East Jefferson Family Practice
Notice of Privacy Practice

3848 Veterans Memorial Blvd, Ste 101
Metairie, La 70002
2109 David Drive, Metairie, LA, 70003
504-885-2505

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

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

➢ *See page 2 for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ *See page 3 for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- 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 government requests
- Respond to lawsuits and legal actions

➢ *See pages 3 and 4 for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, 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 • Include your information in a hospital directory *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 • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat 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.*
Run 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.*
Bill 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.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **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
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond 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 information.*
- *We must follow the duties and privacy practices described in this notice and give you a copy of it.*
- *We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.*

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site: ejfamilypractice.com

For more information:

If you have any questions or would like more information, please contact the general manager, Amani Ismail at 504-885-2505. To obtain medical records, please email the general manager at MANAGER@EJFPONLINE.COM with your request.

East Jefferson
Family Practice

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

PHONE: (504) 885-2505
FAX: (504) 885-2510
Email: Eastjeffersonfamilypractice@ejfponline.com
WEB: www.ejfamilypractice.com

PATIENT INFORMATION:

Name:_____ Social Security ____/____/____

Date of Birth_____/_____/_____Gender: ☐ Male ☐ Female

Home Address:_____

City:_____State:_____Zip_____

Email_____

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

GUARDIAN/EMERGENCY CONTACT INFORMATION:

First Name:_____Last Name:_____

Home Address (If different from patient's):_____

_____Relationship to patient:_____

SSN:_____Home Phone #:_____

Work Phone #:_____Cell Phone #:_____

PRIMARY INSURANCE INFORMATION:

Insured's Name:_____Insured's DOB:_____

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

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

Insured's relationship to patient:_____Insurance company name:_____

Insurance company's phone #:_____

Policy #:_____Group #:_____

SECONDARY INSURANCE INFORMATION:

Insured's Name:_____Insured's DOB:_____

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

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

Insured's relationship to patient:_____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., OR DUNG (ALEX) HOANG, M.D.,CHARLIE LE, MD, AND TAI NGUYEN, MD, 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_____

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

NAME: _____ **DOB:** _____

SOCIAL SECURITY NUMBER _____

I agree and consent to a medical examination by East Jefferson Family Practice's physicians. I understand that additional diagnostic procedures and treatments may be recommended by the physician and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the result of any procedure or medical treatment.

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 restrict the disclosure of my health information to the following people or entities:

_____

_____

_____ I allow the disclosure of my health information to the following people or entities:

_____

_____

_____

PATIENT'S OR LEGAL REPRESENTATIVE'S SIGNATURE

DATE _____ **WITNESS** _____

East Jefferson Family Practice, LLC

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3848 Veterans Blvd., Suite 101, Metairie, LA 70002
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(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)

EAST JEFFERSON FAMILY PRACTICE

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

PHONE: 504-885-2505
FAX: 504-885-2510
WEBSITE: EJFAMILYPRACTICE.COM

PATIENT NAME: _____ **DATE OF BIRTH**_____/_____/_____

PHARMACY NAME:_____ **PHARMACY NUMBER:**_____

CROSS STREETS:_____ **AND**_____

1. **PAST MEDICAL HISTORY** (please check if you had any of the following):

__Heart Disease	__Thyroid Disease	__Mood Disorder	__Reflux	__Tuberculosis
__Diabetes	__Lung Disease	__Gout	__Liver Disease	__Insomnia
__High Blood Pressure	__Asthma	__Colon Polyps	__Hepatitis	__Snoring
__Hig Cholesterol	__Anemia	__Cancer	__Kidney Disease	__Daytime Napping
__Stroke	__Osteoporosis	__Ulcers	__Sinus Allergies	

ANY OTHER MAJOR ILLNESSES?_____
ANY SURGERIES?_____
NAMES OF ANY 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?_____

TOBACCO HISTORY:

STARTED SMOKING AT AGE:___
NUMBER OF PACKS PER DAY: 1/2 1 2
QUIT DATE: _____

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

__Heart Disease	__Breast Cancer	__Aneurysms	__Sleep Apnea
__Diabetes	__Colon Cancer	__Thyroid Disease	
__High Blood Pressure	__Skin Cancer	__Mental Disorder	
__Hig Cholesterol	__Prostate Cancer	__Drug Abuse	
__Stroke	__Strokes	__Alcohol Abuse	

PLEASE LIST ANY OTHERS:_____

4. **PLEASE LIST ANY ALLERGIES:**_____

_____ **NO KNOWN DRUG ALLERGIES**

5. **MEDICATIONS**: Please list name, strength, and how oftern taken- EX: Aspirin, 81mg once daily)

MEDICATION:_____STRENGTH:_____MG TIMES A DAY:_____
MEDICATION:_____ STRENGTH:_____MG TIMES A DAY:_____
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MEDICATION:_____ STRENGTH:_____MG TIMES A DAY:_____

PREVENITIVE HEALTH QUESTIONNAIRE

NAME:_____
(LAST) (FIRST)

DATE OF BIRTH:_____ HEIGHT:_____ WEIGHT:_____

PLEASE WRITE DOWN THE MOST RECENT DATES OF EACH PREVENITIVE HEALTH MEASURE:

MEASURES	MONTH	YEAR
EYES EXAM		
COVID-19 VACCINE **TYPE:**		
PNEUMONIA-13 VACCINE		
PNEUMONIA-23 VACCINE		
FLU VACCINE		
TETANUS VACCINE		
SHINGLES VACCINE		
COLONOSCOPY		
PSA (PROSTATE-SPECIFIC ANTIGEN)		
MAMMOGRAM		
PAP SMEAR		
BONE DENSITY		

HAVE YOU **FALLEN** IN THE LAST 3 MONTHS?	YES	NO
DO YOU HAVE ANY PROBLEMS CONTROLLING YOUR **BLADDER**?	YES	NO
DO YOU HAVE ANY **DEPRESSION** OR **ANXIETY**?	YES	NO
DO YOU HAVE ANY **PAIN**?	YES	NO
DO YOU EXERCISE REGULARLY? HOW OFTEN?	YES	NO