ACADIANA PEDIATRICS, LLC

717 CURTIS DRIVE, SUITE A, RAYNE, LA. 70578
337-334-7554

REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____Middle: _____

Date of Birth:_____/_____/_____ Sex: Male Female Primary Language: _____

Social Security #: _____ Marital Status _____Race: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown

Address: _____ City/State_____Zip Code: _____

Home Phone: _____ Cell Phone: _____Work Phone:_____

Access to patient portal: Yes No Email Address: _____
This is now a requirement to receive health records

How would you like to be contacted for the following:

Medical Issues: Home Phone / Work Phone / Cell Phone

Appointment Reminders: Home Phone / Work Phone / Cell Phone

Emergency Contact Name: _____

Relationship: _____ Home Phone: _____Work Phone:_____

INSURANCE:

Please give all current insurance cards to the receptionist

Primary Insurance:_____

Policy Holder Name: _____DOB: _____

Relationship to Patient: Parent / Self / Other

Secondary Insurance:_____

Policy Holder Name: _____DOB: _____

Relationship to Patient: Parent / Self / Other

COMPLETE IF PATIENT IS A MINOR:

Primary Contact Full Name: _____Date of Birth: _____

Relationship to child: _____Is Primary Contact a patient here? Yes / No

Address: _____ City/State_____Zip Code: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email Address: _____

Secondary Contact Full Name: _____Date of Birth: _____

Relationship to child: _____Is Secondary Contact a patient here? Yes / No

Address: _____ City/State_____Zip Code: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email Address: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this facility or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

Medical Information

Please complete all of the following as accurately as possible:

Name: _____ Birthdate: _____

Children (ages) _____

How did you hear about us? _____

What is the Level of Your Health? Excellent_____ Good_____ Fair_____ Poor_____

Past Medical History:

Please list any serious medical conditions for which you have been treated/hospitalized in the past:

1. _____
2. _____
3. _____
4. _____
5. _____

Specifically, please place a check next to any of the following that you have had. If you place a check, please explain:

_____ Heart Disease	_____ Allergies	_____ HIV / AIDS
_____ Stroke	_____ Eczema	_____ Tuberculosis (TB)
_____ Diabetes	_____ Depression	_____ Polio
_____ Hypertension	_____ Cancer	_____ Sexually Transmitted
_____ Asthma	_____ Major Trauma	Disease

List any other doctors you currently see:

_____

_____

_____

When was your last:

Wellness Exam _____ Colonoscopy _____

Eye Exam _____ Mammogram _____

Past Surgical History:

Please list any Surgical Procedures you have had and the approximate date:

1. _____
2. _____
3. _____
4. _____
5. _____

Revised 5/8/18

Family History:

Please circle any of the following disease that tend to run in your family (parent, grandparent, children) and list who had the problem.

Diabetes _____ Cancer _____

Heart Disease _____ Asthma_____

Stroke _____ Allergies _____

High Blood Pressure _____ Eczema_____

Seizures _____ Blood Disorder _____

Mother: Living or Deceased Cause of Death and Age _____

Any medical or health problems: _____

Father: Living or Deceased Cause of Death and Age _____

Any medical of health problems: _____

Are you adopted: Y or N If yes, Do you know your biological family history: Y or N

Social History:

Please check beside any of the following you have used in the past or currently. If you place a check, please state how often you use or when you stopped using:

Alcohol (beer, wine or spirits) _____ Tobacco (cigarettes, cigar, pipe) _____

Illegal drugs _____ Tobacco (chewing)_____

Birth Control Pills _____ Coffee_____

Vitamins/Supplements_____ Herbal Products _____

Medications:

List all of the Prescription Medications or Over the Counter Drugs you are now taking:

_____

_____

_____

Allergies:

Please list any medications or foods to which you are allergic or sensitive:

_____

_____

Do/did you serve in the military? _____

Were you deployed during wartime? _____

If there anything else related to your health that we should be aware of?

_____

_____

Revised 5/8/18

To help us run our office in a Reasonable and Timely Manner, we ask that you consider the following rules that are being enforced:

LATE: If you are late for your appointment (10 minutes or more), we will do our best to accommodate you. However, on certain days, it may be necessary to reschedule your appointment.

NO SHOWS: We ask that you call our office to cancel or reschedule at least 24 hours before your appointments. If you have 3 or more NO SHOW appointments, you may be asked to find another physician.

