SOUTHEAST NEUROSCIENCE CENTER

Critical Contact Information

Print your **NAME (as spelled on your primary insurance card):** _____

DOB: ____/____/____ SSN: ___ ___ ___- ___ ___ - ___ ___ ___ ___

****

Name of INSURED (if different than Patient): _____

DOB of insured: ____/_____/_____ SSN of Insured: ___ ___ ___- ___ ___ - ___ ___ ___ ___

Your current address:
Street # and Street Name _____

Apartment # _____

City and ZIP Code _____

Your *Primary Personal Cell Phone* Area code ( )_____

Your Personal *Home* phone Area Code ( ) _____

SNC is now using the Patient Portal. This Portal gives you easy access to SNC as well as near full access to your medical record. We will sign you up today for access, but you must have an email that you use personally or shared only with those who are HIPAA cleared to see your personal health information (PHI).

Please write your email here: _____

You may also register another person on the portal to access for you. He/she would need to be listed in the HIPAA release Form you will sign later.

Please write his/her email here: _____

SOUTHEAST NEUROSCIENCE CENTER

Disclosure of Financial Interests

Dear SNC Patient:

Louisiana law (R.S. 37:1744 and LAC 46: XLV.4211-4215) 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.

The physician-owners of SNC (Donald Gervais, MD, Edward Haight, MD, Wendy Gervais, MD) have a financial interest in the health care provider/facilities to whom we are referring you, as listed below:

☐ **Imaging Center of South Louisiana (ICSL)** is fully owned solely by SNC and is an integral part of your neurological care at SNC. Wendy Gervais, MD, is the medical director of ICSL.

☐ **PPS Pharmacy** is owned (<5% of the entity) by Edward Haight, MD and Donald Gervais, MD.
Palliative Pharmacy Solutions, L.L.C.
620 Guilbeau Road
Suite D.
Lafayette, LA 70506

You are hereby given written notice that you may receive the same services/medications from an alternate supplier or pharmacy of your choice.
If you choose to have your prescriptions sent to a specific pharmacy, please alert one of our clinical staff members and your prescribing provider.

PLEASE NOTE: Our office generally does not do pre-authorizations for medications, except in very limited circumstances.

PATIENT ACKNOWLEDGEMENT

I,_____, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the Disclosure of Financial Interests.

_____ _____
Patient/Patient Representative Date

ePrescribing Information and Patient Consent

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Southeast Neuroscience Center can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to SNC to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient Name (PRINT) Date

_____

Patient Signature

SNC
SOUTHEAST NEUROSCIENCE CENTER

NOTICE TO PATIENTS REGARDING CHOICE OF SUPPLIERS

Federal law requires that Southeast Neuroscience Center ("SNC") provide our patients for whom we refer to the Imaging Center of South Louisiana, written notice that they may receive the same services from an alternate supplier. Below is a list of alternative suppliers of imaging services, all located within a twenty-five (25) mile radius of our offices.

By identifying these suppliers, SNC is neither endorsing nor recommending them to our patients. If you wish to receive your MRI/X-Rays from another supplier, you may need to contact them to schedule an appointment. In making a decision regarding which alternative supplier to use, you may want to consider whether the supplier participates in your health insurance plan and the cost to you. Other suppliers of MRI/X-Ray services in our area include the following:

Headache & Pain Center	123 Frontage Road A Gray, LA 70359	(985) 580-1200
Houma Medical Imaging	313 Civic Center Boulevard Houma, LA 70360	(985) 274-0550
Open MRI of Louisiana	1001 School Street Houma, LA 70360	(985) 857-9790
Thibodaux Regional Medical Center	602 North Acadia Road Thibodaux, LA 70301	(985) 447-5500
Terrebonne General Medical Center	8166 Main Street Houma, LA 70360	(985) 873-4141

If you choose to receive your MRI\X-Ray from a supplier other than through our practice, please let us know who will be providing the MRI\X-Ray. We will work with you and your chosen supplier to provide any information they may require in order to perform the MRI\X-Ray.
PLEASE NOTE that if your health insurance coverage requires precertification or preauthorization for MRI\X-Ray services, you should coordinate with the supplier providing the service to make sure that any pre-certification or pre-approval is obtained.

