OHL COMMUNITY HEALTH CENTER

NEW PATIENT PACKET

WELCOME to the Odyssey House Louisiana Community Health Center!

We are very happy to have you as a patient and will make your health and well-being our top priority.

We are a Federally Qualified Health Center and your Patient Centered Medical Home. That means that we care for the whole body and we put you, the patient, at the center of the circle of care. Your voice matters. Our role, as providers, is to support you and to get you actively involved in your healthcare plan. We believe you should have a say in the decision making. Together we are a strong team.

This is your New Patient Packet. Get comfortable because there are some forms you need to fill out, so that we will have the most up-to-date information about you and your history. Some forms you will need to sign and return to us.

Here's what you need to complete to help us serve you better:

- Initial Patient Registration Form
- Notice of Privacy Practices & HIPM Compliance
- Consent for Treatment
- Patient Rights and Responsibilities
- Statement of Patient Financial Responsibility
- Sliding Fee Scale Application (if applicable)

Please bring the following items to your first visit:

- Photo ID
- Insurance Card (if applicable)
- Co-pay (we accept cash, checks, and credit cards)

That is all there is to it. You are officially a patient of the Odyssey House Louisiana Community Health Center. Please visit our website www.ohlinc.org to get familiar with all that we do. And if you are on Facebook or Instagram please "like" us. We use these platforms to distribute important and fun information.

Thank you for choosing the Odyssey House Louisiana Community Health Center. Our promise to you is that you will receive the best health care possible.

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INITIAL PATIENT REGISTRATION FORM

<table>
<tr><td colspan="3">SSN:</td></tr>
<tr><td>Legal First Name:</td><td>MI:</td><td>Last Name:</td></tr>
<tr><td>Preferred Name:</td><td colspan="2">Date of Birth:</td></tr>
<tr><td>Address:</td><td>City:</td><td>State:</td></tr>
<tr><td>Parish:</td><td colspan="2">Zip Code:</td></tr>
<tr><td>Home Phone:</td><td colspan="2">Cell Phone:</td></tr>
<tr><td>Employed: ☐ Yes ☐ No</td><td colspan="2">Employer:</td></tr>
<tr><td colspan="3">Email:</td></tr>
<tr><td colspan="3">Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single</td></tr>
<tr><td>Emergency Contact:</td><td colspan="2">Emergency Contact Phone Number:</td></tr>
</table>

<table>
<tr><td>Are you insured? ☐ Yes ☐ No</td><td>Insurance:</td><td>Member ID:</td></tr>
<tr><td colspan="3">If uninsured, would you like to apply for Medicaid? ☐ Yes ☐ No</td></tr>
<tr><td colspan="3">Please note if you are uninsured and choose not to apply for Medicaid you will be responsible for the cost of your visit today.</td></tr>
</table>

<table>
<tr><td colspan="3">Race:
☐ Asian ☐ Black ☐ Pacific Islander ☐ American Indian ☐ White ☐ More than one race
☐ Decline to Answer</td></tr>
<tr><td colspan="3">Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino</td></tr>
<tr><td colspan="3">Primary Language Spoken:</td></tr>
<tr><td colspan="3">Do you need a translator for today's visit? ☐ Yes ☐ No</td></tr>
<tr><td>Homeless: ☐ Yes ☐ No</td><td colspan="2">Homeless Type: ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street</td></tr>
<tr><td colspan="2">Do you receive public housing assistance? ☐ Yes ☐ No</td><td>Veteran: ☐ Yes ☐ No</td></tr>
<tr><td>Gender: ☐ M ☐ F</td><td>Trans: ☐ M2F ☐ F2M</td><td>Sexual Orientation:</td></tr>
</table>

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HIPPA ACKNOWLEDGEMENT/ CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996(HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.
- I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: ______________________________

Signature: ______________________________

Signature Date: ____________________

Relationship to Patient (if Patient unable to sign): ____________________

OHL COMMUNITY HEALTH CENTER

DESIGNATION OF HEALTH CARE SURROGATE

In the event I have been determined to be incapacitated to provide informed consent for the medical treatment and surgical and diagnostic procedures, I wish to designate a surrogate for the health care decisions.

I fully understand that these designations will permit my designee to make health care decisions and to provide, or withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from health care facility.

Name of Surrogate:			
Address:	*City:*	State:	Zip:
Home Phone:	*Cell Phone:*		

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternative surrogate:

Name of Surrogate:			
Address:	*City:*	State:	Zip:
Home Phone:	*Cell Phone:*		

Patient Signature　　　　Print　　　　Date

Witness Signature　　　　Print　　　　Date

I affirm that that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

Name (person that is not Surrogate): ______________________

Name (person that is not Surrogate): ______________________

OHL

ODYSSEY HOUSE LOUISIANA

PATIENT RIGHTS & RESPONSIBILITIES

At Odyssey House Louisiana, our goal is to provide excellent health care to every patient. Our patients have the following rights and responsibilities regardless of race, color, culture, language, ethnicity, religion, sex, sexual orientation, gender identity or expression, socioeconomic status, age, national origin, physical or mental disability, and/or veteran status:

It is your responsibility to:

- Give correct and complete information about your health status and health history.
- Ask questions if you do not understand information or instructions.
- Inform your caregivers if you do not intend to or cannot follow the treatment plan.
- Accept health consequences that may occur if you decide to refuse treatment plan.
- Cooperate with your caregivers.
- Respect the rights and property of other patients.
- Tell your caregivers of any of the medication you brought from home.
- Report any changes in your health status to your caregivers.

