Griffin
FAMILY MEDICINE
CLINIC

Welcome to Griffin Family Medicine Clinic. We are honored that you have chosen us for your healthcare needs and the needs of your family. Dr. Chris and Amy Griffin are both native Louisianans. They are residency trained and board certified in family medicine and preferred providers for most major insurance companies. Our mission is to provide you prompt and courteous care. We are committed to quality care in Central Louisiana for years to come.

We carry full admitting privileges at Christus St. Francis Cabrini and Rapides Regional Hospital. While we have full privileges, the majority of hospital patient care will be provided by an inpatient specialist. We feel this provides the best care for you whether in our clinic or in the hospital.

Below are a few of our office policies:

- We carry a pager for EMERGENCIES ONLY! We can be reached by calling the office number after hours, 7days a week, 24 hours a day. This is a service for your convenience. Please reserve this for emergencies only.
- Routine medication refills will be done during office hours only. Please provide a 24 hour notice for ALL refills. No narcotics or sedative medications will be called in after office hours or on the weekends.
- There will be a fee for all forms filled out and signed by the provider. This fee is NOT included in your visit charge. 1st page- $25 Additional pages- $10 each.
- You will be reminded about your appointment one day prior. If your appointment is confirmed by yourself or a family member, you are expected to keep your appointment. Failing to do so will result in a $25 fee. This may be avoided by a 24 hour notice. You may leave a message with the answering service.
- If you can not get in touch with physicians after hours and you have an emergency medical need, call 911 or go to the Emergency Room.
- Patients are seen by appointment only. Dr. Chris Griffin, Dr. Amy Griffin, Jamie Perrotti PA-C, Anna Parten MPAS, & Wesley Coleman MPAS will make every effort to accommodate your acute needs.

Office hours are as follows:
Monday-Thursday 8am-5pm
Friday 8am-2pm

_____ _____
Patient signature upon agreement Date

HEALTH HISTORY

Patient Name: _____ Today's Date: _____
Age: _____ Birthdate: _____ Date of last Physical Examination: _____
What is your reason for visit? _____

SYMPTOMS check (√) symptoms you currently have or have had in the past year

GENERAL
- □ chills
- □ depression
- □ dizziness
- □ fainting
- □ fever
- □ forgetfulness
- □ headache
- □ loss of sleep
- □ loss of weight
- □ nervousness
- □ numbness
- □ sweats

GASTROINTESTINAL
- □ appetite poor
- □ bloating
- □ bowel changes
- □ constipation
- □ diarrhea
- □ excessive hunger
- □ excessive thirst
- □ gas
- □ hemorrhoids
- □ indigestion
- □ nausea
- □ rectal bleeding
- □ stomach pain
- □ vomiting
- □ vomiting blood

EYE, EAR, NOSE, THROAT
- □ bleeding gums
- □ blurred vision
- □ crossed eyes
- □ difficulty swallowing
- □ double vision
- □ earache
- □ ear discharge
- □ hay fever
- □ hoarseness
- □ loss of hearing
- □ nosebleeds
- □ persistent cough
- □ ringing in ears
- □ sinus problems
- □ vision – flashes
- □ vision – halos

MEN ONLY
- □ breast lump
- □ erection difficulties
- □ lump in testicles
- □ penis discharge
- □ sore on penis
- □ other

WOMEN ONLY
- □ abnormal pap smear
- □ bleeding between periods
- □ breast lump
- □ extreme menstrual pain
- □ hot flashes
- □ nipple discharge
- □ painful intercourse
- □ vaginal discharge
- □ other
- •Date of last menstrual period_____
- •Date of last Pap Smear _____
- •Had a mammogram?____
- •Are you pregnant?_____
- •Number of children_____

MUSCLE/JOINT/BONE
pain, weakness, or numbness:
- □ arms □ hips
- □ back □ legs
- □ feet □ neck
- □ hands □ shoulders

