Tulane Center for Autism and Related Disorders

TULANE UNIVERSITY

Thank you for your interest in the Tulane Center for Autism and Related Disorders (TCARD). Please review carefully and complete the enclosed paperwork. The detailed information you include on the intake form will aid our team in the evaluation process. Once completed, please return all forms to our office by fax, email, or mail. After receipt of completed forms, you will be added to our waitlist for an appointment. You may contact the office for information on your waitlist position. We look forward to meeting you and/or your family and providing the best possible services for your needs.

Fax: 504-988-0496

Download or print and scan, then email: autism@tulane.edu

Mail: Tulane Center for Autism and Related Disorders
1430 Tulane Ave.
#8055
New Orleans, LA 70112

In order to schedule an appointment, you must complete the entire packet **including the details of your insurance plan** if no copy of the card is included. We must have this information to proceed with evaluation. Please contact the clinic with questions at 504-988-3533 or autism@tulane.edu

TCARD - ADULT CASE HISTORY

Today's Date: _____ Referred by: _____

Person completing questionnaire: _____

Relationship to the individual in question:_____

IDENTIFYING INFORMATION AND FAMILY BACKGROUND

Name of Individual:_____
(First) (Middle) (Last) (Nickname)

Date of Birth: ____/_____/_____ Age: _____ Gender:_____

Ethnicity: ☐ Black/African American ☐ Hispanic/Latino ☐ White/Caucasian

☐ Asian/Pacific Islander ☐ Native American ☐ Other: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____-_____Work: (_____) _____-_____Cell: (_____) _____-_____

Email: _____

Relationship Status: ☐ Single, never married ☐ Engaged ☐ Married ☐ Separated
☐ Divorced ☐ In a Relationship ☐ Widowed ☐ Other:_____

With whom does the individual live: ☐ Alone ☐ Spouse

☐ Roommates ☐ Parents ☐ Group Home ☐ Relatives

☐ Other: _____

Preferred Method of Contact: ☐ Cell phone ☐ Work phone ☐ Home phone

☐ Email ☐ Case Worker (please provide name and contact information):_____

Are the individual's parents still living and able to be contacted for an interview?

☐ Yes ☐ No

Is there another relative or close contact available to provide collateral information? ☐ Yes ☐ No

***Please provide contact information on the following page for potential collateral sources. These will not be contacted unless deemed necessary and only with your permission.

POTENTIAL COLLATERAL SOURCES:

Name: _____

Relationship to individual seeking evaluation:_____

Preferred Method of Contact: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Home Phone: ( ) _____

Cell Phone: ( ) _____

Work/Other Phone: ( ) _____

Email: _____

Name: _____

Relationship to individual seeking evaluation: _____

Preferred Method of Contact: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Home Phone: ( ) _____

Cell Phone: ( ) _____

Work/Other Phone: ( ) _____

Email: _____

Name: _____

Relationship to individual seeking evaluation:_____

Preferred Method of Contact: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Home Phone: ( ) _____

Cell Phone: ( ) _____

Work/Other Phone: ( ) _____

Email: _____

Patient Information:

Preferred Language: _____

Primary Care Provider: _____

Address: _____
(Street) (City) (State) (Zip)
Phone: (____) ____-_____

Other Healthcare Provider: _____

Type of Provider: _____

Address: _____
(Street) (City) (State) (Zip)
Phone: (____) ____-_____

Other Healthcare Provider: _____

Type of Provider: _____

Address: _____
(Street) (City) (State) (Zip)
Phone: (____) ____-_____

Other Healthcare Provider: _____

Type of Provider: _____

Address: _____
(Street) (City) (State) (Zip)
Phone: (____) ____-_____

Tulane Medical Center Hospital and Clinic

PRE-REGISTRATION

No appointment can be scheduled without this information filled out completely.

Patient's Name_____
last first middle maiden

Address_____
number, street, apt city, state zip code

Parish or County_____ Patient's Home Phone(_____)_____

Date of Birth_____Patient's Age_____Patient's Soc. Sec. No._____

Patient's Sex_____Marital Status_____Race_____

Patient's Religion_____Patient's Employer_____

Patient's Employer's Address_____

Patient's Business Phone(_____)_____Patient's Occupation_____

Employment Status: ☐ full time ☐ part time ☐ retired ☐ self-employed Referring

Physician_____Phone_____

Address_____

Guarantor: (Person Responsible for Bill)

Name_____Soc. Sec. No._____

Address_____

Home Phone(____)_____Date of Birth_____Sex_____Relationship_____

Employer_____Phone (_____)_____

Address_____

Occupation_____Date or length of employment_____

Employment Status ☐ full time ☐ part time ☐ retired ☐ self-employed

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Next of Kin:

Name_____Soc. Sec. No._____Home Phone(_____)_____

Address_____Date of Birth_____

Relationship_____Employer_____

Employer's Address_____Business Phone(_____)_____

Occupation_____ Empl. Status ☐ full time ☐ part time ☐ retired ☐ self-empl.

