MISS LOU FAMILY HEALTH, INC

ADULT PATIENT INFORMATION

PATIENT INFORMATION

Full Name: _____ Nickname/AKA: _____

Last *First* *Middle*

Maiden Name: _____ Date of Birth: _____

Month/Day/Complete Year

Address: _____ SS#: _____

_____ Sex *(Male or Female)* : _____

City, State, Zip: _____

County: _____ Primary Phone: ( ) _____

PO Box: _____ (Required if applicable) Alternate Phone: ( ) _____

City, State, Zip: _____

Preferred language: _____ Preferred E-mail: _____

_____ _____

Marital Status: _____ Race: _____

Single, Married, Divorced, Widowed, Partnered

Caucasian (white), Native American, African-American (black), Latin, Asian, other

EMPLOYMENT

Employer: _____

Address: _____

_____ Work Phone: ( ) _____

City, State, Zip: _____

EMERGENCY CONTACT

Only one (1) emergency contact is required

Name: _____ Primary Phone: ( ) _____

Address: _____ Alternate Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Relationship: _____ Employer Name: _____

Optional

Name: _____ Primary Phone: ( ) _____

Address: _____ Alternate Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Relationship: _____ Employer Name: _____

Patient Name: _____ DOB: _____

MISS LOU FAMILY HEALTH

BILLING INFORMATION

ACCIDENTAL INJURY

Is visit result of an accident? (Examples: auto accident, workers compensation, etc.) YES / NO Date: _____

GUARANTOR INFORMATION (This is the person responsible for the balance after insurance pays on the account.)

Parent/guardian *presenting minor child for treatment will be listed as the guarantor. This person will be responsible for any balances due after insurance has paid.* ***If 18 or older,*** *you are your own guarantor and do not have to complete this section unless there is a legal designation for your care, such as a power of attorney.*

*****IF SELF DO NOT COMPLETE THIS SECTION*****

Guarantor Name: _____ Guarantor SS#: _____
(Last First Middle)

Relationship: _____ Primary Phone: ( ) _____

Address: _____ Alternate Phone: ( ) _____

City, State, Zip: _____

PO Box: _____ (Required if applicable)

City, State, Zip: _____

Guarantor Employer: _____ Work Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Co. Name: _____

ID#: _____ Effective Date: _____

Patient Employment Status: _____
(full-time, part-time, unemployed, retired, military, retired military, full or part-time student)

SUBSCRIBER INFORMATION (This is the person insured by the company listed above.)

*****IF SELF DO NOT COMPLETE THIS SECTION*****

Patient Relationship to Subscriber: _____

Full Name: _____ Sex: _____ Date of Birth: _____
M or F

Address: _____ SS#: _____

City, State, Zip: _____ Phone: ( ) _____

Employer: _____ Work Phone: ( ) _____

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: _____

ID#: _____ Effective Date: _____

Patient Employment Status: _____
(full-time, part-time, unemployed, retired, military, retired military, full or part-time student)

SUBSCRIBER INFORMATION (This is the person insured by the company listed above.)

*****IF SELF DO NOT COMPLETE THIS SECTION*****

Patient Relationship to Subscriber: _____

Full Name: _____ Sex: _____ Date of Birth: _____
M or F

Address: _____ SS#: _____

City, State, Zip: _____ Phone: ( ) _____

Employer: _____ Work Phone: ( ) _____

AUTHORIZATION

I authorize medical evaluation & treatment, and release of information for insurance/medical purpose concerning my illness and treatment. I hereby, authoize payment from my insurance company to the Miss Lou Family Health, for services rendered. i will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: _____ Date: _____

Today's Date _____ Patient Name _____ DOB _____

MISS LOU FAMILY HEALTH

MEDICATIONS, ALLERGIES AND IMMUNIZATIONS

PRESCRIPTION MEDICATIONS -- List all medications you are presently taking.

