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 your 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.

After hours, weekends, and holidays:

- 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. For routine matters such as refills, scheduling, and billing questions, please place your call during regular business hours.

Below are a few of our office policies:

- Routine medication refills will be done during office hours only. Please provide **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 two days 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 $75 fee. **This may be avoided by 24-hour notice.**
- If you cannot 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 will make every effort to accommodate your acute needs.

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

Phone System:

Our front desk staff assists patients both in person and over the phone. If they are helping other patients and cannot answer your call, please leave a detailed voicemail message. **Please leave only one voicemail message**. Leaving multiple messages may delay our response to your call. We typically return calls within 2-3 hours after the initial voicemail has been left.

- Please leave your name, date of birth, call back number, and brief message.

Option 1: Appointments

Option 2: Nurse Call

Options 3: Medication refills

Option 4: Billing

Refills:

Routine refills should be requested at the time of your appointment or during regular business hours.

- If you are calling for a medication refill, please leave the medication name and preferred pharmacy.
- For written prescriptions, you will be notified by the office when it is available for pick up.

Kindly wait until you've been informed that your pickup is ready before coming into the clinic area. Providers are busy with patients during the day and cannot process refill requests between appointments. Please note that completing your request may take 24 to 48 hours.

Request for written correspondence:

The completion of letters or other correspondence from the providers may require a processing time of one week or longer.

Payment Policy:

- Payment is due at the time of service. For insured patients with participating plans, applicable copays and deductibles will be collected during the visit.
- We accept personal checks, cash, money orders, Visa, Mastercard, American Express, and Discover. NSF checks returned to the office will incur a $25 fee.
- We respectfully request that you inform us of any changes to your insurance coverage prior to seeing the provider. An image of your current insurance card and picture ID maybe requested prior to each visit.
- If medical claims are denied for reasons other than physician office error, payment responsibility will be transferred to the patient or designated guarantor.
    - Do not ask physician or office staff to change a medical diagnosis for the purpose of securing payment from your insurance company. This request is not appropriate and may be considered unethical or fraudulent.

No show policy:

- We reserve the right to charge a $75 fee for any missed appointment that occurs without timely prior notice. Cancellations must be received at least 4 hours before your appointment time. This fee is not covered by insurance.
- If you have **three no show appointments**, you will be dismissed from the clinic.

Authorization for care:

By signing to acknowledge receipt of these documents, you are giving your authorization and consent for any treatment necessary for the patient's care. This may include, but is not limited to, medications, procedures, laboratory tests, x-rays, or other evaluations the practitioners deem appropriate. You also authorize Griffin Family Medicine to provide information about your illness or injuries to insurance carriers. Additionally, you permit your insurance company to pay benefits directly to Griffin Family Medicine for any charges related to your medical treatment.

Patient Consent for Use and Disclosure of Protected Health Information:

I hereby give my consent for Griffin Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The notice of privacy practices provided by Griffin Family Medicine has been given to me and described such uses and disclosures more completely.

I am entitled to review the notice of privacy practices before providing my consent. Griffin Family Medicine retains authority to amend its notice of privacy practices at any time. To obtain a revised notice of privacy practices, please submit a written request to the office manager at Griffin Family Medicine.

By providing this consent, Griffin Family Medicine is authorized to contact my home or alternative locations and to leave messages via voicemail or in person regarding matters that facilitate the practice's execution of treatment, payment, and healthcare operations (TPO). These communications may include appointment reminders, insurance-related information, and calls related to my clinical care, including laboratory results and other pertinent details.

By providing this consent, Griffin Family Medicine is authorized to send to my residence or an alternative designated location any materials necessary to facilitate treatment, payment, or healthcare operations, including appointment reminder cards and patient statements.

I am entitled to request that Griffin Family Medicine limit its use or disclosure of my Protected Health Information (PHI) when conducting treatment, payment, or healthcare operations (TPO). While the practice is not obligated to accept such restrictions, it must adhere to any agreed-upon limitations.

By signing this form, I give my permission for Griffin Family Medicine to use and share my Protected Health Information (PHI) as needed for treatment, payment, or healthcare operations.

I understand that I may revoke my consent in writing, except where disclosures have already been made by the practice based on my previous consent. If I choose not to sign this consent, or subsequently withdraw it, Griffin Family Medicine reserves the right to decline providing treatment to me.

Patient Signature upon agreement

Date

Medicare Shared Savings Program
Accountable Care Organizations

Working together to give you the best care.

GRIFFIN FAMILY MEDICINE

is part of an Accountable Care Organization (ACO). We've teamed up with other doctors, hospitals, and health care providers to make sure you get the best care.

We provide coordinated care for you to get well & stay well

- You get patient-centered care focused on YOUR needs.
- Your health care providers can see the same test results, treatments, and prescriptions.
- More coordination helps prevent medical errors and drug interactions.
- You may save time, money, and frustration by avoiding repeated tests and appointments.
- Better communication can help protect against Medicare fraud and waste.

You may have access to expanded benefits

- We may offer telehealth services, which let your primary care doctor care for you without an in person visit.
- Ask your health care provider if you qualify for these benefits.

Get the most from your care with our communication & support

- When you choose a health care provider that participates in an ACO, they'll help you get the right care at the right time. You can visit Medicare.gov and log into (or create) your secure Medicare account to choose a primary care doctor.
- Medicare protects the privacy of your health information. If you don't want Medicare to share information with your health care providers for care coordination, call 1-800-MEDICARE (1-800-4227). Medicare may still share general information to measure provider quality. For more information on how Medicare may use and give out your information, visit Medicare.gov and search for "privacy."

Want more information?

- **Ask our front desk, or call us at 3184458380** . You can also visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.To report a Medicare-related concern or complaint, call 1-800-MEDICARE (1-800-633-4227). To learn more about Accountable Care Organizations, refer to the link here: Medicare.gov Accountable Care Organizations webpage

Centers of Medicare and Medicaid Services, Medicare Shared Savings Program

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
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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	___ Radiology Reports	___ History & Physical
___ Face Sheet	___ Consultation Reports	___ Lab Reports
___ X-Ray Films/Reports	___ Pathology Reports	___ Operative Reports
___ Immunization Reports	___ Discharge Summary	___ 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