In case of Emergency, please notify: Name_____

Phone (_____)_____Relationship_____

INSURANCE INFORMATION

No appointment can be scheduled without this information filled out completely.

PRIMARY INSURANCE CARRIER

Insurance Company's Name_____Address_____

Phone Number (_____)_____ Is this through your employment? YES☐ NO☐

If so, what is the employer's name_____Phone(_____)_____

Employee ID#_____Group Name_____

Contract or Individual #_____Group #_____

Policyholder's Name _____Relationship to patient_____

SECONDARY INSURANCE CARRIER

Insurance Company's Name_____Address_____

Phone Number (_____)_____ Is this through your employment? YES☐ NO☐

If so, what is the employer's name_____Phone(_____)_____

Employee ID#_____Group Name_____

Contract or Individual #_____Group #_____

Policyholder's Name _____Relationship to patient_____

WORKMAN'S COMENSATION / THIRD PARTY BILLING

Name_____

Address_____

Phone (_____)_____Ext_____

Confirmed by_____Title_____Date_____

MEDICARE ELIGIBILITY DETERMINATION

Part I. WORKMAN'S COMPENSATION

Was your illness/injury due to a work related accident/condition? Yes☐ No ☐

Is your condition covered by Workmen's Compensation plan or the Federal Black Lung Program?Yes☐ No☐

Part II. ACCIDENT

Was your illness/injury due to an accident? Yes☐ No ☐

Part III. ESRD/KIDNEY DIALYSIS

Are you age 65 or over? Yes☐ No ☐

Are you undergoing kidney dialysis for ESRD? Yes☐ No ☐

Part IV. DISABILITY

Are you a disabled Medicare beneficiary under age 65? Yes☐ No ☐

Part V. EMPLOYER'S GROUP HEALTH PLAN

Are you or your spouse employed and participating in the Employer's Group Health Plan? Yes☐No☐

MEDICARE ELIGIBITY: MEDICARE PRIMARY_____ SECONDARY_____

Patient/Parent Signature_____ Date_____

Interviewed by_____

PURPOSE OF EVALUATION

1. Who referred you/the individual and for what reason? If you were not referred, what prompted you to seek this appointment?

2. What are your questions or concerns regarding yourself or the individual in question?

3. In what ways would you like us to be of help to you?

PREGNANCY HISTORY

This information is regarding the mother of the individual seeking evaluation.

Did mother receive any assisted reproductive technology? ☐ Yes ☐ No ☐ Unsure

Was this child a planned pregnancy? _____

This child was pregnancy number _____

This child was delivery number _____

Number of pregnancies you have had _____

Number of live births _____

Number of stillbirths _____

Number of miscarriages _____

Number of living children _____

Number of deceased children _____

PREGNANCY & PERINATAL HISTORY

Age of mother at delivery: _____ Age of father at delivery: _____

Did the mother have any problems during this pregnancy? ☐ Yes ☐ No ☐ Unk.
If yes, please describe:

Did the mother have any health problems during this pregnancy? ☐ Yes ☐ No ☐ Unk.
If yes, please describe the problem and the time it occurred during the pregnancy (such as infections, high blood pressure, diabetes, bleeding, weight loss, accidents, fever, etc.)

Did the mother smoke during this pregnancy? ☐ Yes ☐ No ☐ Unk.
If yes, please list how many cigarettes per day: _____

Did the mother use alcohol or other drugs during this pregnancy? ☐ Yes ☐ No ☐ Unk.
If yes, please describe your use (i.e., what and how often)

LABOR AND DELIVERY

Was the baby carried a full 9 months? ☐ Yes ☐ No ☐ Unk.
If no, please indicate the length of the pregnancy: _____

Was this person a product of a multiple birth pregnancy (e.g. twins, triplets)? ☐ Yes ☐ No
If yes, was the child A, B, C, etc.? _____

Type of delivery: ☐ Vaginal ☐ C- Section
Reason for C-Section: _____

Where was this person born? _____
(Hospital) (City)

How much did the baby weigh at birth? ____ lb____ oz

Was the baby admitted to the NICU (neonatal intensive care unit)? ☐ Yes ☐ No ☐ Unk.
For what reason?
_____
Total days in NICU: _____days

Did the individual need any special care during the first few days? If yes, please describe: ☐ Yes ☐ No ☐ Unk.

PAST MEDICAL HISTORY

Do you/the patient have any medical diagnoses? ☐ Yes ☐ No
If yes, provide **name** of diagnosis and **date** diagnosed:

_____

_____

_____

_____

Current Medications: ☐ None

Medication Name:	Dosage:	Purpose:	Prescribing Dr.:

Have you/the individual ever (attach pages if necessary):

		Date:	Reason
Been Hospitalized	☐ No ☐ Yes		
Had Surgery	☐ No ☐ Yes		

Have you/the individual had any of the following evaluations?

