SOUTHERN INTERNAL MEDICINE

FULL NAME:_____

EMAIL:_____ **DOB:**_____

ADDRESS:_____

HOME NUMBER:_____**CELL NUMBER:**_____

MALE:___FEMALE:___ RACE: WHITE__BLACK__HISPANIC__ASIAN__OTHER:_____

STATUS: MARRIED__ DIVORCED__ SINGLE__ WIDOWED__ OTHER:_____

OCCUPATION:_____**RETIRED: Y___N___**

PRIMARY INSURANCE PROVIDER:_____**MEMBERID#:**_____

SECONDARY INSURANCE PROVIDER:_____**MEMBERID#**_____

SOCIAL SECURITY NUMBER:_____

PRACTICE POLICY:

Southern Internal Medicine Clinic by Dr. Eric Payne *is a primary care clinic treating patients who suffer from high blood pressure, heart disease, asthma/COPD, obesity, diabetes, high cholesterol, gastrointestinal problems, arthritis, and much more! Here at Southern Internal Medicine of Franklinton, LA, we strive to promote the health and well-being of our community through the delivery of efficient, respectful, and professional medical care. Our role as your internal medicine provider is to provide you with checkups and preventive medicine, as well as medical treatment for any existing conditions you may have.*

This practice has a legal obligation to the insurance companies that we are contracted with to collect copayments, coinsurance and deductibles. Therefore, ***all payments are due at time of service rendered.*** *Once a balance has reached 90 days without any payment, the balance may be transferred to a third party for further collections or other actions. Our office will obtain your insurance benefits: however, it is your responsibility to provide our office with your insurance information prior to your appointment to avoid unnecessary wait times.* ***All refill requests must be done before Friday at noon.*** *Any prescription requests the office receives after 12pm on Fridays will be refilled on the next business day. If you are unable to keep your appointment,* ***please notify our office at least 24 hours in advance to cancel or reschedule your appointment.*** *Your courtesy will allow other patients seeking medical treatment the option to use your scheduled time. Continued no-shows for appointments will cause you to be dismissed from the clinic.*

OFFICE POLICY:

Our philosophy is to provide you with the highest quality medical care. To help us with that, we ask that you fill out our paperwork completely. Failure to finish completing paperwork-leaving questions blank, not listing medication dosages, etc. ***will cause you to be denied upon review****. Our office staff will be happy to answer any questions about scheduling or our policies. Medical questions will be referred to by one of our experienced nurses or provider. For any questions, please call us or message our social media page! Southern Internal Medicine Clinic has recently moved! Our clinic is located at* ***810 Riverside Drive in Franklinton, LA. 70438.*** *We are making a few changes since the move! Such as, extended days, new policies, and much more. Our current hours are* ***TUESDAY-FRIDAY 7AM-5PM CLOSED FOR LUNCH 12PM-1PM.***

By signing below, you are acknowledging that you have read and fully understand our policies

PATIENT'S SIGNATURE:_____***TODAY'S DATE:*** _____

Reason for visit / Current problem:_____

_____

OTHER HEALTHCARE PROVIDERS

We would like to know about other providers and specialists that have been involved in your medical care.

Physician Name	Specialty	Phone Number

Pharmacy:_____

Address and Phone Number:_____

ALLERGIES:_____

_____

MEDICATION LIST:

Be sure to list the correct name and dosage of your medications. If you are not currently on any medications please write N/A down below.

MEDICATION/DOSAGE	PRESCRIBED BY	PHARMACY

MEDICATION LIST:

Be sure to list the correct name and dosage of your medications. If you are not currently on any medications please write N/A down below.

MEDICATION/DOSAGE	PRESCRIBED BY	PHARMACY

VACCINATIONS:

Please check the box if you have received the vaccines listed.
Add any additional vaccines in the empty spaces.

