



Outpatient Medical Center, Inc.

New Patient Registration Form

(For all patients new to OMC or not seen in any OMC Clinic in the last 2 years)

☐ OMC Natchitoches ☐ OMC SBHC ☐ OMC Leesville ☐ OMC Tallulah

Patient Information

First Name:		Last Name:		Middle Initial:
Physical Address:		City:	State:	Zip code:
Mailing Address (☐ Same as Physical):		City:	State:	Zip code:
Primary Phone#:		Secondary Phone#:		
Date of Birth:	Sex at Birth: ☐ Male ☐ Female	Age:	SSN:	
Email Address:				
Preferred Pharmacy:		Pharmacy Phone #:		
Primary Care Provider:		Phone #:		
Other Healthcare Provider:		Phone #:	Specialty:	
Other Healthcare Provider:		Phone #:	Specialty:	
Other Healthcare Provider:		Phone #:	Specialty:	

Emergency Contact

Name:	Phone#:	Relationship to Patient:
Name:	Phone# :	Relationship to Patient:

Insurance Information

Do You Or Anyone In Your Household Have Healthcare Coverage? ☐ Yes (☐ Medical / ☐ Dental) ☐ No (Self Pay)		
Please Check All That Apply To Your Household: ☐ Private Insurance ☐ Medicare ☐ Medicaid		
Primary Insurance:	Policy #:	Group #:

Name of Card Holder:	SSN:	DOB:
Cardholder Employer:	Occupation:	
Secondary Insurance:	Policy #:	Group #:
Name of Cardholder:	SSN:	DOB:
Card Holder Employer:	Occupation:	
Guarantor Information (Person Financially Responsible)		
Check Here If Same As Patient ☐		
Guarantor Name:	Guarantor Phone #:	
Guarantor SSN:	Guarantor DOB:	
Patient Demographics (Please Complete for Federal Grant Support)		
Ethnicity: ☐ NON-Hispanic or Latino ☐ Hispanic or Latino ☐ Choose Not to Disclose Ethnicity		
Race (Check All That Apply): ☐ White ☐ Black/African American ☐ Asian ☐ American Indian / Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race ☐ Unreported / Choose not to disclose	Disclosure of Income: <i>Used for statistical purposes only</i> <i>Does NOT affect your access to care</i> Gross Annual Income: \$ _____ Household Size (#): _____ ☐ Choose Not to Disclose	
Primary Language Spoken: _____		Interpreter Needed?: ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner		
Are You Homeless? ☐ Yes ☐ No Are You A Veteran? ☐ Yes ☐ No	Agriculture Status: ☐ Not Agricultural Worker ☐ Migrant Worker ☐ Dependent of a Migrant ☐ Seasonal Worker ☐ Dependent of a Seasonal Worker	

Required Authorizations

Consent to Treatment:

I consent to any assessments, examinations, diagnostic tests, treatments, and procedures performed by OMC Providers either face to face and/or telehealth. I further understand that I may revoke this authorization, in writing, at any time.

Initial

Financial Responsibility:

I understand that I am responsible for the cost of all services rendered, unless I have healthcare coverage for services provided to me. I understand that I am responsible for either a clinic fee/deposit (uninsured) or copay (required by my private insurance plan) at the time of service. I understand that if I have healthcare coverage that my plan will be billed: however, I agree to pay all charges for any health care services provided by Outpatient Medical Center, Inc., that are not covered or collected from my insurance carrier or other third-party payer, including any deductibles and coinsurance amounts. _____

Initial

This form was completed by: ☐ Patient ☐ Parent ☐ Guardian ☐ Other: _____

The information above is accurate to the best of my knowledge.

Signature of Patient or Representative

Printed Name

Date

Please list all family members who will have authority to discuss your protected health information:

☐ I **DO NOT** authorize OMC to discuss my protected health information with anyone besides myself.