CARDIOVASCULAR
- □ chest pain
- □ high blood pressure
- □ irregular heart beat
- □ low blood pressure
- □ poor circulation
- □ rapid heart beat
- □ swelling of ankles
- □ varicose veins

SKIN
- □ bruise easily
- □ hives
- □ itching
- □ change in moles
- □ rash
- □ scars
- □ sore that wont heal

GENITO-URINARY
- □ blood in urine
- □ frequent urination
- □ lack of bladder control
- □ painful urination

CONDITIONS check (√) symptoms you currently have or have had in the past year

- □ AIDS
- □ alcoholism
- □ anemia
- □ anorexia
- □ appendicitis
- □ arthritis
- □ asthma
- □ bleeding disorders
- □ breast lump
- □ bronchitis
- □ polio
- □ chemical dependency
- □ chicken pox
- □ diabetes
- □ emphysema
- □ epilepsy
- □ glaucoma
- □ goiter
- □ gonorrhea
- □ gout
- □ heart disease
- □ venereal disease
- □ high cholesterol
- □ HIV positive
- □ kidney disease
- □ liver disease
- □ measles
- □ migraine headaches
- □ miscarriage
- □ mononucleosis
- □ multiple sclerosis
- □ mumps
- □ prostate problem
- □ psychiatric care
- □ rheumatic fever
- □ scarlet fever
- □ stroke
- □ suicide attempt
- □ thyroid problems
- □ tonsillitis
- □ tuberculosis
- □ typhoid fever
- □ bulimia
- □ hepatitis
- □ pacemaker
- □ ulcers
- □ cancer
- □ hernia
- □ pneumonia
- □ vaginal infections
- □ cataracts
- □ herpes

MEDICATIONS list medications you are currently taking	**ALLERGIES** to medications or substances

PHARMACY NAME & LOCATION

Patient Information

First Name _____ M _____ Last Name _____

Date of Birth _____ Sex M F Race _____ Social Security # _____-_____-_____

Mailing Address _____ City _____ State _____ Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____Work Phone (_____)_____

Emergency Contact Name _____ Phone (_____)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employment ☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Employer _____ Employer Phone (_____)_____

Guarantor Information (Person Responsible for Payment) ☐ SAME AS PATIENT

First Name _____ Last Name _____ Date of Birth _____

Social Security # _____-_____-_____ Sex M F Phone (_____)_____

Mailing Address _____ City _____ State _____ Zip_____

Relationship to Patient _____

Primary Insurance

Insurance Company _____ Phone (_____)_____

☐ ***SAME AS PATIENT*** Policy Holder Name _____ Date of Birth _____

Social Security # _____-_____-_____ Relationship to Patient _____

Insurance ID # _____ Group # _____

Secondary Insurance

Insurance Company _____ Phone (_____)_____

☐ ***SAME AS PATIENT*** Policy Holder Name _____ Date of Birth _____

Social Security # _____-_____-_____ Relationship to Patient _____

Insurance ID # _____ Group # _____

ALL INFORMATION IS STRICTLY CONFIDENTIAL

FAMILY HISTORY fill in health information about your immediate family

Relation	Age	State of Health	Age at Death	Cause of Death
FATHER				
MOTHER				
BROTHERS				
SISTERS				

Check if your blood relatives had any of the following

	DISEASE	RELATIONSHIP TO YOU
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Stroke	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION

PREGNANCY HISTORY

YEAR OF BIRTH	SEX	COMPLICATIONS, IF ANY

Have you ever had a blood transfusion? □YES □NO

If yes, please give approximate dates:_____

SERIOUS ILLNESS/INJURY	DATE	OUTCOME

HEALTH HABITS

check which substances you use & describe how much you use

	CAFFEINE	
	TOBACCO	
	STREET DRUGS	
	OTHER	

OCCUPATIONAL CONCERNS

CHECK IF YOUR WORK EXPOSES YOU TO THE FOLLOWING:

