DOB	Relationship	Social Security #	Insurance
			SELF		

(Uninsured patients must present proof of household income to qualify for a sliding fee discount)

I certify that I have read or had someone read this questionnaire to me and I understand all of the information provided is correct to the best of my knowledge. I understand that failure to make full disclosure of my household
true gross income is considered an act of fraud and can be punishable by either a fine or imprisonment according to federal law.

I further certify that I have been informed that I will be charged at 100% for my visit if I do not present adequate household income to qualify for a sliding fee scale discount.

Signature: Date:

Patient Name: _____ **Birth date:** _____ **Date:**_____

GENERAL CONSENT FOR TREATMENT

1. I hereby authorize and consent to all necessary medical procedures needed for diagnosis and treatment for me and/or my dependents by Southeast Community Health Systems (SCHS).
2. I understand that no guarantee or assurance has been made as to the results that may be obtained.
3. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees of a cure have been made to me as a result of examinations or treatments by SCHS.
4. I give permission to release to my insurance company medical information necessary in the filing of lawful claims by SCHS' staff for services rendered by SCHS to me or my dependents.
5. I hereby authorize payment directly to SCHS of benefits relative to pending claims and/or Major Medical benefits otherwise payable to me, not to exceed SCHS' regular charges for this service.
6. I certify that the information that I have provided in applying for payments under Title XVII of the SSA Act is correct. I authorize any holder of medical or other information intermediaries, carriers, or any other insurer, any information needed for this or any related Medicare/Medicaid Claims. I request benefits be paid on my behalf.
7. I agree that a photocopy of this form is as valid as the original.
8. I agree and understand that the medical records are the property of SCHS; however, I can request a copy for a nominal fee at any time.
9. I certify that the information provided is true to the best of my knowledge.

Signature of Patient (or Guardian): Date:

PATIENT RIGHTS

I have read and understand my rights and responsibilities as a patient of Southeast Community Health Systems and understand that if the quality of my care is compromised and if SCHS management staff or quality assurance committee cannot address it in a timely fashion, I have the option to report the healthcare compromise to the Joint Commission at (800) 994-6610, or email complaint@jointcommission.org.

PATIENT RESPONSIBILITY

1. I acknowledge that I am fully responsible for any and all expenses incurred at Southeast Community Health Systems for myself and/or dependents/family members.
2. I understand that all payments are due at the time of service.
3. I understand that all payments must be made towards any outstanding balance in addition to the payment for the current date of service rendered.

Signature of Patient (or Guardian): Date: _____

PATIENT RIGHTS Signature of Witness (when patient requires reading of rights): _____

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

I understand that Southeast Community Health Systems does not honor Advanced Directives. In the event of a medical emergency during the clinic visit, first aid measures will be provided, 911 called and hospital transfer initiated.

Signature of Patient: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.
I wish to place the following restrictions on disclosure of my health information (Please list below or write N/A if no restrictions): _____

_____

Signature: _____ Date: _____

Relationship to patient if not signed by patient: _____

Southeast Community Health Systems

MEDICAL HISTORY

Patient Name: _____ **Birth date:** _____ **Date:**_____

Past and Present Illness

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Seizures
- ☐ Blood Clots
- ☐ Depression
- ☐ Anxiety
- ☐ Anemia
- ☐ Asthma
- ☐ Frequent Vaginal Infections
- ☐ Frequent Bladder Infections
- ☐ Peptic Ulcer Disease
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Attack
- ☐
- ☐
- ☐
- ☐
- ☐

Surgery

- ☐ Tonsils
- ☐ Appendix
- ☐ Gallbladder
- ☐ Hernia
- ☐ Breast
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ C-Section
- ☐ D & C
- ☐ Heart
- ☐ Thyroid
- ☐ Stomach
- ☐ Hernia
- ☐ Other (List Below)
- ☐ STD's
- ☐ Risky Sexual Behaviors

_____
_____
_____
_____

Family History (state which family member/s has illness):

Illness/Condition	which family member suffers from each?
Diabetes	
Heart Attack	
High Blood Pressure	
Stroke	
Seizures	
Glaucoma	
Thyroid Disease	
HIV/AIDS	
Migraines	
Mental Illness	
Kidney Disease	
Arthritis	
Cancer	
Type	
Female Cancer	
Male Cancer	

Do you live with someone who has Tuberculosis (TB)? ___ Yes ___ No
Do you live with someone who has Hepatitis? ___ Yes __ No

Do you live with someone who has HIV? ___ Yes ___ No
Do you live with fear of abuse or violence in the home? ___ Yes ___ No
Do you live with anyone who smokes or uses drugs? ___ Yes ___ No

Languages & Barriers

Language(s) Spoken:

Barriers: Language: _____
Reading: _____
Hearing: _____
Vision: _____

Preferences for Learning

Preference for Learning:
Written
Visual
Verbal
_____ Demonstrated

Do you exercise? _____
Do you watch fat, salt and cholesterol in your diet? _____
Do you have any other problems or conditions SCHS should be aware of?_____

Other Surgeries:_____

Current Medications:_____

List of Allergies: _____

Cultural Beliefs: _____

East Baton Rouge Parish

P.O Box 770
Zachary, LA 70791

6351 Main St
Zachary, LA 70791
225-306-2000

8595 Picardy Ave.
Suite 230
Baton Rouge, LA
70809

Livingston Parish

30575 Old Baton Rouge
Hwy
Albany, LA 70711
225-306-2050

Tangipahoa Parish

721 Avenue G
Kentwood, LA 70444
225-306-2100

13318 Berry Bowl Rd
Independence, LA
70443
225-306-2060

St. Helena Parish

490 Sitman St
Greensburg, LA 70441
225-306-2070

Appointment Confirmation & Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. Our providers want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce our revised policy.