Evaluation	No	Yes		If Yes, Date:	If yes, Result:
Audiologic/Hearing Test	☐	☐			
Vision Test	☐	☐			Individual prescribed glasses? ☐ Y ☐ N
Head Imaging (MRI, CT, etc.)	☐	☐			
EEG	☐	☐			
Genetic Testing	☐	☐			
Other, Specify:	☐	☐			

NUTRITION

Did you/the individual ever struggle with being overweight or underweight? ☐ Yes ☐ No
If yes: ☐ overweight ☐ underweight

Were you/the individual a picky eater as a child? ☐ Yes ☐ No
If yes, please describe:

Are you/the individual still picky or have a limited diet for any reason?
☐ Yes ☐ No

If yes, please list:

DEVELOPMENTAL HISTORY

This section is to be completed with help from a parent/caregiver/or knowledgeable source for the individual when they were a child, if possible.

Was your/the individual's development any faster or slower than ☐ Yes ☐ No
other children? If yes, **please explain**:

_____

_____

Did you/the individual walk before 15 months of age? ☐ Yes ☐ No

Did you/the individual begin speaking before 2 years of age? ☐ Yes ☐ No

As a child, did you/the individual have any sleeping difficulties? ☐ Yes ☐ No
If yes, please describe:

Did you/the individual ever fail to progress or
regress (lose skills) in development? ☐ Yes ☐ No
If yes, **please explain**:

BEHAVIORAL/PSYCHIATRIC HISTORY

Do you/the individual have any current mental/behavioral health diagnoses? ☐ Yes ☐ No
If yes, provide **name** of diagnosis and date **diagnosed**:

_____

_____

_____

_____

Are you/the individual currently receiving mental health treatment? ☐ Yes ☐ No
If yes, from whom:

Psychiatrist: _____

Psychologist: _____

Therapist/Counselor: _____

Other: _____

Were there ever concerns about you/the individual's behavior at home or school? ☐ Yes ☐ No
If yes, please explain:

How do you/the individual respond to frustration?

What leisure time activities do you/the individual enjoy?

FAMILY HISTORY

Instructions: The questions below ask about the family history of the individual. Please indicate if there is a family history of the disorder. If "yes," indicate which family member(s). Include only **biological (blood) relatives**.

Disorder	*No*	*Yes*	*Family member with diagnosis (write in)*
Autism Spectrum Disorder	☐	☐	
Intellectual Disability (formerly known as Mental Retardation)	☐	☐	
Speech language disorder (received speech therapy)	☐	☐	
ADHD/ADD	☐	☐	
Obsessive Compulsive Disorder	☐	☐	
Anxiety Disorder	☐	☐	
Depression	☐	☐	
Manic depression or Bipolar disorder	☐	☐	
Schizophrenia	☐	☐	
Seizures	☐	☐	
Neurofibromatosis	☐	☐	
Auto-immune disorders (e.g. Lupus, Rheumatoid Arthritis, Multiple Sclerosis)	☐	☐	
Neurologic disease (e.g. Parkinson's, Huntington's Disease)	☐	☐	
Genetic disorder Specify:	☐	☐	
Other:	☐	☐	

EDUCATIONAL HISTORY

What is the highest level of education attained by you/the individual? _____

Date of graduation from high school if applicable: _____

Date of graduation from college and major if applicable: _____

Date of graduation from graduate school and degree program if applicable:_____

Did you/the individual repeat a grade? ☐ Yes ☐ No

If yes, which grade(s) was repeated? _____

Did you/the individual ever receive special education or accommodations through at school?

☐ Yes ☐ No

If yes, when and for what exceptionality/disability?_____

EMPLOYMENT HISTORY

Are you/the individual currently employed? ☐ Yes ☐ No

If yes, where? _____

Length of current employment:_____

How many jobs have you/the individual had? _____

How many jobs have you/the individual voluntarily left (quit)? _____

From how many jobs have you/the individual been terminated? _____

If you/the individual are not currently employed, how do you/they earn money?

FAMILY DATA

Please list all persons presently living in your home:

	Name	Sex	Birthdate	Relation to Individual	Grade/degree
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

If you/the individual lives with his/her parents or caregivers, please complete:

Caregiver 1/Mother's Information: Age: _____ Highest Grade Completed: _____

Occupation: _____

Place of Employment: _____

Caregiver 2/Father's Information: Age: _____ Highest Grade Completed: _____

Occupation: _____

Place of Employment: _____

If the individual is married, please complete:

Spouse Information: Age: _____ Highest Grade Completed: _____

Occupation: _____ ☐Full-time ☐Part-time

Place of Employment: _____

Have you/the individual ever experienced a traumatic event that affected your/their ability to function?