☐ I **DO** authorize OMC to discuss my protected health information (Please Check One):

☐ All ☐ Medical Only ☐ Dental Only ☐ Behavioral Health / Psychiatry Only

Authorized Person:	Relationship:
Home Phone#:	Cell Phone#:
☐ I <u>DO</u> authorize OMC to discuss my protected health information (Please Check One): ☐ All ☐ Medical Only ☐ Dental Only ☐ Behavioral Health / Psychiatry Only	
Authorized Person:	Relationship:
Home Phone#:	Cell Phone#:

Patient Information Documents:

- **Statement of *Patient Rights and Responsibilities*** – defines my rights and responsibilities as a patient that received health care services from Outpatient Medical Center, Inc., and includes the Patient Complaint Procedure / Notice Concerning Complaints – explains how to file a complaint and/or grievance.
- ***Notice of Privacy Practices*** – provides information about how Outpatient Medical Center, Inc. and its workforce may use and/or disclose my protected health information for treatment, payment, health care operations and as otherwise permitted by law.

Acknowledgement of Receipt:

I acknowledge and agree that I have received a copy of my *Patient Rights and Responsibilities*. I understand that if I neglect to fulfill my responsibilities that I may be terminated as a patient of the clinic. _____

Initial

I acknowledge and agree that I have received a copy of *OMC's Notice of Privacy Practices*. By signing this form, I consent OMC's use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. _____

Initial

How Did You Hear About Us? (Please Check One):

- ☐ Employee ☐ Patient/Friend ☐ Flyer/Brochure ☐ OMC Website ☐ Newspaper ☐ Facebook/Social Media
☐ Other _____

FOR OFFICE USE ONLY:

**ITEMS NEEDED FOR REGISTERING AS A OMC PATIENT: (PLEASE CHECK ALL PROVIDED BY PATIENT AND
SCANNED INTO THE SYSTEM)**

A. Picture Identification:

- | | |
|--|--|
| ☐ Driver's License or State Issued ID | ☐ Birth Certificate (Children) |
| ☐ Passport | ☐ High School or College Student ID |
| ☐ U.S. Military ID | ☐ School Records (Children) |
| ☐ U.S. Permanent Resident Card | ☐ Employer Issued Identification Card |
| ☐ Consular or International ID Card | ☐ Transportation Worker ID Credential Card (TWIC) |
| ☐ Foreign Government Issued ID | ☐ US Immigration Documents |

B. Proof of Address:

- | | |
|---|--|
| ☐ Current Driver's License | ☐ Business Mail Postmarked within 30 days |
| ☐ Current State Issued ID | ☐ Utility Bill (Electric, Water, Gas, Phone/Cell, Cable TV) |
| ☐ Consular or International ID Card | ☐ Current Lease Agreement (Signed) |
| ☐ School Registration Records (Children) | ☐ Federal/State Housing Documents |
| ☐ Voter's Registration | ☐ Mortgage Documents (Signed) |
| ☐ Automobile Insurance Documents | ☐ Property Tax Documents (Within 12 Months) |

Documents verified and scanned into the system by (PSR): _____ Date: _____



Outpatient Medical Center, Inc.

New Patient Medical History Questionnaire

Patient Name: _____

Date: _____

Instructions: Please fill out as much as you can and give to nurse when you are called.

Drug Allergies
Are you allergic to any medications? ☐ No ☐ Yes If yes, please list them & your reaction: _____
Have you had a recent ER, Urgent Care, Hospital visit? ☐ No ☐ Yes If yes, where: _____

Past Medical History: (Please Check All That Apply)							
	NO	YES	TYPE		NO	YES	TYPE
ADD / ADHD	☐	☐	_____	Hepatitis	☐	☐	_____
Allergies	☐	☐	_____	High Blood Pressure	☐	☐	_____
Anemia	☐	☐	_____	High Cholesterol / Lipids	☐	☐	_____
Anxiety	☐	☐	_____	HIV / Aids	☐	☐	_____
Arthritis / Gout	☐	☐	_____	Insomnia / Sleep Problems	☐	☐	_____
Asthma / COPD	☐	☐	_____	Kidney Infection / Stones	☐	☐	_____
Bleeding Disorder/Blood Clots	☐	☐	_____	Neuropathy	☐	☐	_____
Cancer	☐	☐	_____	Pain	☐	☐	_____
Circulatory Problems	☐	☐	_____	Pneumonia	☐	☐	_____
Constipation	☐	☐	_____	Psychiatric / Depression	☐	☐	_____
Diabetes	☐	☐	_____	Rectal Bleeding	☐	☐	_____
Diarrhea	☐	☐	_____	Reflux / Heartburn / Ulcer	☐	☐	_____
Difficulty Hearing	☐	☐	_____	Seasonal Allergies	☐	☐	_____
Diverticulitis / Diverticulosis	☐	☐	_____	Seizures	☐	☐	_____
Eye Disease	☐	☐	_____	Sexually Transmitted Diseases	☐	☐	_____
Gallstones / Liver Disease	☐	☐	_____	Thyroid Problems	☐	☐	_____
Headaches	☐	☐	_____	Tuberculosis	☐	☐	_____
Heart Disease/ Irregular Beat	☐	☐	_____	Vitamin Deficiency	☐	☐	_____
Hemorrhoids	☐	☐	_____	Other: _____			_____