VACCINE	DATE	VACCINE	DATE

SOCIAL HISTORY:

What is your exercise level?
NONE__ OCCASIONALLY__ MODERATE__ HEAVY__

Do you use any illegal or recreational drugs?
YES__NO__

Do you or have you ever smoked tobacco?
NEVER__ FORMER__ CURRENTLY__

What is your level of alcohol consumption?
NONE__ OCCASIONALLY__ MODERATE__ HEAVY__

SURGICAL HISTORY:

Please list any surgeries or procedures you have had below.

Surgery/Procedure	Date/Year

PROBLEMS:

Please circle Yes or No.

Y N Acid Reflux
Y N Alcohol Addiction
Y N Allergies
Y N Anemia
Y N Anxiety
Y N Arthritis
Y N Asthma
Y N Bleeding Disorder
Y N Bronchitis/COPD
Y N Depression
Y N Headaches
Y N Heart Disease
Y N High Cholesterol
Y N Irritable Bowl

Y N Chronic Pain
Y N Diabetes Type I
Y N Diabetes Type II
Y N Seizure Disorder
Y N Hearing Loss
Y N High Blood Pressure
Y N Endometriosis
Y N Cancer
Y N Thyroid Disease
Y N Stroke
Y N Smoker
Y N Liver Disease
Y N Kidney Disease
Y N Insomnia

FAMILY HISTORY:

Please fill in the circles that apply to your Mother, Father, Brother, Sister, or Other.

M	F	B	S	O		M	F	B	S	O	
○	○	○	○	○	Acid Reflux	○	○	○	○	○	Headaches
○	○	○	○	○	Allergies	○	○	○	○	○	Heart Disease
○	○	○	○	○	Anemia	○	○	○	○	○	High Cholesterol
○	○	○	○	○	Anxiety	○	○	○	○	○	Irritable Bowel
○	○	○	○	○	Arthritis	○	○	○	○	○	Kidney Disease
○	○	○	○	○	Asthma	○	○	○	○	○	Liver Disease
○	○	○	○	○	Alcohol Addiction	○	○	○	○	○	Smoker
○	○	○	○	○	Bleeding Disorder	○	○	○	○	○	Stroke
○	○	○	○	○	Depression	○	○	○	○	○	Thyroid Disease
○	○	○	○	○	Bronchitis/COPD	○	○	○	○	○	Chronic Pain
○	○	○	○	○	Diabetes Type I	○	○	○	○	○	Diabetes Type II
○	○	○	○	○	Seizure Disorder	○	○	○	○	○	Hearing Loss
○	○	○	○	○	High Blood Pressure	○	○	○	○	○	Endometriosis
○	○	○	○	○	Cancer	○	○	○	○	○	Insomnia

Do you have any other medical condition, injury or anything else we should be aware of that we have not mentioned?

Scheduling an appointment:

Our philosophy is to provide you with the highest quality of care. To help us with that, we request that you return your paperwork and provide us with your insurance cards before we schedule your appointment. We know that your time is as valuable as ours and we make every effort to keep our schedule on time. If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance. Thank you!

Office Hours:

Southern Internal Medicine Clinic is open ***Tuesday-Friday from 7am-5pm*** **we are *closed for lunch from 12pm-1pm.*** Our office lab is open Tuesday-Friday from 8am-11am-*No appointment is needed for labs! We are located at* ***810 Riverside Drive in Franklinton, LA 70438.***

Contact Us:

Our office staff will be happy to answer your questions about scheduling and policies. Any medical questions will be referred to one of our experienced nurses or provider. Extended phone consults or after-hour calls may be billed as a nurse visit. For any questions, please call us or message one of our social media pages!

P: (985)205-0083 F: (985)322-2076 @SouthernInternalMedicineClinic

Privacy and Security:

Southern Internal Medicine Clinic holds all information pertaining to the care and treatment of our patients in the strictest confidence. All information in the patient's medical record is maintained with the utmost care and respect to preserve privacy and confidentially. SIMC fully complies with the Federal Government's mandated HIPAA requirements for patient confidentially and privacy of healthcare information. As a new patient, you will be asked to review and acknowledge receipt of our Notice of HIPAA Privacy Practice that outlines the circumstance for which we can disclose protected health information for instances not related to your ongoing treatment and/or payment claims. A patient may request to view a copy of their medical records in the office.

