East Jefferson Family Practice

DUNG MICHAEL TRAN, M.D.
ALEX HOANG, M.D.
CHARLIE LE, M.D.

PHONE: (504) 885-2505
FAX: (504) 885-2510
WEB: www.ejfamilypractice.com

PATIENT INFORMATION:

Name:_____
(LAST) (FIRST) (MIDDLE)

DOB:_____/ _____/_____ __ GENDER: ☐ MALE ☐ FEMALE SSN:_____-_____-_____

Home Address:_____

City:_____State:_____Zip:_____

EMAIL:_____

Home Phone#:_____-_____-_____Cell Phone#:_____-_____-_____Work Phone#:_____-_____-_____

GUARDIAN/EMERGENCY CONTACT INFORMATION:

Name:_____

Home Address (If different from patient):_____

City:_____State:_____Zip:_____

SSN: _____-_____-_____ Relationship to patient:_____

Home Phone#:_____-_____-_____Cell Phone#:_____-_____-_____Work Phone#:_____-_____-_____

PRIMARY INSURANCE INFORMATION:

Insured's Name:_____Insured's DOB:_____/ _____/_____

Insured's relationship to patient:_____

Insured's SSN: _____-_____-_____ Insured's Phone#:_____-_____-_____

Insured's Place of Employment:_____Employment Phone#:_____-_____-_____

Insurance company name:_____ Insurance company's phone#:_____-_____-_____

Policy #:_____Group #:_____

SECONDARY INSURANCE INFORMATION:

Insured's Name:_____Insured's DOB:_____/ _____/_____

Insured's relationship to patient:_____

Insured's SSN: _____-_____-_____ Insured's Phone#:_____-_____-_____

Insured's Place of Employment:_____Employment Phone#:_____-_____-_____

Insurance company name:_____Insurance company's phone #:_____-_____-_____

Policy #:_____Group #:_____

I REQUEST PAYMENTS OF AUTHORIZED INSURANCE/MEDICARE BENEFITS BE MADE ON MY BEHALF TO EAST JEFFERSON FAMILY PRACTICE, LLC, DUNG (MICHAEL) TRAN, M.D., CHARLIE LE, M.D., OR DUNG (ALEX) HOANG, M.D. FOR ANY SERVICES FURNISHED TO ME BY THAT PROVIDER. I AUTHORIZED ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER/CMS (CENTER FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BENEFITS NOT COVERED BY MY INSURANCE.

Signature_____Date_____

SIGN HERE

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Date of Birth: _____/_____/_____ **Today's Date: _____/_____/_____**

Patient Name _____
Last First M.I.

Pharmacy Name: _____ **Pharmacy #:** _____-_____-_____

Cross Streets:_____ **AND** _____

1. PAST MEDICAL HISTORY (please check if you have had):

___Heart Disease	___Thyroid Disease	___Mood Disorder	___Ulcers	___Sinus Allergies
___Diabetes	___Lung Disease	___Gout	___Reflux	___Tuberculosis
___High Blood Pressure	___ Asthma	___ Colon Polyps	___ Liver Disease	___Insomnia
___High Cholesterol	___Anemia	___Cancer	___Hepatitis	___Snoring
___Stroke	___ Osteoporosis	___	___ Kidney Disease	___Daytime Napping

Any other major illnesses? _____
Any Surgeries? _____
Name of Other Doctors?_____

2. SOCIAL HISTORY:

Do you smoke or use tobacco products? YES or NO
Do you drink any alcoholic beverages? YES or NO
Do you use any recreational drugs? YES or NO
What is your current occupation? _____

WOMEN ONLY:

Number of kids _____
Number of pregnancies _____
Number of full term births _____
Number of pre-term births _____

3. FAMILY HISTORY (please check any conditions that run in your family):

___Heart Disease	___Breast Cancer	___Strokes	___Drug Abuse
___Diabetes	___Colon Cancer	___Aneurysms	___Alcohol Abuse
___High Blood Pressure	___Skin Cancer	___Thyroid Disease	___Sleep apnea
___High Cholesterol	___Prostate Cancer	___Mental Disorder	

PLEASE LIST ANY OTHERS _____

4. PLEASE LIST ANY ALLERGIES: _____

☐ **NO KNOWN DRUG ALLERGIES**

5. MEDICATIONS: (Please list name, strength, and how often taken – Ex: Aspirin, 81 mg once daily)

Medication: _____ Strength: _____mg Times a day: _____
Medication: _____ Strength: _____mg Times a day: _____
Medication: _____ Strength: _____mg Times a day: _____
Medication: _____ Strength: _____mg Times a day: _____
Medication: _____ Strength: _____mg Times a day: _____
Medication: _____ Strength: _____mg Times a day: _____
Medication: _____ Strength: _____mg Times a day: _____
Medication: _____ Strength: _____mg Times a day: _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME: _____ DATE: _____

SOCIAL SECURITY NUMBER_____

DATE OF BIRTH: _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- **A basis for planning my care and treatment.**
- **A means of communication among the many healthcare professionals who contribute to my care.**
- **A source of information for applying my diagnosis and surgical information to my bill.**
- **A means by which a third-party payer can verify that services billed were actually provided.**
- **A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.**

I understand that I have the right:

- **To object to the use of my health information for directory purposes.**
- **To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.**
- **To revoke the consent in writing, except to the extent that the organization has already taken action in reliance thereon.**

_____ I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____ I allow the following disclosure of my health information.

_____

_____

_____

(PATIENT's SIGNATURE OR LEGAL REPRESENTATIVE's)

DATE _____ WITNESS _____

Tran Medical Associates, LLC
Dung Michael Tran, M.D.
3848 Veterans Blvd., Suite 101
Metairie, LA 70002
(504) 885-2505

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement ***

I, _____ , have received a copy of this office's Notice of Privacy Practices.

Please print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

Notice of Privacy Practices

East Jefferson Family Practice, LLC
3848 Veterans Blvd., Ste. 101
Metairie, LA 70002

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. *For example* – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected information to obtain payment for the health care services we provide you. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities of our practice. *For example* – we may use medical information about you to review and evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointment or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Other Involved in Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research. We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other recorded we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copy by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.
If you wish to inspect or copy your medical information, you must submit your request in writing to our office manager, Julie Nguyen, 3848 Veterans Blvd., Ste. 101, Metairie, LA 70002. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off site, we are allow up to 60 days to respond but must inform you of this delay.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

1. the information was not created by us, or the person who created it is no longer available to make amend.
2. the information is not part of the record which you are permitted to inspect and copy;
3. the information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is need for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-months period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdrawal your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will communicate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make in writing within 180 days of the suspected violation. Provide as much details as you can about the suspected violation and send it to Michael Dung Tran, M.D., 3848 Veterans Blvd., Ste. 101, Metairie, LA 70002. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have any questions or would like additional information, you may contact Julie at 504-885-2508.