SNC neither endorses nor recommends any supplier identified in this notice, rather we provide the list of alternative suppliers as an informational resource to you as our patient.
We value you as our patient and appreciate you allowing us to provide for your health care needs. Please feel free to contact our office if you have any questions regarding the services to be provided.

My signature below is stating that I acknowledge receipt of this information and understand the supplier options have been provided.

_____ _____ _____
Print Patient/Legal Rep Name Signature Date

SOUTHEAST NEUROSCIENCE CENTER

PATIENT COMMUNICATION

Southeast Neuroscience Center does not release confidential medical information regarding your treatment to family members or friends, unless they fall under one of the following categories:

- Parent of a minor under the age of 18
- Legal Guardian
- Emergency Contact
- Persons authorized by the patient
- Instances permitted by HIPAA.
- As we may reasonably infer from the circumstances.

Example: If a family member or friend accompanies a patient into the exam room, we will assume, unless stated otherwise, that that person is entitled to receive information regarding the patient's treatment, but only during that visit unless indicated otherwise in writing below.

If you feel you will need or want your medical information to be provided to specific family members, friends, or caregivers, please provide their name and contact information below. If you do not wish for anyone besides you to have access to your records, please print your name below stating, "No, I do not wish for anyone to have access to my protected health information."

Name:_____ Phone Number:_____Relationship:_____

Name:_____ Phone Number:_____Relationship:_____

Name:_____ Phone Number:_____Relationship:_____

Name:_____ Phone Number:_____Relationship:_____

YES: I, _____ understand that by signing this document, the persons listed above
(Print Patient Name)
will have access to my protected health information. If at any point in time I wish to add or remove one or more persons, I must do so in writing.

NO: I, _____ understand that by signing this document, I have stated that no
(Print Patient Name)
persons may have access to my protected health information. If at any point in time I wish to add anyone to my contacts, I must do so in writing.

_____ _____ _____
Patient's Signature Patient's Date of Birth Date

SOUTHEAST NEUROSCIENCE CENTER

Review of Systems

Patient Name: _____

Please Check All that Apply:

Date: _____

Constitutional Symptoms	Endocrine	Skin	Lymphatic
☐ Fever	☐ Weight gain/loss	☐ Rash	☐ Swelling in arms/legs
☐ Weight loss	☐ Frequent urination	☐ Blisters/vesicles	☐ Lymph node pain or bumps
☐ Fatigue	☐ Thirsty	☐ Burning Sensation	
HEENT	**Neurological**	**Musculoskeletal**	**Allergic**
☐ Blurry Vision	☐ Loss on consciousness	☐ Neck Pain	☐ Frequent sneezing
☐ Loss of Vision	☐ Seizures	☐ Back Pain	☐ Mold Exposure
☐ Eye Pain	☐ Tremors	☐ Limb Pain	☐ Rash
☐ Hearing loss	☐ Abnormal Walking/Balance	☐ Joint Pain	
☐ Ringing in the ears	☐ Headaches	☐ Missing limbs	
☐ Ear Fullness	☐ Weakness	☐ Limited Range of Motion	
☐ Ear Pain	☐ Numbness/Tingling		
☐ Nose bleeds	☐ Double Vision		
☐ Nose Discharge	☐ Falls		
☐ Throat Pain	☐ Pain in arms/legs		
Cardiovascular	**Gastrointestinal**	**Hematologic**	**Immunologic**
☐ Palpitation	☐ Nausea/Vomiting	☐ Anemia	☐ Fever
☐ Pain in legs with walking	☐ Heart Burn	☐ Bruising	☐ Frequent infection
☐ Irregular heart rate	☐ Burping		
☐ Passing out			
Respiratory	**Genitourinary**	**Psychiatric**	**Other**
☐ Shortness of Breath	☐ Burning when urinating	☐ Depression	
☐ Wheezing	☐ Urinary retention	☐ Anxiety	
☐ Pain with breathing	☐ Frequent urination	☐ Hallucinations	
☐ Cough	☐ Erectile dysfunction		
	☐ Urinary leakage		