☐Yes ☐No

If yes, please briefly describe event and date:

Thank you for completing this questionnaire. Please return to:
Tulane Center for Autism and Related Disorders
1430 Tulane Ave. #8055
New Orleans, LA 70112

Autism@tulane.edu
504-988-0496 fax

You may return in person at our physical address:
131 S. Robertson St., 14th floor
New Orleans, LA 70112

TCARD Policy and Procedure for

No Shows and Late Cancellations

No-shows and late cancellations are very disruptive to the clinic schedule. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient and increases waiting list times. No-shows and late cancellations delay the delivery of services to other patients, some who are in great need. Below are the policies and procedures that we have implemented regarding these situations.

A "no-show" is missing a scheduled appointment without any notification prior to the start of the appointment time. A "late cancellation" is cancelling an appointment without calling us to cancel 24 hours in advance of an intake and feedback or 48 hours in advance of a testing appointment.

INTAKE APPOINTMENTS

New clients who no-show for their first appointment will NOT be automatically rescheduled. Less than 24 hours advance notice for intake appointments will be considered a no-show. Monday appointments must be cancelled by the Friday before the appointment. Consideration of extraordinary circumstances with proper documentation will occur on a case by case basis. (No-show fees *may* apply.) If the new client initiates a phone call requesting to be rescheduled after their first no-show, they may first be returned to the waiting list. If the new client no-shows for an intake a second time, they will not be rescheduled and will have to seek services elsewhere.

TESTING APPOINTMENTS

Less than 48 hours advance notice of cancellation for testing will be considered a no-show. Monday appointments must be cancelled by the Friday before. If there is a no-show for testing, the client may NOT be rescheduled. Consideration of extraordinary circumstances with proper documentation will occur on a case by case basis. No-show fees *may* apply.

FEEDBACK APPOINTMENTS

Less than 24 hours advance notice for feedback appointments will be considered a no-show. Monday appointments must be cancelled by the Friday before the appointment. Consideration of extraordinary circumstances with proper documentation will occur on a case by case basis. If a client no-shows for a feedback appointment, they will not be rescheduled and the final report will be mailed to the caregiver.

No-show/late cancellation fees are the FULL responsibility of the client—insurance companies do not pay for missed appointments.

By signing below, you are agreeing to the terms of this policy and you understand your responsibility in making scheduled appointments.

_____ _____

Signature Date

EMAIL CONSENT FORM

If you wish to correspond with via electronic mail (email) please read and sign the following. This form provides guidelines for the intended use of this type of communication, and documents your consent.

IN A MEDICAL EMERGENCY, DO NOT USE EMAIL. CALL 911

E-mail Use:	Generally, e-mail correspondence should be between the provider and an adult patient 18 years or older, or parent or legal guardian of a minor.
Privacy and Confidentiality:	Unless your provider tells you specifically that the e-mail will be conducted via a secure server, consider e-mail like a postcard that can be viewed by unintended persons. In addition, the content of the email may be monitored by the hospital to ensure appropriate use. Discuss with your provider who will process your e-mail messages during business hours, vacations or illness. All e-mails regarding your care will be included in your medical record.
Creating a Message:	On the "Subject" line, include the general topic of the message, for example, Prescription of Appointment or Advice. In the body of the message, include your name.
Content of The Message:	E-mail should be used only for non- sensitive and non-urgent issues. Types of information appropriate for e-mail include: • Questions about resources • Routine follow-up inquiries • Appointment scheduling
Ending E-mail Relationship	Either you or your provider may request via e-mail or letter to discontinue using e-mail as a means of communication.
Disclaimer:	Tulane Center For Autism And Related Disorders And Tulane University Medical Group are not responsible for e-mail messages that are lost due to technical failure during composition, transmission and /or storage.

I have read and understand the information above, and had any questions answered to my satisfaction. I agree to the guidelines for e-mail communication.

_____	_____	_____
Date	Signature of patient, parent or Personal representative	Relationship (if other than patient)

Patient E-mail address (please print): _____

Provider Name: _____ Phone Number: _____

Provider E-mail address (please print): _____

CONSENT TO BE CONTACTED FOR FUTURE RESEARCH

What is the purpose of this consent? The providers in the TCARD Clinic are doing research that is designed to lead to better treatments for the types of problems experienced by the people who come to this clinic. They want to know if you wish to learn more about their research studies of if you may wish to participate in any of the studies that may be appropriate for you. By signing this form, you will allow qualified professional people on the staff on this clinic to contact you in the future to ask if you want to participate in any studies. You have no obligation to actually participate in any study.

What happens if I sign this form? If you sign this form, you are giving consent for information to be taken from your TCARD medical records. This list includes information about your diagnosis, your name, medical record number, date of birth, diagnosis and contact information. This information will be kept indefinitely, unless you withdraw your permission. If a study on your condition needs subjects, you may be contacted to ask if you want to participate. You do not have to participate. You may withdraw permission to be contacted at any time by contacting the clinic.

What happens if I don't sign this form? Declining to participate will have no influence on your present or future status as a patient in this clinic. You will receive the same care as any other patient seen in this clinic. There will be no penalty or loss of benefits to which you are otherwise entitled. Your clinic records will indicate that you do not want to be asked about future research by or through anyone but your treating physician.

Are there any risks to my signing this form? Participation in research may involve some loss of privacy. However, your records will be handled as confidentially as possible. Access will be limited to the data manager and the doctor organizing the study and will require a password. No information will be used for research without additional permission. Your contact information will not be shared with anyone outside this clinic.

Are there any financial considerations? There will no cost or payment to you if you sign this form.

What do I do if I have questions, now or later? You can talk with the study researcher about any questions, concerns or complaints you have about this study. Contact the study researcher(s) Lisa Settles, Psy.D. at 504-988-8533

If you wish to ask questions about the study or your rights as a research participant to someone other than the researchers or if you wish to voice any problems or concerns you may have about the study, please call the office of the Institutional Review Board at 504-865-5000. [If there are additional informational sources related to the study (e.g., patient representatives or individuals at other study sites as appropriate), list here with contact information.]

What do I do to consent? If you agree to be contacted in the future, please indicate your preferred contact method and sign below.

Preferred contact method:

- o Phone: _____
- o Mail: _____
- o Email address: _____

_____ _____

Signature Date

_____

Signature of Person Obtaining Consent Date

Informed Consent for Telemedicine Services

I understand that telemedicine is the use of interactive telecommunication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I understand that my initial visit with a Tulane University Medical Group physician will be a consultation and that it will not necessarily give rise to an ongoing treatment relationship. I understand that some physicians that Tulane University Medical Group uses to provide telemedicine services are employed by an independent company and not Tulane University Medical Group. Whenever used in this document, "Tulane University Medical Group physician" shall include both physicians employed by Tulane University Medical Group and physicians employed by independent companies. I understand that I should continue to consult with my other healthcare providers as recommended.

I consent to receive health care delivery, diagnosis, consultation, treatment, and transfer of medical data by a Tulane University Medical Group physician by telemedicine.

I acknowledge that the risks, benefits, and alternatives to receiving health care by telemedicine have been discussed with me. I understand that the alternatives to receiving health care by telemedicine are to receive health care in-person in a clinical setting or to receive no health care/treatment. I acknowledge that the risks and benefits of receiving no health care/treatment have been discussed with me.

I understand that the provision of health care by telemedicine involves risks that are different than the risks associated with receiving health care in an in-person clinical setting. The primary health risk of receiving health care by telemedicine is that certain assessments can only be performed and certain diagnosis can only be made in person. If I believe or am told that my condition presents a medical emergency, I will immediately dial 911 and/or proceed to the nearest emergency department. If during the course of my telemedicine encounter I am told that I need to be seen in an in-person setting and/or receive tests that can only be obtained in-person, I understand that it is my responsibility to schedule and attend the recommended in-person visit and/or test. I understand and consent to receiving health care by telemedicine knowing that certain assessments and diagnosis can only be made in person.

I acknowledge that I have been notified of my right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, and that my decision to withdraw will not affect my right to future care or treatment. I understand that I may revoke my consent to telemedicine services orally or in writing. As long as this consent is in force (has not been revoked), I authorize Tulane University Medical Group to provide health care services to me via telemedicine without the need for me to sign another consent.

I have the right, as a patient, to be informed about my condition and the recommended treatment or diagnostic procedure to be used so that I can make the decision whether or not to undergo treatment after knowing the risks and hazards involved, as well as the benefits and any treatment options. All medical or surgical treatment involves risks. I will ask my physician if I would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks. I understand that all information given to me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures or as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either

express or implied, as to the success or other results of any treatment.

I understand that the federal and state laws that protect the privacy and confidentiality of medical information also apply to telemedicine. I understand that as an existing patient of Tulane University Medical Group my health information will be used and disclosed in accordance with Tulane University Medical Group's Notice of Privacy Practices, a copy of which may be requested at any time. I understand that I can obtain copies of my medical records by contacting the Privacy Official at the contact information provided in the Notice of Privacy Practices. The clinic staff will release my records after they have received written authorization permitting the release of my medical records to my designated recipient. I understand that the use of telemedicine poses a risk to the protection of my personal health information that is different from receiving health care in an in-person clinical setting. I have read Tulane University Medical Group's Notice of Privacy Practices. I understand and consent to receiving health care by telemedicine knowing the steps taken to protect my personal health information and the risk that despite those steps, the use of telemedicine creates a risk to the privacy of my personal health information.

I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. I understand that in the event of a technology or equipment failure, I should call my provider's office to receive further instructions. I understand that telemedicine is not used to provide emergency care and such emergency care should be sought by calling 911.