Past Surgical / Hospitalization History							
	NO	YES	Date		NO	YES	Date
Gallbladder	☐	☐	_____	Pacemaker/Defibrillator	☐	☐	_____
Orthopedic	☐	☐	_____	Other: _____			_____
Tonsils/Adenoids	☐	☐	_____				

Social History
Do you drink alcohol? ☐ No ☐ Yes If yes, how much? _____
Do you use tobacco? ☐ No ☐ Yes If yes, how much? _____
Do you use marijuana or other drugs? ☐ No ☐ Yes If yes, what kind and how much? _____

Family History: (Please List Any Immediate Family Members Who Have or Had A History of Illness or Cancer and Their Relationship to The Patient)

Medications: (Please Include Over The Counter)

Medication	Strength	How Often	Purpose

Vaccines: (Please Write Most Recent Date Received)**Wellness Screening**

COVID: _____	PAP Smear	NO	YES	DATE
Flu: _____	Colonoscopy	☐	☐	_____
Hep B: _____	Eye Exam	☐	☐	_____
Pneumococcal: _____	Mammogram	☐	☐	_____
Shingles: _____	TB Test	☐	☐	_____
Tetanus: _____				

Men's Health

Any prostate problems? ☐ No ☐ Yes If yes, please explain: _____

Do you suffer from erectile dysfunction? ☐ No ☐ Yes

Women's Health

Are you currently pregnant? ☐ No ☐ Yes

Do you use contraception? ☐ No ☐ Yes Type: _____

Have you ever had a caesarean section (C-section)? ☐ No ☐ Yes If yes, when? _____

Have you ever had a tubal ligation? ☐ No ☐ Yes If yes, when? _____

Have you had a hysterectomy? ☐ No ☐ Yes If yes, when? _____

Are you post-menopausal? ☐ No ☐ Yes

Do you have osteoporosis? ☐ No ☐ Yes

Have you ever had Hormone Replacement Therapy? ☐ No ☐ Yes

Do you have frequent infections? ☐ No ☐ Yes Type: _____

Do you have a lump in your breast? ☐ No ☐ Yes Type: _____

Do you have a family history of the following? If so, please list family relationship to patient.

☐ Breast Cancer _____ ☐ Ovarian Cancer _____

NOTICE OF PRIVACY PRACTICES:

Your Information. Your Rights. Our Responsibilities.



This notice describes how health information about you may be used and disclosed by Outpatient Medical Center, and how you can gain access to this information. **Please review it carefully!**

Your Rights:

- Request a copy of your paper or electronic health record.
- Correct your paper or electronic health record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a copy of this privacy notice.
- Get a list of those with whom we've shared your information.
- Choose someone to act and/or make decisions for you.
- File a complaint if you feel as if your privacy rights have been violated.

Your Choices. You have some choices in the way that we use and share your health information in regards to:

- Telling family and friends about your condition.
- Providing disaster relief.
- Providing mental health care.
- Marketing our services and raising funds.

Our Uses and Disclosures. We may use and share your information as we:

- Treat You.
- Run our organization.
- Bill for your services.
- Assist in public health and safety endeavors.
- Participate in or conduct research studies.
- Comply with the law.
- Respond to organ and tissue donation requests.
- Work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, and other governmental requests.
- Respond to lawsuits and other legal actions.

Your Rights. When it comes to your health information, you hold certain rights. This section explains and some of the ways in which we can assist you.

