Brentwood Outpatient Clinic
1006 Highland Avenue
Shreveport, Louisiana 71101
318-222-6226
Fax 318-524-7252
BrentwoodLAOutpatient@uhsinc.com

Dear New Patient,

Thank you for choosing the Brentwood Outpatient Clinic. Enclosed you will find your registration information. Please fill out the forms in their entirety. Upon completion, please bring the forms to the office or mail, email, or fax. **After we receive the forms and verify you insurance benefits, we will call you to set up an appointment**. ****** We are medicine management only – we refer out to counselors and therapists ******

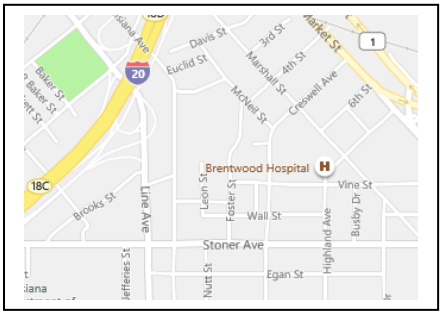
We request that you bring the following information to your appointment**:**

Current Medication List
Insurance card(s) and photo ID.
Co-pay, co-insurance, deductible

Please arrive 15 minutes early for your appointment. If you are 15 minutes or more late for your appointment we may have to reschedule you to the next available date.

If you need to cancel and/or reschedule your initial appointment, you will be charged $125.00 if our office is not contacted at least 24 hours in advance. This balance must be paid before future appointments can be scheduled.

Directions:



▼ Directions to Brentwood from East Texas
1.Take I-20 into Downtown Shreveport, Exit 19 Market St. Stay in far right lane.
2.The 3rd street you come to will be Highland Ave. Take a right on Highland.
3.Continue straight and you will see Brentwood on your right.

▼ Directions to Brentwood from Monroe
1.Take I-20 to Downtown Shreveport, Exit 19A Market St. Go under I-20 and merge to your far right lane.
2.The 3rd street you come to will be Highland Ave. Take a right on Highland.
3.Continue straight and you will see Brentwood on your right.

▼ Directions to Brentwood from South Louisiana
1.Take I-49 North to I-20 East. Take Exit 19 Market St Stay in far right lane.
2.The 3rd street you come to will be Highland Ave. Take a right on Highland.
3.Continue straight and you will see Brentwood on your right.

▼ Directions to Brentwood from Texarkana
1.Take Hwy 71 South to Shreveport, Hwy 71 turns into North Market St. Stay in the right lane.
2.The 3rd street you come to will be Highland Ave. Take a right on Highland.
3.Continue straight and you will see Brentwood on your right.

Parking: Handicap entrance is located in the back of the hospital. The ramp is even with the parking lot. Once you enter you follow the hallway all the way thru the double doors. You may parallel park on Highland Avenue but this entrance will require walking upstairs on the outside of the building. After inside you may take the elevator to the 2nd floor or take the stairs. The Outpatient Clinic is located on the 2nd floor. You do not have to go to the main hospital lobby to access the clinic.

Brentwood Hospital

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Patient Registration Form

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Social Security #: _____

City/State/Zip: _____ Gender: Male / Female

Cell Phone: _____ Home Phone: _____

Email: _____

Marital Status: Married Single Separated Divorced Widowed Minor: Grade: _____

If a minor: Mother's Name: _____ Father's Name: _____

Employer: _____ Work #: _____

If different from Patient: Parent / Guardian / Power of Attorney

Name: _____ Social Security #: _____

Address: _____

Cell Phone: _____ Home Phone: _____

Primary Insurance

Name of Insurance: _____

Phone Numbers: _____

Insured Name: _____ Member ID #: _____

Plan Name: _____ Group #/Name: _____

Policy Holder (if different than insured): _____ DOB: _____

Relationship to Policy Holder: _____ SS#: _____

Secondary Insurance

Insured Name: _____ Member ID #: _____

Plan Name: _____ Group #/Name: _____

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Patient Questionnaire

Patient Information

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Allergies

Do you have any known allergies? _____ Yes _____ No If yes, _____

Referral Source

How did you hear about us? Doctor Family Friend Internet Insurance Other _____

Have you or any member of your immediate family been treated by our physicians before? YES NO

If yes, name of Physician: _____ Family Member Name: _____

***** Reason for Visit ******

_____

_____

_____

Current Medications: List Name and dosage:

Please list all medications you are currently taking – both prescription and non-prescription. Please vitamins, anti-inflammatories, pain relievers, sleeping aids, etc. Attach another sheet if required.

_____

_____

_____

_____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

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Authorization to Release Information Concerning Your Care

Authorization to Release Information Concerning Your Care

I, _____, hereby authorize the staff of Brentwood Outpatient Clinic to disclose information to the following person(s). I am aware this may be my spouse, significant other, child/children, family member, friend, etc. I am aware that if someone were to ask for information concerning my visits with this office that is not listed below, no information can be released to them. I understand that this authorization extends to all or any part of the records, which may include treatment for physical and mental illness, chemical or alcohol dependency. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

_____ I do **NOT** authorize anyone to receive information regarding my medical care.

_____ I authorize my physician and the employees of this clinic to speak with the following concerning my appointments, account/bill, lab results, medical care and treatment:

Person _____ Relationship _____

Person _____ Relationship _____

Person _____ Relationship _____

This consent is subject to written revocation at any time except to the extent that the action has already been taken in reliance upon this consent. This consent will automatically expire upon completion of this transaction and no late than 240 days from the date signed unless otherwise stated herein. It is further understood that information released is for professional purposes only and may not be provided in whole or part of any agency, organization, or person other than stated above. I understand and consent that this information may be sent via facsimile transmission. TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you form the records whose confidentiality may be protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

_____ _____

Patient Name (Please Print) Date

_____ _____

Patient's Signature / Parent or Guardian Witness

Office Policies

Clinic Hours: No Prescriptions on Friday's/Weekends/Holidays

Monday – Thursday: 9:00am – 4:30am **Friday: 900 am – 11:30am**

Appointments ** Please initial that you have read and understand each line **

Patients are seen by appointment only. Your appointment is scheduled at a specific time and is reserved for you. For your convenience and benefit of the physician's schedule, appointments are confirmed. **If you need to change your appointment time, it is required you call (please leave a message), email BrentwoodLAOutpatient@uhsinc.com fax or use the online portal at least 24 hours in advance.** This balance must be paid before future appointments can be scheduled and/or medication refills.

_____ ** New Patients will be charged $125.00 for any missed appointments if our office is not contacted at least 24 hours in advance. This balance must be paid before future appointments can be rescheduled.

_____ ** Established patients will be charged $25.00 for any missed appointments if our office is not contacted at least 24 hours in advance. This balance must be paid before future appointments can be rescheduled.

_____ ** Three no shows and you may be officially discharged from care and referred to another physician/facility.

_____ ** Please arrive 15 minutes early for your appointment. If you are 15 minutes or more late for your appointment, we may have to reschedule you for another day.

_____ ** Payment is due at the time service is rendered. Co-pays, Deductibles, and Co-insurance are due at time of service. Please plan to pay any balance due at your appointment to be seen and/or prior to prescription refills.

_____ ** Please be advised that every doctor is NOT in the office every day. No doctors are in on Friday's.

Safety ** Please initial that you have read and understand each line **

_____ ** Please be advised that NO WEAPONS of any kind are allowed in the building. This includes patients with a Concealed Carry Permit.

_____ ** Please be advised that respect is to be given to all Brentwood staff. This includes no cursing and/or threatening comments. Doing so may be cause for discharge from the facility and another physician/facility can be provided for you.

Letters / Medical / Disability Forms

Letters, forms, and/or medical information needed by your employer, insurance company or other entities will be forwarded once a medical release is signed and obtained along with a $40 payment. We require 7-14 days in order to complete these requests. It is important you contact us immediately when such information is needed to enable our office time to complete requests. We will not guarantee same day service. Please be assured, every consideration is made, and this office will make every effort to accommodate your request in a timely manner.

Insurance / Billing ** Please initial that you have read and understand each line**

Brentwood Outpatient Clinic will file your insurance IF the physician is a contracted provider for the insurance company. Prior to your scheduled appointment the office will contact the insurance company and confirm

behavior/mental health benefits. If we are not a participating provider (out of network) with your insurance company, the visit will need to be paid in full but we will file the claim as a courtesy for you. If we are not a participating provider for your insurance company, fee for service will be expected and all patients will be furnished, upon request, a detailed bill to file with their insurance company. You may pay by cash, check (from local banks), and money orders, Visa, American Express, Discover or MasterCard. Any relationship with an insurance company is strictly between the patient and the insurance company. We will file your insurance as a courtesy to you.

_____ ** Please inform the office, prior to you next appointment, if your insurance has changed. If the office is not notified prior to your appointment, you will be financially responsible for any charges that may incur as well as any visits requiring prior authorization.

_____ ** Payment is due at the time service is rendered. Co-pays, Deductibles, and Co-insurance are due at time of service. Please plan to pay any balance due at your appointment to be seen and/or prior to prescription refills

_____ ** Please be aware that Behavior/Mental Health Benefits may not be the same as your Medical Benefits. Additional deductibles and co-pays may apply.

_____ ** There is a $25.00 charge for any checks returned by the bank. After a check has been returned from the bank, future payments must be paid with cash, credit card or money order.

_____ ** Collection Agency referrals will be made as a last resort to collect fees on patients whose accounts have been inactive for over 120 days. All collection agency fees will be passed on to the patient. Once turned over to collections the balance must be taken care of for future appointments and/or medication refills.