FINANCIAL POLICY: All payments are due at the TIME OF SERVICE. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of service. If your child comes alone for the appointment, he/she must bring payment with them. We must see your insurance card at every visit to verify eligibility. All patients should know the limitations and guidelines of their insurance benefits. Although we may be a participating provider with your insurance network, we do not know your company's benefit agreement with your carrier. If the service being provided is not covered under a set copay, then you are responsible to pay at the time of service. It is in the patient's best interest to call their insurance carrier before a service is provided to determine their financial responsibility. Depending on your company's benefit option not all services are covered under a copay or certain limitations may apply.

SIBLINGS WITHOUT APPOINTMENTS: We respectfully ask that you refrain from asking the doctor to examine a sibling that does not have an appointment. This prevents the doctor from properly documenting the visit in the medical record, as well as prevents them from being on time for their next patients. We ask that you call us ahead of time and we will gladly add the sibling to the appointment schedule.

DIVORCE DECREE: We are not part of your divorce decree. The responsibility for payment and the presentation of active insurance cards are the responsibility of the accompanying parent at the time of service.

PAYMENTS: We accept cash, personal checks, debit and credit cards. Any outstanding balances are due within 30 days of the statement. If no payments are made within 90 days (3 months) of the statement, the account will be sent to in house collections and no further appointments will be made until paid in full. Credit cards may incur a transaction fee.

RETURNED CHECKS: Checks returned to us by the bank will be assessed a $25.00 fee in addition to the original amount of the check. After receiving a returned check, we will no longer accept checks from you.

REFILL OF MEDICATIONS: All prescription refills require a minimum of 48 hours to be completed. Please request refills before you are out of medication.

LAB/TEST RESULTS: Any lab and test results require a minimum of 72 hours to be received and reviewed by your doctor. Once the results have been reviewed, you will be contacted by a nurse or your physician and given the results.

Revised 5/8/18

ADD/ADHD APPTS.: It is a requirement for any patient being treated for ADD/ADHD to be seen in office every 3 months before renewing the prescription. Prescription refills must be picked up in the office and require 48 hours to be refilled.

PATIENT PORTAL: It is now a requirement to receive health care records through our patient portal. This information can be received at the front reception. Any copies of medical records that must be printed for personal reasons will incur a charge.

CONTROLLED SUBSTANCES: This includes, but is not limited to, Tylenol with codeine, Norco, Lortab, Vicodin, Percodan, Lorcet, Percocet, Mepergan Forte, Tramadol, Ultram, Ultracet, Xanax, Valium, Flexeril, Soma, narcotic containing cough syrups, ADD and ADHD medications. You will be required to use one pharmacy for your narcotics, if you must change your pharmacy we must be notified immediately. No duplication of narcotic prescriptions from other doctor offices will be given, if you received a prescription from another doctor we must be notified immediately. You will not change the dose of your narcotic unless previously authorized by this office. Early refills will not be authorized. Lost prescriptions will not be replaced.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physicians rendering services at this medical facility to release to my insurers, billing and certain medical information including final diagnosis and operative procedure(s) relative to this or related hospital/office claim for the purpose of determining eligibility for coverage and payment of charges for services rendered in connection with their care. I also give permission for the physicians associated with this facility to treat my child to the best of their ability and to release my medical information to another physician assisting in my healthcare.

AUTHORIZATION TO LEAVE MESSAGES ON VOICEMAIL/ANSWERING MACHINES

Under state law, the facility is not permitted to leave specific medical information on voicemail without your explicit consent. I understand that signing this form allows the doctors with this facility to leave voicemails on the phone numbers listed on my account with details such as patient's name, laboratory results, request for follow-up appointments, information about referrals, or any other pertinent information not specifically listed.

- I understand this authorization is not mandatory or required.
- I understand that if a wish to rescind this authorization, I must do so in a written form and address it to the office manager.

_____ yes, please leave a message on one of the numbers listed on my account

_____ no, don't leave any specific messages

Signature of Patient/Legal Guardian: _____

Date: _____

Revised 5/8/18

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CONSENT FOR MEDICAL CARE AND
CONSENT FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The purpose of this form is to fulfill the obligations of this medical facility under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) with regard to Protected Health Information (PHI), by implementing the regulations ensuring the integrity and confidentiality of PHI. PHI is individually identifiable health information created for a patient which is then transmitted and/or maintained electronically or in any other form.

Patient Name: _____ DOB: _____

I hereby consent to medical care and to the use and disclosure of my personal health information to those of my family listed below and healthcare providers for the purposes of treatment, payment, medication history and health care operations. I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing. I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section for this form. I further understand that this medical facility is not required to accept my restriction request. I understand that I may revoke this consent at any time by contacting this medical facility to sign the revocation section on this form. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

I authorize this medical facility to release/discuss my medical information with:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

Patient Signature (Guardian Signature if Minor Patient): _____

COMPLETE THIS PART ONLY IF PATIENT IS A MINOR:

Primary Contact Name: _____

Phone #: _____ Relationship to Patient: _____

The individuals listed below have authorization to talk to your staff on the phone and/or bring my child into the office. Both parents will automatically have authorization unless court documents are presented and specifically state one is not authorized.