You have the right to:

- Respect and Privacy
  - Respect in a caring and safe environment
  - Personal privacy and confidentiality of your health information
- Quality Care
  - Proper evaluation and treatment
- Have your concerns heard and resolved when possible. If you have concerns about your care, contact your caregivers or a supervisor or request to submit written patient grievance. Our agency values your concerns.
- Information & Communication
  - Know the names and the roles of those caring for you.
  - Communicate with caregivers in a language or method you can understand.
  - Be informed about your health status, recommended treatments, options, risks and benefits.
  - Information about the costs of your care and payment methods.
  - Review and receive a copy of your medical record, subject to state law and hospital policy.
- Make decisions
  - Be involved with your care through discussions with your caregiver.
  - Be informed of benefits and risks of your treatment options and agree to or refuse a course of action.

- Designate a support person or persons of your choosing to be involved in your care when appropriate.
- Direct your care through Advance Directive. Advance Directives are legal forms which state your choices about the care you want to receive in serious health situations. Advance Directives are also used to name someone to make decisions for you if you cannot speak for yourself. At your request, we will help you create an Advance Directive.
- Seek an alternate doctor or ask for a second opinion.

ODYSSEY HOUSE LOUISIANA

OHL COMMUNITY HEALTH CENTER

MEDICAL HISTORY

Patient Name: _____

Date of Birth: _____

PERSONAL HEALTH HISTORY

Have you EVER HAD, or do you CURRENTLY HAVE, any of the following?
Check each item, if YES, please explain below.

Condition	Y	N	Condition	Y	N
Chicken Pox or Shingles	Y ☐	N ☐	Drug or Alcohol Dependency	Y ☐	N ☐
Measles	Y ☐	N ☐	Eating Disorders	Y ☐	N ☐
Mumps	Y ☐	N ☐	Bleeding or Blood Disorder	Y ☐	N ☐
Skin Problems or Chronic Rash	Y ☐	N ☐	HIV/AIDS	Y ☐	N ☐
Eye Problems	Y ☐	N ☐	Chronic/ Recurrent Infection	Y ☐	N ☐
Hearing Loss	Y ☐	N ☐	Tumor/Cancer	Y ☐	N ☐
Chronic Cough	Y ☐	N ☐	Anemia	Y ☐	N ☐
Asthma	Y ☐	N ☐	Diabetic	Y ☐	N ☐
COPD	Y ☐	N ☐	Psychiatric or Emotional Problems	Y ☐	N ☐
Shortness of Breath	Y ☐	N ☐	Liver Disease/ Hepatitis	Y ☐	N ☐
Lung Problems	Y ☐	N ☐	Kidney Disease	Y ☐	N ☐
Tuberculosis or Positive TB Skin Test	Y ☐	N ☐	Weight Loss or Gain	Y ☐	N ☐
Chest Pain	Y ☐	N ☐	Thyroid Problems	Y ☐	N ☐
Heart Trouble/ Attack	Y ☐	N ☐	Seizures/ Brain Injury	Y ☐	N ☐
High Blood Pressure	Y ☐	N ☐	Joint Pain/ Injury	Y ☐	N ☐
Stoke	Y ☐	N ☐	Arthritis/ Gout	Y ☐	N ☐
Stomach or Intestinal Problems	Y ☐	N ☐	Back Pain/ Injury	Y ☐	N ☐
Heartburn	Y ☐	N ☐	Neck Pain/ Injury	Y ☐	N ☐
Dizziness/ Fainting	Y ☐	N ☐	Memory Loss	Y ☐	N ☐
Weakness/Tiredness	Y ☐	N ☐	Severe Headaches	Y ☐	N ☐

Have you had any surgeries? _____

Additional information:

Are you currently taking any medications? If so, please list below:

Medication	Amount	Frequency	Do you need a refill?
			Y ☐ or N ☐
			Y ☐ or N ☐
			Y ☐ or N ☐
			Y ☐ or N ☐
			Y ☐ or N ☐
			Y ☐ or N ☐
			Y ☐ or N ☐

Do you have any known allergies? If so, please list below:

What is the reason for your visit today:

Symptoms include:

When did the symptoms start?

Have you been to the Emergency Room in the past 3 months? If so, what were you seen for:

When was your last menstrual period?

Date of late Tetanus shot:

Have you had any recent falls? Y ☐ or N ☐
If so, please explain:

Have you had any medical care from another medical provider in the past two (2) years?
Y ☐ or N ☐
If so, please explain: