HH

Hometown Healthcare

WHERE CARE COMES HOME

Jessica Wooten, MSN, APRN, FNP-BC

(318) 704-0025

5630 Hwy 28 E. Pineville, LA 71360

Fax (318) 314-2065

PATIENT REGISTRATION FORM

NAME: ______________________ EMAIL: ______________________

ADDRESS: ______________________ MAIN PHONE: ______________________

____

Personal Information

SEX: ________ DOB: ______________ MARITAL STATUS: ______________________

EMPLOYER: ______________________ WORK PHONE: ______________________

SSN: ______________________ ADVANCED DIRECTIVE ☐ Yes __________ ☐ No

Insurance Information

☐ I do not have insurance coverage. ☐ Another person is responsible for my bill

PRIMARY: ______________________ SECONDARY: ______________________

Please Provide a Copy of your Insurance Card

I certify that all the information provided by me on this form is true and correct and grant permission for Hometown Healthcare LLC to proceed with the provision of healthcare.	
Print Name:	
Signature:	Date:

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: ______________________________

____

Signature: ______________________________ Date: ______________

Hometown Healthcare LLC
5630 HWY 28 E
PINEVILLE, LA 71360
Telephone: 318-704-0025

Please fax records to: (318) 314-2065

Date: ____________________

To: ____ Patient: ________________________________

____ SSN: ________________________________

Fax#: ____________________ DOB: ________________________________

We would appreciate your cooperation in forwarding medical records or information to assist our medical staff in the examination and/or treatment of the above noted patient. Our office needs the following information:

Final summary or report of hospitalization ________________________________

Brief report of examination or treatment ________________________________

X-ray films and report ________________________________

Other *(specify)* ________________________________

I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire after the requested information has been supplied to VA. I understand that I may receive a copy of this form after I sign it.

I understand that redisclosure of my medical records by those receiving the authorized information may be accomplished without further written authorization and may no longer be protected.

____ ____________________
(Signature of Patient or Authorized Representative) *(Date)*

Hometown Healthcare LLC
5630 Highway 28 East
Pineville, LA 71360
P (318) 704-0025
F (318) 314-2065

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NO SHOW AND TERMINATION POLICY

A. **Termination Policy:**
   1. **Every patient that is terminated from the care at HHC will receive a letter from the provider or designee stating the reason for termination.**
   2. **Once an individual provider has terminated the care of a HHC patient, no provider within the HTHC system will provide care for the patient.**
   3. **If the patient feels the termination of care is unjust, then he/she can, during the 30-day period, make a appointment to discuss the extenuation circumstances with the office manager.**
   4. **The patient's file will be document to verify that all measures were taken to fully inform and educate the patient about the importance of complying with the provider's recommendations and the medical protocol before termination.**
   5. **The following are considered reasons to terminate a patient from Hometown Healthcare Clinic**
      a. **Misuse/abuse of prescriptions and medications**
      b. **An individual who fails to show for their first appointment without notification or rescheduling.**
      c. **The provider determines he/she cannot provide continued, effective care.**
      d. **Threat of legal action against HHC providers and employees.**
      e. **Chronically not showing for appointments**
      f. **Failure of patient to comply with the provider's orders regarding the patient's care if that decision prevents the provider from providing adequate medical care.**
      g. **Discharge will be immediate for a threatening behavior or any implication of harm to any HHC staff member.**

B. **No-Show Policy:**
   1. **Three (3) missed appointments without cancelling is considered chronically no show/call**
   2. **On the first and second no-show/call appointments, a patient will receive a no-show/call On the third no-show/call appointment, a patient may be terminated from the practice.**
   3. **Once a patient is discharged from the practice for no-shows/calls, the patient has to wait outside the practice for one (1) year before readmission to practice.**

Every effort will be made to provide ongoing health care to all patients at HHC. The medical practice does not discriminate in providing care to a patient due to race, color, sex, religion, national origin, age, handicap, or any other factors prohibited by law.

I have read and agree to abide by the above policy:

______________________________ ______________

Signature and (Printed Name) **Date**