_____I do NOT want to authorize anyone other than the parents/guardians.

List contacts that you will allow to come with the patient:

Name:	Relationship to patient:	Phone #:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that authorization to anyone other than myself or the other parent/guardian is voluntary and I can revoke authorization at any time. I also understand that no one other than those listed above can bring my child to the doctor.

Parent/Guardian Signature: _____

Revised 5/8/18

RESTRICTION OF MEDICAL INFORMATION

The individuals listed below are restricted from having access to my medical record information. (The parent of a minor can't be restricted from receiving information without legal documentation saying the parent is not allowed medical information)

Name: Relationship:

_____

_____

_____

_____

REVOCATION OF ACCESS TO MEDICAL INFORMATION

I hereby revoke access from receiving medical information from the following:

Name: Relationship:

_____

_____

_____

_____

Authorized by: _____ Date: _____

Revised 5/8/18

ACADIANA PEDIATRICS
RURAL HEALTH CLINIC SURVEY

THIS SURVEY IS TO HELP US BETTER YOUR EXPERIENCE AT OUR FACILITY. PLEASE BE COMPLETELY HONEST. THE SURVEY CAN BE RETURNED IN THE BLACK MAILBOX LOCATED AT THE DOOR ON YOUR WAY TO CHECK OUT. THANKS FOR YOUR ASSISTANCE.

Patients Name: _____ **Date of Service**: _____
(Name is needed to input response into survey form. Response will remain anonymous from doctors and staff but you may only put first and last name initials if you would like to remain completely anonymous.)

Survey Conducted By: _____ **Survey Conducted On**: _____

Provider Name: (circle one) Mark Dawson Marin Dawson Gretchen Zaunbrecher

Access, Delivery and Service	**Yes**	**No**	**N/A**
1. I received an appointment in a timely fashion.	❍	❍	❍
2. The person who answered the phone and made the appointment was courteous and helpful.	❍	❍	❍
3. The wait time to be seen by a provider was timely.	❍	❍	❍
4. The services I received were appropriate and addressed my needs.	❍	❍	❍
5. My appointment needs were handled in a confidential and professional manner.	❍	❍	❍
6. My medical questions were answered and addressed in a way that I understood.	❍	❍	❍
7. I have been informed and understand my diagnosis.	❍	❍	❍
8. I have been informed of and understand the treatment plan.	❍	❍	❍
9. All of the staff that I interacted with treated me respectfully and professionally.	❍	❍	❍
10. I was 100% satisfied with my overall experience and the health services provided.	❍	❍	❍

Comments:_____

_____

_____

_____

Revised 5/8/18

Acadiana Pediatrics

717 Curtis Drive
Rayne, LA 70578
337-334-7554

Mark Dawson, MD
Gretchen Zaunbrecher, FNP
Marin Dawson, DO
Jennifer Ritchie, LPN
Jaquira Brown, LPN
Acreisha Rochon, MA
Brandy Royer, CMA

Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physicians to participate in your healthcare. We look forward to providing you with comprehensive healthcare. As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians and office staff work closely in a team approach to support your patient care.

Our office is open **Monday through Friday from 8:00am-5:00pm** as well as **Saturdays from 8:00am-11:00am**. Every effort is made to see our patients for medical problems during office hours. Booking an appointment is essential to ensuring all patients receive the time they require for quality medical care. For urgent concerns after hours care will be available by the on-call physician, who can be reached by calling our office directly.

You can always send a secure message directly to the practice through the patient portal instead of calling the practice. You can request appointments and medication refills, submit questions and request your lab results. Please see the patient portal brochure to register.

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to working with you.

Sincerely,

The Providers and Staff of Acadiana Pediatrics

NOTICE OF PRIVACY PRACTICES

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.

This medical facility is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at this facility please contact:

Privacy Officer/Office Manager, 717 Curtis Dr. Ste. A, Rayne, LA 70578 Phone: (337) 334-7554

I. **How this facility may Use or Disclose Your Health Information**

This facility collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this facility, but the information in the medical record belongs to you. This facility protects the privacy of your health information. The law permits this facility to use or disclose your health information for the following purposes:

1. Treatment: We may disclose your health information to doctors, nurses, technicians, medical students and medical personnel for the purpose of treatment.
Ex: Johnny came into doctors office with right side pain. Doctor sent Johnny to lab technician for blood work (disclosure was made to lab for purpose of treatment)
2. Payment: We may disclose your health information as necessary to yourself, your insurer, or third-party such as Medicare of Medicaid for the purpose of payment of medical service.
Example: Johnny came into doctors office for medical service. He had an office visit. When then filed his office visit with date, procedure and diagnosis codes to his insurance carrier for payment of his service. (disclosure made for purpose of payment)
3. Regular Health Care Operations: We may disclose your health information to your health carrier in order to review treatment and services and in order to evaluate the performance of staff. This includes quality assurance, peer review and credentialing. Medication History: We may run a medication reconcile to verify medication. Acadiana Pediatrics shares an electronic health system with AFMA as where access is accessible by both of these entities.
Example: PPO Health Plan Company sends out nurse to review charts. They may ask provider to pull five charts for review. Mrs. Jones' chart is pulled and a representative from her insurance company comes in to check record keeping, office policies, clinic and quality of care given. (disclosure made for purpose of health care operations)
4. Information provided to you.
5. Notification and communication with family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family.
6. Required by law: As required by law, we may use and disclose your health information.
7. Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, report domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.
8. Health Oversight Activities: We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
9. Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative of judicial proceedings.
10. Law Enforcement: We may disclose your health information to a law enforcement official for purpose such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
11. Deceased Person Information: We may disclose your health information to coroners, medical examiners and funeral directors.
12. Organ Donation: We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
13. Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or this facility privacy board.
14. Public Safety: We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
15. Specialized Government Functions: We may disclose your health information for military, national security, prisoner and government benefits for Medicare, Medicaid, Tricare or other affiliated federal insurance/agency. (Note that disclosures for government benefits purposes are limited to health plans only)
16. Workers' Compensation: We may disclose your health information as necessary to comply with workers' compensation laws.
17. Change of Ownership: In the event that this facility is sold or merged with another organization, your health information/record will become the property of the new owner.
18. Records: We may disclose medical records with the person written in the consent signed only.

II. When this facility may not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this facility will not use of disclose your health information without your written authorization. If you do authorize this facility to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. This facility is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at AFMA, LLC Suite A or Acadiana Pediatrics Suite B, 717 Curtis Drive, Rayne, LA 70578 by request in writing, with proper signed authorization and upon payment of a reasonable copying charge. $1.00 first 25 pages, .50 cents per page for 25-500 pages, .25 cents per page thereafter, $7.50 handling charge and actual postage. AFMA, LLC must provide your medical records within a reasonable time not to exceed 15 days from the date of your request and payment.
3. You have the right to inspect and copy your health information.
4. You have the right to request that this facility amend your health information that is incorrect or incomplete. AFMA, LLC is not required to change to health information and will provide you with information about this facility denial and how you can disagree with the denial.
5. You have the right to receive an accounting of disclosures of your health information made by this facility except that this facility does not have to account for the disclosures described in Part I, #'s 1. Treatment, 2. Payment, 3. Health care operations, 4. Information provided to you, and 16. Certain government functions of Section I of this Notice of Privacy Practices
6. You have the right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one of more of these rights, contact our privacy officer.

IV. Change to this Notice of Privacy Practices

This facility reserves the right to amend this Notice of Privacy Practices at any time in future. Until such amendment is made, this facility is required by law to comply with this notice. Covered entity will provide individuals with new notice of changes when they come into our office.

V. Complaints

Complaints about this Notice of Privacy Practices or how this facility handles your health information should be directed to our privacy officer.

Revised 5/8/18

Acadiana Pediatrics is participating in a Medicare Shared Savings Program Accountable Care Organization

What's An Accountable Care Organization (ACO)?

- An ACO is a group of doctors and other health care providers who voluntarily work together with Medicare to give you high quality service and care at the right time in the right setting. **Acadiana Pediatrics** is participating in Aledade Louisiana ACO, LLC, a Medicare Shared Savings Program ACO.
- An ACO is **not** a Medicare Advantage Plan, (like an HMO or PPO), or an insurance plan.
- ACO's don't change your Medicare benefits.

How will An ACO Help My Doctor Coordinate Care?

- Your doctors will have a more complete picture of your health through talking with your other doctors.
- To help you get better, more coordinated care, Medicare will share certain health information with us about the care you get from your doctors and other health care providers unless you ask Medicare not to share it. Medicare may also share your health information with other ACO's in which your other doctors or health care providers participate.
- **Acadiana Pediatrics** may continue to recommend that you see particular doctors for your specific health needs, but it's always your choice about what doctors you see or hospitals you visit.