Collection Policy:

Southern Internal Medicine Clinic has a legal obligation to the insurance companies they are contracted with to collect copayments, deductibles, and coinsurance. All payments are due at time of services rendered. Once a balance reaches 90 days old, regardless of payment received, it may be transferred to a third party for further collections.

SIGNATURE:_____ DATE:_____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

NAME:_____DOB:_____
SOCIAL SECURITY #:_____
MAILING ADDRESS:_____
CITY/STATE/ZIP CODE:_____
TELEPHONE #:_____

I authorize any provider that has treated me or is presently treating me to release requested Protected Health Information PHI to:
NAME: Southern Internal Medicine Clinic Eric Payne, MD
MAILING ADDRESS: 810 Riverside Drive
CITY/STATE/ZIP CODE: Franklinton, LA 70438

As the purpose of this authorization is to authorize the release of medical information following protected health information:
Medical History, Examination, Reports, Surgical Reports, Treatment or Tests, Prescriptions, Immunizations, Hospital Records including Reports, Laboratory Reports, X-ray Reports, DD Records, Discharge summaries.
In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release any of the following records that are applicable:
Alcoholism, Drug Abuse, Mental Health, Vocational Rehabilitation, HIV(AIDS), Sexually Transmitted Diseases, Genetics, Psychotherapy Notes.

I do not authorize the release of the following types of my health information: (if none, leave blank)

_____

Please provide medical records for the time period of _____ through _____. This authorization to release medical information will expire on: _____. I understand that if I do not specify an expiration date, this authorization will expire six months from the date on which it was signed.

SIGNATURE:_____DATE:_____

PATIENT PORTAL USER AGREEMENT

Southern Internal Medicine is pleased to provide a Patient Portal in partnership with *Joint Efforts* for the exclusive use of patients in our practice. The Patient Portal is designed to enhance patient physician communication. All users must be established by a previous office visit. We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services: which may or may not be utilized at this time:

- *Request prescription refills*
- *Receive educational material*
- *View current and past statements*
- *Send messages to our staff*
- *Receive health maintenance reminders*

The Patient Portal is not intended to provide internet based diagnostic medical services. The following limitations also apply:

- *No internet-based triage treatment requests. Diagnosis can only be made, and treatment rendered after the patient is seen by a medical provider in our clinic.*
- *No emergent communication or services. Any emergent conditions should be handled by calling the office directly, going to an urgent care clinic or emergency room or calling 911 should the emergency be life threatening.*
- *No requests for narcotic medications will be accepted. No requests for new prescriptions or refills for conditions for which you are not being treated by our clinic will be accepted.*
- *It may take 72 hours to receive a response to a request.*
- *If you lose your password or username, you may request a new one through the web portal or in person at the office by providing valid identification.*
- *Always remember to logout and close your browser when you are finished accessing password protected patient portal services. This prevents someone else from accessing your personal information.*
- *You should never use a public computer to access the patient portal.*

PATIENT PORTAL USER AGREEMENT

This patient portal is provided as a courtesy to our patients. However, if abuse or negligent usage of the Patient Portal persists, we reserve the right, at our discretion, to terminate Patient Portal offering, suspend user access and modify services available through the Patient Portal. This service is provided in partnership with Joint Efforts. The data his HIPAA compliant with high level encryption that exceeds the HIPAA standards.

Patient Acknowledgement and Agreement: *I acknowledge that i have read and fully understand this consent form. I have been given the risks and benefits of the Patient Portal and agree that i understand the risks associated with online communication. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Portal. In addition, I agree to adhere to the polices set forth as well as any other instruction's or guideline's that Joint Efforts may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all have been answered to my satisfaction.*

SIGNATURE: _____ ***DATE:*** _____

SECURE EMAIL: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions, which explains how my medical information will be used and disclosed.

_____

Signature Date

_____

Name Of Personal Representative and Relation. Date

I am giving authorization to Southern Internal Medicine Clinic to disclose my medical and insurance information to the below person(s).

