Gerard K. Williams, M.D. APMC
Adult Internal Medicine & Pediatrics
901 West Gloria Switch Road•Lafayette, La 70507

PATIENT INFORMATION

Patient: _____ Title: Mr. /Mrs. / Other: _____ Suffix: Jr. / Sr. / Other: _____

Mailing Address: _____ Cell # :(_____) _____ Hm # :(____) _____

_____ Alt# (_____) _____
city state zip

Email: _____ *We will contact you by cell phone unless otherwise specified

Date of Birth: _____/_____/_____ Sex: M or F

Marital Status: Single Married Widowed Divorced (circle one) African American___ White____ Hispanic_____ Other_____

RESPONSIBLE PARTY/INSURED INFORMATION

Same as above: Yes/ No If the patient is a **minor** this section must be completed

Mom _____ _____ Dad _____

Mailing Address:_____ _____
city state zip

Hm.#:(_____)_____ cell.#:(_____)_____._____ Hm# (____) _____ Cell (_____)_____-_____

Social Security# _____ DOB ___/___/____ Social Security #:_____ DOB ___/___/__

INSURANCE INFORMATION

Primary	Secondary
Insurance Company:_____	Insurance Company:_____
Patient's Relationship to Insured: Self Child Spouse Other	Patient's Relationship to Insured: Self Child Spouse Other
Group #:_____ Policy#:_____	Group #:_____ Policy#:_____
CoPay:Primary Care_____ Specialist_____	CoPay:Primary Care_____ Specialist_____
Insured's Name:_____	Insured's Name:_____

Consent To Treat

I give the providers of Gerard K. Williams, M. D. APMC consent to provide and perform medical care, tests, procedures, and administer medications and vaccines as are considered necessary or beneficial for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Signature (Patient)_____Date_____

Authorization to consent for Medical Treatment in my absence:
I hereby grant the following person(s) the authority to bring my child to Gerard K. Williams, M.D. APMC for medical care, tests, procedures, and immunizations. Name _____ relationship _____

Parent Signature_____Date_____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Hm.#:(_____)_____ Wk.#:(_____)_____Ext._____ Cell #:(_____)_____

Patient Name: _____ DOB _____

Release of Protected Healthcare Information

{Unless informed in writing only the Mother and Father if you are a minor may receive protected health care information.}
I give consent and authorization for the medical, or billing staff of Gerard K. Williams, M.D. APMC to discuss protected Health Care Information about my child or myself if Adult with the following person(s):

Name Relationship Phone
_____
_____

Do you have an Advanced Directive? Yes / No

Policies

Appointments

In order to provide the best care possible, we ask that you arrive promptly for your scheduled appointment. A "no show" is a call to cancel the day of your appointment, or when you do not arrive by 10 minutes after your scheduled appointment. If you have three "No Shows" there is a **$25.00** charge to schedule you again and we do not accept walk-ins. This allows us to make available appointments for urgent care and provide a great environment for you and our staff. Please sign below to indicate you have read this policy.

Sign here_____ Date _____

Assignment of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Gerard K. Williams, M.D. APMC, and any assisting physicians or Nurse Practitioners for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to **pay all cost of collections**, **and reasonable attorney's fees**. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Sign here_____ Date _____

Financial Policy

We require you to pay your **Copay, Co-Insurance and deductible,** which is the amount not covered by your insurance company at the time services are rendered.
Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company.

Sign here_____ Date_____

TELEHEALTH ACKNOWLEDGEMENT FORM

Patient's Name:_____ Birthdate: _____

1. I understand that my health care provider, , has recommended to me that I engage in a telehealth appointment with provider.

2. My health care provider has explained to me how the telehealth technology will be used to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that the health care provider may use devices such as a stethoscope or otoscope or other peripheral devices to assist in the examination.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my healthcare provider and specialty health care provider in order to operate the equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time.

5. I have had the alternatives to a telehealth appointment explained to me, and in choosing to participate in a telehealth appointment, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the specialty health care provider or the primary care provider.

6. In an emergency situation, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as emergency room. Or the telehealth provider may discuss with and advise my local provider. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection.

7. I understand that billing for the telehealth consultation may occur from 1) the primary care provider and 2) telehealth provider, and 3) as a facility fee from the site from which I am presented. Billing is at the discretion of the provider. Billing procedures will be explained to me.

8. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

_____ _____

Patient/Guardian signature Date