Payment is due at the time service is rendered. Appointments must be canceled 24 hours in advance (through the text reminder service, online on the portal, call 318-222-6226 (please leave a message), email BrentwoodLAOutpatient@uhsinc.com, or fax 318-524-7252) or there will be a $125.00 charge for new patients and $25.00 for established patients for that appointment. This balance must be paid before future appointments can be rescheduled. I understand that no guarantees can be made regarding treatment. I agree to be responsible for treatment rendered to myself and/or family member. I acknowledge that the evaluation and treatment given at the Brentwood Outpatient Clinic may include services such as mental health evaluations and medication management. I also understand that the Brentwood Outpatient Clinic, as part of Brentwood Hospital, is affiliated with various health professional training programs, and therefore during my treatment in the program, I may have contact with such staff.

Signature of Patient/ Responsible Party _____ Date _____

Prescriptions ** Please initial that you have read and understand each line **

Patients are responsible to ensure they receive their Rx **BEFORE** their medication runs out, i.e. call your pharmacy to request a refill request form be faxed to our office (318-524-7252), giving the office at least 48 hours in advance.

_____ ** No Prescriptions will be refilled on Friday, Weekends or Holidays. New Patients must be seen before prescriptions will be written and/or filled.

_____ ** Our Clinic may not prescribe certain medications that can become addictive.

_____ ** Prior Authorizations MUST come from your pharmacy electronically or faxed (318-524-7252). Please allow at least 48 hours to start the process. It may take 72 hours after prior authorization is sent to your insurance company for a reply.

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Assignment of Benefits

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

_____ _____

Signature of Patient (or parent/guardian) Date

I hereby authorize the Brentwood Outpatient Clinic (all physicians, nurse practitioners, and therapists) to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request on my behalf for any reimbursement from my insurance company be made to the Brentwood Outpatient Clinic (or to the party who accepts assignment).

I certify that the information I have reported regarding my insurance coverage is correct. I permit a copy of this authorization be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

_____ _____

Signature of Patient (or parent/guardian) Date

Acknowledgement Receipt of Notice of Privacy Practices

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices. (Brentwood, A Behavioral Health Company reserves the right to modify the privacy practices outlined in this notice)

Please acknowledge receipt of the Notice of Privacy Practices by signing next to the appropriate statement.

_____ I have received a copy of the Notice of Privacy Practices for Brentwood, A Behavioral Health Company. (Copy given to patient to take home)

_____ I understand a copy of the Notice of Privacy Practices for Brentwood, A Behavioral Health Company, are available at the receptionist desk upon my request. (Explained to patient Notice of Privacy Practices would be made available upon request as the patient indicated not needing a copy to take home)

The acknowledgement was not obtained **(staff signature only, when not signed by patient)** _____

The patient was undergoing emergency treatment **(staff signature only)** _____

The patient verbalized unable/declined to sign acknowledgement **(staff signature only)** _____

The above information is accurate as to what action was taken by the patient regarding the Notice of Privacy Practices

Respecting Your Privacy

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.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital, clinic, employees, volunteers and related personnel.

The practices described in this Notice is also followed by health care providers who are members of our Medical Staff. Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers and related personnel, including those members of the Medical Staff must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT:

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in a laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, procedure or other types of treatment related procedures.

FOR PAYMENT:

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to the insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS:

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or, we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES:

Your relationship to us as a patient might require using or disclosing or disclosing your PHI in order to:

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW:

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES:

Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts.

- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI:

When required by law, for example, when ordered by a court.

For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.

To report neglect, abuse or domestic violence.

To government regulators or agents to determine compliance with applicable rules and regulations.

In judicial or administrative proceedings as in response to a valid subpoena.

To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.

For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.

For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.

In accordance with the legal requirements of a Worker's Compensation program.

When properly requested by law enforcement officials, for instance, in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.

If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.

For national security purposes, including to the Secret Service or if you are an Armed Forces personnel and it is deemed necessary by appropriate military command authorities.

In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM:

Under the federally required privacy program, patients have specific rights.

YOUR RIGHTS TO REQUEST LIMITED USE OR DISCLOSURE:

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

- the disclosure is for the purpose of carrying out payment or healthcare operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION:
You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY:
You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI:
If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI:
You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment , payment or operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH:
You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE:
You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

WHAT IF I HAVE A COMPLAINT?
If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at: **1-800-852-3449.** Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington D.C. 20201 or call **1-877-696-6775.**

CONTACT FOR ADDITIONAL INFORMATION:
If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM:
Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

BRENTWOOD PRIVACY OFFICER:
June Lee
1006 Highland Avenue
Shreveport, LA 71101
(318)678-7575
June.Lee@uhsinc.com

COMPLIANCE WITH CERTAIN STATE LAWS:
When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Effective Date: This notice takes effect on: August 1, 2019.

Revised 08/01/2019

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