	STRESS
	HAZARDOUS SUBSTANCES
	HEAVY LIFTING
	OTHER

YOUR OCCUPATION:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of patient, parent, guardian or personal representative — Date

_____ _____

Please print name of patient, parent, guardian or personal representative — Date

AUTHORIZATION AND RELEASE

I, the undersigned, have insurance coverage with (Name of Insurance Company) _____

and assign directly to Dr. _____ 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 the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured or Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to Dr. _____ on my behalf for any services furnished to me by that physician. I authorized any holder of medical information about me to be released to the health care financing administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

Griffin Family Medicine Clinic

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used for the following:

- conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly

- obtain payment from third party payers

- conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name _____

Signature of Patient or Guardian _____

Date _____

Griffin FAMILY MEDICINE CLINIC

AUTHORIZATION FOR MEDICAL RECORD INFORMATION RELEASE

(request can not be processed if all fields are not completed)

I, _____, do hereby authorize the release of the following records and/or information with limitations, which may include treatment of psychiatric illness, alcohol or drug abuse, HIV test results or AIDS diagnoses, and/or sexual preference. Review of the record is also authorized.

Patient Name _____

Date of Birth _____

Social Security # _____-____-_____

Street Address _____

City-State-Zip _____

Phone Number (_____)_____

Records Requested From:

Doctor _____

Address _____

_____

Phone _____

Fax _____

Records to be Sent To:

Doctor _____

Address _____

_____

Phone _____

Fax _____

Please release the following information:

___ ALL RECORDS
___ Face Sheet
___ X-Ray Films/Reports
___ Immunization Reports
___ Radiology Reports
___ Consultation Reports
___ Pathology Reports
___ Discharge Summary
___ History & Physical
___ Lab Reports
___ Operative Reports
___ Other (specify) _____

For the following time period _____ to _____

I understand that this authorization shall remain in affect for 90 days from the date of my signature unless an earlier expiration date is specified in the following space (_____). I also understand that except to the extent that actions are taken based on my authorizations, I may withdraw this authorization at any time by written notification to the parties involved. I further agree Griffin Family Medicine may charge me or my designated recipient's cost incurred in preparing copy of the requested medical records.

_____ _____

Signature of Patient/Parent/Guardian/Authorized Rep — Date

_____ _____

Signature of Physician/Nurse/Office Employee that Witnessed — Date

GRIFFIN FAMILY MEDICINE CLINIC

145 Yorktown Dr
Alexandria, LA 71303
Telephone: 318-445-8380

IMPORTANT: List all persons (family, friends, etc) that you authorize Griffin Family Medicine to release or speak with about your medical information. Please be aware anyone that is not listed will be unable to receive any of your information, written or verbal, from our clinic.

Name:_____

Name:_____

Name:_____

Name:_____

Name:_____

Name:_____

***Email for patient portal (print):**_____

Your Name (print):_____

Date of Birth:_____

Signature:_____

Date:_____

Griffin Family Medicine Clinic
145 Yorktown Drive
Alexandria, La 71303
(318)445-8380]

DISCLOSURE OF FINANCIAL INTEREST

As Required by R.S. 37:1744 and LAC 46:XLV.4211-4215

TO: _____
(Patient Name)

ADDRESS: _____
(Patient Address)

DATE: _____
(Date)

Louisiana law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to another health care provider or facility in which the physician has a significant financial interest. I am referring you, or the named patient for whom you are the legal representative to:

Central Louisiana Surgical Hospital
651 North Bolton Avenue
Alexandria, LA 71301

to obtain a procedure / surgical procedure _____
(Purpose of the referral)

I have a financial interest in the health care provider to which I am referring you. The nature and extent of my interest is that I am one of several physicians who own an interest in the hospital to which you are being referred.

PATIENT ACKNOWLEDGMENT

I, the above-named patient, a legal representative of such patient, hereby acknowledge receipt, on the date indicated and prior to the described referral, a copy of the foregoing Disclosure of Financial Interest.

_____
Signature of Patient or Patient Representative