Lake Area Psychiatry, LLC
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Patient Registration Information

Please fill out this form completely. For children, include parent's name(s). Also list all phone numbers where you can be reached.
We must have an emergency number for all patients.

Patient Name: First Middle Last			**Today's Date:**
Social Security # of patient	Date of Birth:	Age:	Sex: Male Female
The following questions are optional and are used for Statistical and research purposes. If you choose not to answer, please check "Declined"	Race: Declined:	Ethnicity: Declined:	Preferred language: Declined:
Mailing Address:			
City	State / ZIP	e-mail address:	
Home Phone:	Cell Phone:	Alt No#	
May we leave a message? Yes/ No	Yes/ No	Yes /No	
Patient's Employer:		Occupation:	
Circle One: Married Divorced Widowed Single	Spouse, Parent or Guardian's Name:		
Spouse, Parent or Guardian's Employer:		Spouse, Parent or Guardian's SS#	
Primary Physician:	Phone #	Known allergies:	
Responsible Party/Guarantor (if other than patient):			
Guarantor's Address:			
City	State / ZIP		
Guarantor's Phone:	Relationship to Patient:		
Primary Insurance Company:	Policy Holder:	DOB:	
Group #	Member #	Phone #	
Secondary Insurance Company:	Policy Holder:	DOB:	
Group #	Member #	Phone #	

Please present insurance card, so we may photocopy for our records.

I, the undersigned, do hereby irrevocably assign and transfer to _____ all rights and benefits whether statutory, common law, contractual or implied, including, but not limited, to right to sue or recover penalties LSR 22:657. A photo static copy of this assignment of healthcare benefits shall be as valid and effective as if it were the original.

_____ _____ _____ _____

Signature of PATIENT or Authorized Person Date **Signature of Insured** or Authorized Person Date

Persons to contact in case of emergency: Name	Relationship:	Phone #
Name:	Relationship:	Phone #

Please list the names of people that you authorize our staff to communicate with regarding your appointments and medication:

_____ _____

_____ _____

I certify that I am giving my permission to communicate with the names listed above

_____ _____

Signature Date Signed

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you including demographic information that may identify you and that relates to your past, present, or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services your receive, manage our healthcare operations and for other purposes that are permitted or required by law. If you have any questions about this notice, please contact our Privacy Manager at **337-478-9331.**

Individuals are sometimes hesitant to seek mental health treatment because of privacy concerns. While we are committed to protecting your confidentiality to the fullest extent possible, we ask that you also protect the privacy of other patients. Please do not reveal the identity of other patients you may see in our office by sharing such information verbally, photographically, or by any other type of social media or other communication. This insures privacy for all patients and their family members.

YOUR RIGHTS UNDER THE PRIVACY RULE

The following is a statement of your rights, under the Privacy Rule, in reference to your PHI:

- You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time.
- You have the right to authorize other use and disclosure. This means you have the right to authorize any use or disclosure that is not specified within this notice. For example, we would need your authorization to use or disclose your PHI for marketing purposes or for any use or disclosure of psychotherapy notes. You may revoke an authorization, at any time, in writing, except to the extent that your Healthcare Provider or our office has taken an action in reliance on the use or disclosure indicated in the authorization.
- You have the right to request an alternative means of confidential communication. This means you have the right to ask us to contact you about medical matters using a method (i.e., e-mail, telephone, etc.), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. We will follow all reasonable requests. You must inform us in writing how you wish to be contacted (using a form provided by our practice).
- You have the right to inspect and copy our PHI. This means you may inspect and obtain a copy of PHI about you that is contained in your patient record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We ha eth right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines. ***However, under Federal Law, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.***
- You have the right to request a restriction of your protected health information. This means you may ask us in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. If we agree to the requested restriction, we ill abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you or someone on your behalf has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.
- You may have the right to request an amendment to your protected health information. This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.
- You have the right to request a disclosure accountability. This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Following are examples of uses and disclosures of your PHI that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

- Treatment- We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your protected health information as necessary to a pharmacy that would fill your prescriptions. For example, we would disclose your PHI to other healthcare providers who may be involved in your care.
- Special Services- We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results for exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right opt out of such special notices by notifying our office in writing.
- Payment- Your PHI will be sued, as needed, to obtain payment for your healthcare services. This may include certain activities that our health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits
- Healthcare operations- We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to, business planning and development, quality assessment and improvement, medical review, legal services, and audition functions.