Cancellation policy

After the second missed appointment or no show, the patient will not be allowed to schedule an appointment with our office for 6 months. The patient can only have same day appointments if available.

Confirmation Policy

If patient does not confirm their appointment within 24 hours of appointment time, they will be taken off the schedule and their appointment slot will be filled.

As of March 8, 2017 this policy is effective. Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Print name Signature Date

SOUTHEAST COMMUNITY Health Systems
Health, Vitality & Wellness

Albany 225.306.2050
Greensburg 225.306.2070
Independence 225.306.2060
Kentwood 225.306.2100
Zachary 225.306.2000
Picardy 225.763.4990

The **Southeast Community Health Systems** Patient Portal provides an easy-to-use, secure, web-based method for patients to access portions of their medical records on-line. This is available from any computer (desktop, laptop or tablet) with Internet access. When you log into the **Southeast Community Health Systems** Patient Portal, you will be able to view information, including your medical conditions, medications, vital signs, lab results, allergies, and insurance policies.

Register for the Southeast Community Health Systems Patient Portal

Use this form to request a **Southeast Community Health Systems** Patient Portal account. .
Once you have been registered for the **Southeast Community Health Systems** Patient Portal, you will receive an email from **Southeast Community Health Systems** with instructions to complete your Patient Portal registration.

Patient Registration Form

By completing this form, you are authorizing to set up a *Southeast Community Health Systems* Patient Portal Account.

Please complete using CAPITAL LETTERS with one character in each block.

FIRST NAME:	
LAST NAME:	
DATE OF BIRTH:	/ /
Last 4 Digits of SSN	
EMAIL ADDRESS:	
ZIP (Postal) Code #	-
Signature:	
Today's Date	/ /

☐Yes, I would like to be enrolled in the Southeast Community Health Systems Patient Portal.

Please allow 3 business days for your request to be processed.
A Southeast Community Health Systems representative may contact you to verify your information.

SOUTHEAST COMMUNITY Health Systems
Health, Vitality & Wellness

Name_____ **Date of Birth**_____ **Date**_____

The Generalized Anxiety Disorder 7 – Item Scale

Over the last 2 weeks, how often have you been bothered by the following problems? (use "√" to indicate your answer)	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Some-what difficult	Very difficult	Extremely difficult

Add Columns: _____ + _____+ _____

Total Score: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ – 9)

Over the last 2 weeks, how often have you been bothered by the following problems? (use "√" to indicate your answer)	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Some-what difficult	Very difficult	Extremely difficult

Add Columns: _____ + _____ + _____

Total Score: _____

Name: _____ **Date of Birth:** _____ **Date:** _____

Domestic Violence Screening Tool

Instructions: This is a screening measure to help you determine whether you might be involved in an abusive relationship that needs attention. This screening measure is not designed to make a diagnosis or take the place of a professional diagnosis or consultation. For each item, indicate the extent to which it is true, by checking the appropriate box next to the item.

1. Do you feel anxious or nervous when you are around your partner?	No	Sometimes	Regularly
2. Do you watch what you are doing in order to avoid making your partner angry or upset?	No	Sometimes	Regularly
3. Do you feel obligated or coerced into having sex with your partner?	No	Sometimes	Regularly
4. Are you afraid of voicing a different opinion than your partner?	No	Sometimes	Regularly
5. Does your partner criticize you or embarrass you in front of others?	No	Sometimes	Often
6. Does your partner check up on what you have been doing, and not believe your answers?	No	Sometimes	Often
7. Is your partner jealous, such as accusing you of having affairs?	No	Sometimes	Often
8. Does your partner tell you that he or she will stop beating you when you start behaving yourself?	No	Yes	
9. Have you stopped seeing your friends or family because of your partner's behavior?	No	Yes	
10. Does your partner's behavior make you feel as if you are wrong?	No	Sometimes	Regularly
11. Does your partner threaten to harm you?	No	Sometimes	Regularly
12. Do you try to please your partner rather than yourself in order to avoid being hurt?	No	Sometimes	Regularly
13. Does your partner keep you from going out or doing things that you want to do?	No	Sometimes	Regularly
14. Do you feel that nothing you do is ever good enough for your partner?	No	Sometimes	Regularly
15. Does your partner say that if you try to leave him or her, you will never see your children again?	Yes	No	Not Applicable
16. Does your partner say that if you try to leave, he or she will kill him or herself or you?	No	Sometimes	Regularly
17. Is there always an excuse for your partner's behavior? ("The alcohol or drugs made me do it! My job is too stressful! If dinner was on time I wouldn't have hit you! I was just joking!")	No	Sometimes	Regularly
18. Do you lie to your family, friends and doctor about your bruises, cuts and scratches?	Yes	No	Not Applicable

CAGE Questions Adapted to Include Drug Use (CAGE-AID)-Drugs

1. Have you ever felt you ought to cut down on your drinking or drug use? YES / NO

2. Have people annoyed you by criticizing your drinking or drug use? YES / NO

3. Have you felt bad or guilty about your drinking or drug use? YES / NO

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? YES / NO