What Do I Need To Do?

- If you want Medicare to share information about the health care you received with Aledade Louisiana ACO, LLC or with other ACOs in which your other doctors or health care providers participate, **there's nothing more you need to do.**
- If you **do not** want Medicare to share your health care information, **you need to call** 1-800 MEDICARE (1-877-633-4227) and tell the representative that your doctor od am ACO and you don't want Medicare to share your health care information. TTY users should call 1-877-486-2048.
- If you change your mind in the future, you can call 1-800-MEDICARE and tell the representative what you have decided. We can't communicate with Medicare on your behalf.
- Even if you decline to share your health care information, Medicare will still use your information for some purposes, like assessing the financial and quality of care performance of the providers participating in ACOs. Also, Medicare may share some of your health care information with ACO's when measuring the quality of care given by healthcare providers participating in those ACOs.

Questions

If you have any questions or concerns, call us at **337-334-7554,** or we can discuss them next time you're in our office. Or you may review our Beneficiary Information Notice included in this packet, that offers more information about ACOs and care coordination.

You can also call 1-800- MEDICARE and tell the representative you're calling to learn more about ACOs, or visit Medicare.gov/acos.html.

Revised 5/8/18

BENEFICIARY INFORMATION NOTICE:
Acadiana Pediatrics Participating in a Medicare Shared Savings Program Accountable Care Organization

Accountable Care Organizations (ACOs): Providing Better, Coordinated Care for you

Acadiana Pediatrics participating in Aledade Louisiana ACO, LLC, a Medicare Shared Savings Program ACO. AN ACO is a group of doctors, hospitals, and/or other health care providers working together with Medicare to give you better, more coordinated service and health care. We share important information and resources about your individual needs and preferences.

You can Still Choose Any Doctor or Hospital

Your Medicare benefits are not changing. ACOs are **not** a Medicare Advantage plan, an HMO plan, or an insurance plan of any kind. You still have the right to use any doctor or hospital that accepts Medicare, at any time. Your doctor may recommend that you see particular doctors or health care providers, but it's always your choice about what doctors and providers you use or hospitals you visit.

Select Your Primary Clinician On MyMedicare.gov

As a Medicare beneficiary, you can log in to MyMedicare.gov and select your primary clinician. Your primary clinician is the health care provider that you believe is responsible for coordinating your overall care. Selecting a primary clinician does not affect your benefits or restrict your ability to get care from any doctor or other clinician you choose. Your selection of a primary clinician will remain the same unless you decide to change your designation. To select your primary clinician, log in to your MyMedicare.gov account or call 1-800 MEDICARE (1-800-633-4227). Search for your primary clinician by typing their name into the provider tool. Then select the "Add as my primary clinician" option under the provider's name.

Having Your Health Information Gives Us a More Complete Picture of Your Health

To Aledade Louisiana ACO, LLC give you better coordinated care, Medicare will share information with us about your care. The information will include things like dates and times you visited a doctor or hospital, your medical conditions, and a list of past and current prescriptions.

This information from other health care providers will give Acadiana Family Medical Associates and other health care providers in ACOs a more complete and up-to-date picture of your health. Over time, you may notice that you don't have to fill out as many medical forms that ask for the same information, you don't need to repeat medical tests because your results are shared among your health team, and other benefits because your providers are communicating with one another.

If you choose to let Medicare share your health care information with Aledade Louisiana ACO, LLC it may also be shared with other ACOs in which your other doctors or health care providers participate. If you don't want your health care information shared, you can ask Medicare not to share it.

Your Privacy is Very Important to Us

Just like Medicare , ACOs must put important safeguards in place to make sure all your health care information is safe. ACOs respect your choice on the use of your health care information for care coordination and quality improvement.

Yes, share my information: If you want Medicare to share information about the health care you received with Aledade Louisiana ACO, LLC or with other ACOs in which your other doctors or health care providers participate, **there's nothing more you need to do.**

Revised 5/8/18

No, please don't share my information: If you do not want Medicare to share your health care information, **you need to** do the following:

- Call 1-800-MEDICARE (1-800-633-4227). Tell the representative that your doctor is part of an ACO and you do not want Medicare to share your health care information. TTY users should call 1-877-486-2048
- If you change your mind in the future, call 1-800-MEDICARE and tell the representative what you have decided. We can't communicate with Medicare on your behalf.

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Questions?

If you have questions or concerns, call us at 337-334-7554, or we can discuss them next time you're in our office. You can also call 1-800-MEDICARE and tell the representative you're calling to learn more about ACOs, or visit Medicare.gov/acos.html.