I understand that Tulane University Medical Group may determine that its clinical services are not appropriate for some or all of my treatment needs and may elect not to provide clinical services to me through telemedicine.

By checking the box below, I acknowledge the above information and consent to receiving telemedicine services from Tulane University Medical Group and its participating providers.

☐ I consent to the terms listed above

_____

Patient Signature or Check Mark

_____

Date and time stamp

Print Patient Name

_____

Name of Personal Representative and description of authority to act on behalf of the patient, if applicable

TUMG CONSENT AND RELEASE

ASSIGNMENT OF BENEFITS: I authorize direct payment to Tulane University Medical Group ("TUMG"), of all medical benefits, settlements, or judgments applicable to my treatment by TUMG physicians and other clinicians at the hospital or clinic. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked in writing by me. I understand that I am personally responsible for payment of all fees applicable to my treatment by TUMG physicians at the hospital or clinic, including copayments, deductibles, and fees for non-covered services, irrespective of other insurance coverage or other parties' responsibility to me for such fees. If unpaid balances are overdue and are referred for collection, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with collection. **INITIAL** _____

RELEASE OF INFORMATION: I authorize TUMG and/or its physicians and other clinicians to disclose all or part of my medical or billing records to any insurance carrier or persons employed by such carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to group health plans for group insurance coverage, workman's compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release TUMG and its physicians and clinicians from any and all responsibility relative to the release of such information. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records: decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. **INITIAL** _____

RX ELIGIBILITY CONSENT: By signing this consent form you are agreeing that TUMG can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors. I hereby provide informed consent to TUMG 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. **INITIAL** _____

CONSENT FOR TREATMENT: I, THE PATIENT LISTED BELOW OR SOMEONE WITH LEGAL CAPACITY TO MAKE HEALTHCARE DECISION FOR THE PATIENT, KNOWING THAT (I AM/HE OR SHE IS) SUFFERING FROM A CONDITION REQUIRING DIAGNOSIS AND/OR MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND HOSPITAL, MEDICAL, AND SURGICAL CARE AS NECESSARY IN THE JUDGMENT OF PHYSICIAN(S) IN CHARGE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE ME AS TO THE RESULTS OF EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE TUMG TO RETAIN OR DISPOSE OF ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY DURING MY TREATMENT, AND TO USE SUCH SPECIMENS OR TISSUES FOR SCIENTIFIC, EDUCATIONAL, OR RESEARCH PURPOSES, TO THE EXTENT THAT SUCH SPECIMENS AND TISSUES ARE NOT KEPT AT TULANE UNIVERSITY HOSPITAL AND CLINIC. **INITIAL**_____

REFUSAL OF CONSENT FOR TREATMENT. I, the patient listed below or someone with legal capacity to make healthcare decision for the patient, refuse to consent to treatment. I have been advised of the consequences and risks of such refusal, and hereby release the physicians, clinicians, and TUMG from liability for injuries arising from such refusal. ***(ONLY COMPLETE THIS SECTION IF YOU DO NOT CONSENT TO MEDICAL TREATMENT)***

LIST PROCEDURE: _____ **PATIENT SIGNATURE:** _____

PATIENT NAME	**DATE OF BIRTH**	**RELATIONSHIP TO PATIENT**
SIGNATURE (PATIENT OR PERSON AUTHORIZED TO CONSENT)	**DATE AND TIME**	**WITNESS**

Tulane University

Notice of Privacy Practices

Effective as of November 30, 2021

THIS NOTICE OF PRIVACY PRACTICES ("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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this Notice which describes the health information privacy practices of Tulane University Medical Group. This notice covers information held by non-hospital based (including telehealth) Tulane University Medical Group sites. A copy of our current Notice will always be maintained in our office. You will be given a Notice at the time you first seek treatment. You will also be able to obtain your own copy by calling 504-988-7739, or asking for one at the time of your next visit, or by visiting our website: https:// counsel.tulane.edu/upo/hipaa-privacy-policies-procedures-forms

This Notice does not cover health information generated and maintained by a hospital for hospital services provided to you by a Tulane University Medical Group physician. Please refer to the hospital notice of privacy practices for how that medical information may be used or maintained.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a Tulane University Medical Group patient or receiving treatment or health-related services from Tulane University Medical Group.
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future (such as an operation); or
- information about your health care benefits under an insurance plan (such as whether a prescription is covered); *when combined with:*
    - o demographic information (such as your name, address, or insurance status)
    - o unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); or
    - o other types of information that may identify who you are.

REQUIREMENT FOR WRITTEN AUTHORIZATION

We will obtain your written authorization before using your health information or sharing it with others outside Tulane University Medical Group, except as we describe in this Notice. Uses and disclosures of health information that require your written authorization include: most uses and disclosures of psychotherapy notes (where appropriate), most uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information. Uses and disclosures of your protected health information by us notdescribed in this Notice will be made only with your written authorization.