- **Retrieve an electronic or paper copy of your health record.** You may ask to see or obtain an electronic or paper copy of your health record and other health information about you that we have on-file. Upon making such a request, we will provide you with a copy of your record or a summary of your health information, usually within thirty (30) days of receiving the request. In doing so, we may charge a reasonable, cost-based fee for labor and material.
- **Request that your health record be corrected.** You may ask us to correct health information about you which you believe to be incorrect or incomplete. If your request is denied, we'll provide you written notification within sixty (60) days of the reason for the denial.
- **Request confidential communications.** You may ask us to contact you in a specific way (i.e. via your home or cell phone), or to mail correspondences to an alternative address. All reasonable requests will be adhered to.
- **Ask that we limit the information about you which we use or share.** You may request that we not use or share certain health information for your treatment or payment. We are not required to agree with this request should we believe that it will adversely affect your care, or if it is impermissible. Should you pay for a service or health care item out-of-pocket in full, may ask that we not share this information for the purpose of payment or operations with your health insurer. Unless precluded by law, we will generally agree to this request.
- **Get a list of those whom we've shared your information with.** You may ask for a list that denotes with whom, why and the frequency that we've shared your health information with over the prior six years. We reply by issuing you with a written notice regarding all permissible disclosures requested. In doing so, we may charge a reasonable, cost-based fee for labor and material.
- **Receive a copy of this privacy notice.** You may ask for a copy of this notice at any time, even if you have agreed to receive the notice electronically. A paper copy will be provided to you promptly.
- **Choose someone to act for or represent you.** If someone is your legal guardian or has medical power of attorney over you, that person can exercise your rights and make choices about your health information. We'll ensure that this person presents proof of this authority prior to observing any of their requests.

- **File a complaint if you feel your rights are violated.** You may complain if you feel we have violated your rights by contacting the Chief Executive Officer or designee at 318-357-2071, or via email at info@outpatientmedical.org. Additionally, you may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Outpatient Medical Center will not retaliate against you should a complaint be filed.

Your Choices. For certain health information, you may notify us of your choices about information that we share. If you have a clear preference for how we share your information in the situations described below, please talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
 - In these cases we never share your information unless you give us written permission: marketing purposes, most sharing of psychotherapy notes.

Our Uses and Disclosures. We typically use or share your health information in the following ways:

- **Treating you.** We can use your health information and share it with other professionals who are treating you (*Example: A doctor treating you for an injury asks another doctor about your overall health condition*).
- **Running our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary (*Example: We use health information about you to manage your treatment and services*).
- **Billing for your services.** We can use and share your health information to bill and get payment from health plans or other entities (*Example: We give information about you to your health insurance plan so it will pay for your services*).

We are permitted and at times required to share your information in other ways, usually in ways that contribute to the public good, such as for public health research. In order to share this information however, we must adhere by federal regulation. For more information, please visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues.** We can share health information about you for certain situations such as: preventing disease, assisting with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence; and/or preventing or reducing a serious threat to anyone's health or safety.
- **Researching.** We can use or share your information for health research when legally permissible.
- **Complying with the law.** We will share information about you if it is required by state or federal law.
- **Responding to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.
- **Working with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual passes away.
- **Addressing workers' compensation, law enforcement, and other government requests.** We can use or share health information about you for workers' compensation claims, law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law and for special government functions such as military, national security, and presidential protective services.
- **Responding to lawsuits and legal actions.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your personal information.
- All patients must be provided with a copy of this notice upon their initial visit to Outpatient Medical Center and we must follow the duties and privacy practices described in this notice.
- We will not use or share your information other than for the purposes described within this notice.

Changes to the Terms of this Notice: We can change the terms of this notice at our discretion, and these changes will apply to all information we have about you. Should this occur, we will mail you a summary of the changes along with a copy of the new notice, which will also be in our clinic locations

Effective Date of this Notice: 06/5/2025



Outpatient Medical Center, Inc.

"Caring For You Is What We Do"

PATIENT RIGHTS AND RESPONSIBILITIES

Welcome to Outpatient Medical Center. Our goal is to provide quality health care to people in this community, regardless of their ability to pay. As a patient, you have rights and responsibilities. Also, the clinic has rights and responsibilities. We want you to understand these rights and responsibilities, so you can help us to provide health care to you. Please read and sign this statement and inform us if you have any questions.