_____

Person to whom information may be disclosed. Date

SOUTHERN INTERNAL
MEDICINE

CONTROLLED SUBSTANCE AGREEMENT

Name:_____ **DOB:**_____

You have agreed to receive a controlled substance as part of your treatment from **Dr. Eric Payne.** It is important that you have an understanding of the risks and responsibilities that go along with this treatment. Please read each statement and sign this agreement/contract below. If you have any questions regarding this information or the office policy regarding the prescribing of controlled substances, please request clarification.

I,_____**understand that:**

Any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand that the goal of using a controlled substance is to decrease my symptoms and increase my functional level. If my symptoms do not significantly decrease and/or my function increase, the medication will be stopped.

I am aware that the use of such medicine has risks associated with it, including, but not limited to *sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal, and the possibility that the medicine will not provide complete relief.*
The overuse of controlled substances can result in serious health risks including respiratory depression or even death.

Medications will be strictly monitored, and all my medications should be filled at the same pharmacy. Should the need arise to change pharmacies our office must be informed. **The pharmacy I have selected is:**

_____

Please read each statement carefully and sign below.

Early refill requests will not be honored. All patients are responsible for making and keeping up with scheduled appointments.

I will take the narcotic medication only as prescribed. Any changes must first be discussed and agreed upon with *Dr. Eric Payne*.

I understand that my medications will not be refilled if I miss my appointment, fail to schedule a follow-up appointment or refuse a urine test.

Medications will not be replaced for any reasons. Including if they get lost, wet, destroyed, stolen, etc. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

I agree that only my physician at **Southern Internal Medicine Clinic** will prescribe me any controlled substances. (Unless it is authorized by us under limited circumstances). I will not obtain narcotics or other controlled substances from a source besides **Southern Internal Medicine Clinic** for any changes or need for additional narcotic medications. If it is brought to the attention of **Southern Internal Medicine Clinic** that other providers are prescribing medications for me, *Dr. Eric Payne* reserves the right to discontinue prescribing medication and/or discharge me from the clinic.

I will inform **Southern Internal Medicine Clinic** of any changes in my medical condition. Such as, pregnancy, changes in prescription and/or over the counter medication that I take, any side effects that I may experience from any of the medications that I take.

I will communicate fully and honestly with my physician about the character and intensity of my symptoms, the effect of the symptoms on my daily life, and how well the medicine is helping to relieve my symptoms.

Routine blood work and drug screens or random pill counts may be a part of my treatment plan. I agree to have them done on the day the physician requests it.

The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, **all confidentiality is waived**, and these authorities may be given full access to my records.

Patient Signature: _____

It is a **felony** to obtain narcotic medications under false pretenses, forged, or altered prescriptions. This could include getting medication from more than one doctor, mispresenting myself to obtain medications, using them in a manner other than prescribed, or diverting the medications in any other way (selling). These acts will be reported to the law enforcement authority.

I agree to tell **Southern Internal Medicine Clinic** my complete and honest personal drug/medication usage and history.

I will not use any illegal 'street drugs' while receiving medications from **Southern Internal Medicine Clinic**.

I know that my medications will be stopped if any of the following occurs:

- **I trade, sell, share, or misuse the medication.**
- **I refuse a pill count or blood/urine test**.
- **My blood or urine test shows the presence of medications that our physician is not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for**.
- **I get a controlled substance from sources other than *Southern Internal Medicine Clinic*.**
- ***Southern Internal Medicine Clinic* feels that it is my best interest that treatment be stopped.**
- **Any aggressive behavior or verbal abuse toward physician or staff.**
- **I consistently miss scheduled appointments.**
- **I have broken any part of this agreement.**

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no narcotic prescriptions will be written) by **Southern Internal Medicine Clinic.**
By signing this agreement, I affirm that I have read, understand, and accept all of the terms of this agreement.

Patient Signature:_____ **Date:**_____

Clinic Witness:_____ **Date:**_____

Sincerely,

Dr. Eric Payne, MD.