If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please obtain request an authorization revocation form manager of the clinic from the Privacy Official at the contact information at the end of this Notice.

You may also initiate the transfer of your records to another person by completing a written authorization form.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are described below. Not every use or disclosure in a category will be listed. Your health information may be stored in paper, electronic or other form and may be disclosed electronically and by other methods.:

Treatment, Payment, and Health Care Operations

Tulane University Medical Group may use your health care information or share it with others in order to provide health care services to you, obtain payment for those services, and run Tulane University Medical Group's normal business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payor. Below are further examples of how your information may be used and disclosed for treatment, payment, and normal business operations without your written authorization.

Treatment: We may share your health information with doctors or other clinicians in the Tulane University Medical Group who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. Tulane University Medical Group doctors or clinicians may share your health information with another doctor, clinician, or someone at another medical practice or hospital, to determine how to diagnose or treat you. Your doctor or clinician may also share your health information with another doctor to whom you have been referred for further health care.

Payment: We may use your health information or share it with others so that we obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Health Care Operations: We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you.

Appointment Reminders, Treatment Alternatives, Benefits, Services and Information regarding Drugs Currently Prescribed: In the course of providing treatment for you, we may use your health information to contact you about health promotion activities, disease awareness, or case management or to remind you about an appointment for treatment or services. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you. However, to the extent a third party provides financial remuneration to us so that we make these treatments or healthcare operations-related communications to you, we will secure your authorization in advance as we would with any other marketing communication (as described later in this Notice). We may also inform you about generic equivalents of your current prescription, encourage you to continue to take your prescribed medication as directed, remind you to refill your current prescription, or provide you with information regarding self-administration of certain medications, even if a third party pays the reasonable costs incurred by us to make this communication to you.

Business Associates: We may disclose your health information to contractors, agents, and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an accounting firm or law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract with such business

associate to ensure that our business associate protects the privacy of your health information.

Health Information Exchanges: We may participate in one or more Health Information Exchanges ("HIEs") and may electronically share your PHI for treatment, payment, healthcare operations and operations and other permitted purposes with other participants in the HIE. HIEs allow your health care providers to efficiently access and use your PHI as necessary for treatment and other lawful purposes.

Friends and Family Involved in Your Health Care

If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We will share only the information that is relevant to their involvement in your care or payment for that care.

Emergencies or Public Need

Emergencies: We may use or disclose your health information if you need an emergency treatment or if we are required by law to treat you but are unable to obtain your written consent. If this happens, we will try to obtain your written consent as soon as we reasonably can after we treat you.

As Required by Law: We may use or disclose your health information if we are required by law to do so. For example, we may disclose health information about you to the U.S. Department of Health and Human Services if it requests such information to determine that we are complying with federal privacy law. We also will notify you of these uses and disclosures if law requires notice.

Public Health Activities: We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities under the law, such as controlling disease or public health hazards. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so. We may also release your health information to government disease registries. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

Victims of Abuse, Neglect, or Domestic Violence: We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect, or domestic violence.

Health Oversight Activities: We may release your health information to government agencies authorized toconduct audits, investigations and inspections of our office. These government agencies monitor the operation of thehealth care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Disaster Relief: We may disclose your health information to certain entities authorized by law to assist in in disaster relief efforts for certain purposes such as identifying or locating your personal representative or family member to notify them of your location, general condition, or death.

Product Monitoring, Repair, and Recall: We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response

to a subpoena, discovery request, or other lawful request by someone else involved in the dispute.

Law Enforcement: We may disclose your health information to law enforcement officials for certain reasons, such as complying with court orders, assisting in the identification of fugitives or the location of missing persons, or if necessary to report a crime that occurred on our property.

To Avert a Serious and Imminent Threat to Health or Safety: We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases we will only share your information with someone able to prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person, or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security and Intelligence Activities or Protective Services: We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President, foreign heads of state, or other important officials.

Military and Veterans: If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out in their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security, and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation: We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: In the unfortunate event of your death, we may disclose health care information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties consistent with applicable law.

Organ and Tissue Donation: In the unfortunate event of your death, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation ofcadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.to a medical examiner for his other records.

Marketing, Research and Fundraising

Marketing: We may not disclose your health information or share it with others outside Tulane University Medical Group for purposes of marketing without your prior authorization. Marketing is a communication about a product or service that encourages recipients of the communication to purchase or use the product or service.

However, we may inform you about products or services during face-to-face communications with you without your authorization, including providing related written materials to you. We may also, without your authorization, provide to you promotional gifts of nominal value that may encourage you to purchase or use a product or service.

Research: We are permitted to use and disclose your health information for research with your authorization or under limited circumstances as permitted by law, for example, when approved by the institutional review board.

Fundraising: We are permitted to use your demographic information and dates of your health care for purposes of

fundraising. However, you have the right to opt-out of future communications and can do so by following the opt-out instructions provided as part of the fundraising communication. Fundraising is a communication from Tulane University Medical Group or one of its business associates for the purpose of raising funds for Tulane University Medical Group, including appeals for money or sponsorship of events.