Human Rights:

- You have a right to be treated with respect and dignity regardless of race, religion, sex, national origin, physical or mental handicap or disability, age, or other grounds as applicable under federal, state and local laws or regulations.

Payment for Services:

- You are responsible for giving us accurate information about your present financial status and any changes in your financial status. Outpatient Medical Center (OMC) needs this information to determine how much to charge you and/or bill private insurance, Medicaid, Medicare, or other benefits for which you may be eligible.
- If your income is less than the federal poverty guidelines, you will be charged a discounted fee.
- You have a right to receive an explanation of your bill. You must pay or arrange to pay all agreed fees; if you cannot pay right away please contact our billing office at 318-357-2071 or email billing@outpatientmedical.org so that we can provide care for you now and work out a payment plan.

Privacy:

- You have a right to have your interviews, examinations and treatment in private. Your medical records are also private. Only legally authorized persons will see your records unless you ask us to show them to someone else with a signed authorization to release your protected health information. A complete discussion of your privacy rights is included in the Notice of Privacy Practices. This notice details the various rights granted to you under the Health Insurance Portability and Accountability Act (HIPAA).

Health Care:

- You are responsible for providing OMC accurate, complete and current information about your health so that we can give you proper health care. You have a right and are encouraged to participate in decisions about your treatment.
- You have the right to information and explanations in the language you normally speak and in words you understand. You have a right to information about your health or illness, treatment plan (including benefits and risks), and expected outcomes, if known. If you do not wish to receive this information or if

it is not medically advisable to share that information with you, we will provide it to a legally authorized person.

- If you are an adult, you have a right to refuse treatment to the extent permitted by law, and to be informed of the risk of refusing such care. You are responsible for the outcome of refusing treatment.
- You have a right to health care treatment that is reasonable for your condition and within our capability; however, OMC is not an emergency care facility. You have a right to be transferred or referred to another facility for services that we cannot provide. But, we do not pay for services you receive from another healthcare provider.
- You have a right to the appropriate assessment and management of pain within the available resources of the clinic.

Rules:

- You have a right to receive a copy of our patient information about the health services we provide, personal conduct, and the use of our property and resources. You are responsible for obeying these rules.
- You are responsible for appropriate use of clinic services, which includes following our staff's instructions. You have a responsibility to keep your scheduled appointment and to arrive on time.
- You have a responsibility to be courteous and respectful to Outpatient Medical Center staff and other patients.
- You are responsible for bringing a responsible adult to watch children under 12 years of age. You are responsible for their safety and the protection of other clients and our property.

Compliments and Complaints:

- OMC wants to hear what you like and don't like. We expect your experience to be a great one. Let us know how we may gain your satisfaction. If you are not satisfied, please tell us. OMC wants suggestions so we can improve our services. Staff will tell you how to file a complaint. We will not punish you for filing a complaint and will continue to see you as a patient.
- Compliments and complaints can be submitted to the clinic manager or you may call 318-357-2071 or email info@outpatientmedical.org.

Warnings Suspensions and Terminations:

- If you are reported to show inappropriate behavior, you will receive a letter warning you that such behavior will not be tolerated, and you are at risk of being terminated as an OMC patient.
- If you commit a major infraction, you will receive a letter terminating you as an OMC patient.

Reasons for which Outpatient Medical Center may stop providing health care services to you:

- Intentional failure to report accurate information concerning your health.
- Intentional failure to follow the health care program such as instruction about taking medications, personal health practices, or follow-up appointments, as recommended by your provider.
- Creating a threat to the safety of the staff and/or other clients.
- Forging or altering a prescription and/or other criminal acts.
- Intentional failure to accurately report your financial status.
- Failure to contact us to set up a payment plan on your outstanding bill.

If you are issued a termination letter you will have a right to appeal the decision to the Outpatient Medical Center by writing the OMC Chief Executive Officer at 1640 Breazeale Springs Street, Natchitoches, LA 71457. You will also be informed whether or not your termination is for one year (non-criminal infraction) or permanently (criminal infractions). All criminal infractions will be reported to the police.

Renewed by OMC Board of Directors on September 29, 2026; Previously renewed on September 25th, 2025, September 24th, 2024 September 26th, 2023; October 4th, 2022, October 26, 2021; Originally approved on October 27, 2020