Completely De-identified or Partially De-identified Information

We may use and disclose your health care information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also remove most information that identifies you from a set of data and use and disclose this "partially de-identified" health information about you for research, public health, and health care operations if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of treatment session, other patients in the treatment area may see or overhear discussion of your health information.

We want you to know that you have the following rights to access and control your health information:

Right to Inspect and Copy Records

You have the right to inspect and obtain a copy from us in a timely manner of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the manager of the clinic where you have been seen. If you request a copy of the information, we may charge a reasonable, cost-based fee for costs of copying, mailing, or other supplies we use to fulfill your request. If the information you request is stored electronically, we will provide the information in the form and format you request if the information is readily producible in that format, or, if not, we will reach an agreement with you as to alternative readable electronic format. Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide a written denial that explains our reasons for doing so and a complete description of your rights to have that decision reviewed and how you can exercise those rights.

Right to Amend Records

If you believe that the health information that we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept in our records. To request an amendment, please writeto the manager of the clinic where you have been seen who will forward the request to the Privacy Official. Your request should include the reasons why you think we should make the amendment. If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.

Right to an Accounting of Disclosures

You have a right to request an "accounting of disclosures," which identifies certain other persons or organizations to whom we may have disclosed your health information in the previous six years. Many routine disclosures we make will not be included in this accounting; however, the accounting will include many non-routine disclosures. To request an accounting of disclosures, write the request indicating a time period within the past six years for the disclosures you want us to include and address it to the manager of the clinic where you have been seen who will forward the request to the Privacy Official. You have a right to receive one accounting within every 12-month periodfor free. However, we may charge you a reasonable, cost-based fee for the cost of providing any additional

accounting in that same 12-month period. The scope of your right to request an accounting may be modified by changes in federal law from time to time.

Right to Request Additional Privacy Protections, Including Restriction of Disclosures to Health Plans

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. To request restrictions please write to the manager of the clinic where you have been seen who will forward the request to the Privacy Official.

We are not required to agree to your request for a restriction except as described below, and in some cases, the restriction you request may not be permitted under law. *However, if we do agree we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases we will need your permission before we can revoke the restriction. You have the right toWe are required to agree to a request to restrict certain disclosures of protected health information to a health plan where you pay, or another person on your behalf pays, out of pocket in full for the health care item or service.

Right to Request Confidential Communications

You have the right to request that we contact you about your medical matters in a way that is more confidential for you, such as calling you at home instead of at work. To request more confidential communications, please write to the manager of the clinic where you have been seen. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.*

Right to Have Someone Act on Your Behalf

You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf. Your personal representative may exercise any of the rights of an individual described in this Notice.

Right to Obtain a Copy of Notices

You may obtain a paper copy of this Notice by requesting a copy at your visit. We may change our privacy practices from time to time. If we do, we will revise the notice maintained in the office. You will also be able to obtain your own copy of the revised notice. The effective date of the Notice will always be noted in the top left corner of the first page. We are required to abide by the terms of the Notice that is currently in effect.

Right to File a Complaint

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact:

Privacy Official
1440 Canal Street, Suite 1406
Mail Code: 8403
New Orleans, La 70112
hipaa@tulane.edu
504-988-7739

Privacy Official
1430 Tulane Avenue -TW 3
New Orleans, LA 70112

No one will retaliate or take action against you for your complaint.

Right to be Notified Following a Breach of Unsecured Protected Health Information

If you are affected by a breach of your unsecured protected health information, you have the right to, and will, receive notice of such breach. Unsecured protected health information is health information that has not been secured through the use of technology, such as encryption, to render your protected health information unusable, unreadable, or indecipherable to unauthorized individuals.

How to Learn About Special Protections for Certain Kinds of Information

Special privacy protections apply to certain kinds of information under state laws (e.g. HIV-related information). Some parts of this general notice of privacy practices may not apply to these types of information. If your treatment involves this specially protected information, you may be provided with separate notices explaining how the information will be protected. To request copies of these other notices, please contact the Privacy Official.

To exercise any of your individual rights, contact the following:

Privacy Official
1440 Canal Street, Suite 1406
Mail Code: 8403
New Orleans, La 70112
hipaa@tulane.edu
504-988-7739

Privacy Official
1430 Tulane Avenue -TW 3
New Orleans, LA 70112

If you have any questions about this Notice or would like further information, please contact the Privacy Official at 504-988-7739

Tulane University

NOTICE OF PRIVACY PRACTICES

TULANE UNIVERSITY MEDICAL GROUP ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of the Tulane University Medical Group Notice of Privacy Practices.

Signature _____ Date _____

Print Patient's Name _____

If not signed by the patient, please indicate relationship:

_____

Print Name _____ Witness _____