	Name and Dose	Prescribed by:	How Often	Date Started
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

NON-PRESCRIPTION MEDICATIONS -- List all non-prescription medications you are presently taking. Include over-the-counter medications, vitamins/supplements, herbals, and creams.

	Name and Dose	How Often	Date Started
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

CURRENT PHARMACY

	Name & Location	Phone Number
Preferred:		
Other:		

ALLERGIES -- List all allergies or unusual reactions you have to medications, foods, dyes, latex, and other agents.

	Allergy	Reaction
1		
2		
3		
4		

List any reactions to bug bites or stings.

ADULT IMMUNIZATIONS -- Check the box next to or list all immunizations received including the most recent date received.

		Date Received	Others	Date Received
☐	Tetanus			
☐	Flu			
☐	Pneumonia			
☐	HPV			
☐	Hepititis B			

MISS LOU FAMILY HEALTH

Consent for Treatment

The following are the conditions for services provided by MISS LOU FAMILY HEALTH, and the various entities and providers affiliated with them each individually and collectively referred to as MISS LOU FAMILY HEALTH for the patient whose name appears below.

Medical Consent

I consent to all treatment given under the general and special instructions of the attending physician(s). Treatment may include, but is not limited to, diagnostic procedures, administration of anesthetics, use of prescribed medication, medical and physical therapy services, the collection and utilization of cultures and laboratory specimens, and referral to specialty services for radiology, physician consultation, and other medical services, all of which may be considered medically necessary or advisable in the judgment of the attending physician or their designees.

If a health care worker comes in direct contact with a patient's blood or body fluids, I understand that the patient's blood may be tested for the Hepatitis B virus, Hepatitis C virus, or HIV (Human Immunodeficiency virus) to determine whether or not the viruses are present, endangering the health care worker. The results of the testing will be made available to the patient.

Assignment of Insurance Benefits and Third Party Claims

If the account is not paid at time of service, I hereby assign to MLFH the proceeds from the following: TRICARE medical benefits; PIP (personal injury protection); sick benefits; physician benefits; injury benefits; any health, accident or welfare benefits of any type or form relating to the patient, whether insured or self-funded; proceeds of any liability settlement or judgment being paid by or on behalf of a third party; and any other benefits due from the insurance policy. All amounts collected will be applied to the patient's account. I understand that I am responsible for any charges not covered by insurance, Medicare, Medicaid, or other benefits. I further warrant and represent that any insurance or any plan that I assign is valid insurance and in effect, and that I have the right to make this assignment. In the event a claim for payment submitted by MLFH to my insurance carrier or plan administrator is denied, I hereby authorize MLFH to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. Section 8901 et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management.

Financial Agreement

I understand that, if my insurance plan or policy requires a co-payment from me, I am required to pay that co-payment at the time service is rendered. I understand that, if I am self-funded, full payment is due at time of service. I understand that I am obligated to pay the patient account according the regular rates and terms of MLFH. I appoint MLFH as my true and lawful attorney to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. In the event benefits exceed the actual charges for this account, the payment will be posted to the intended account and the refund processed accordingly. I understand that MLFH may obtain my credit report for review in collection of this debt. In the event that this account is placed with a collection agency or an attorney for collection, I will pay all collection fees and reasonable attorney's fees.

Medicare Patients

Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to MLFH on my behalf. I certify that the information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

Disclosure/Use of Health Information

I authorize MLFH to provide any health information related to this patient to the insurance company or other payor, for purposes of payment for the health care provided. I also authorize MLFH to provide health information to other physicians and healthcare facilities for continuing care. I further agree that MLFH can use the health information for operations such as peer review and outcomes analysis. I acknowledge that I have received a copy of the MLFH Notice of Privacy Practices.

_____ **(Patient initial here to acknowledge that Privacy Notice was received.)**

I acknowledge that my agreements hereunder are with and for the benefit of each entity and provider doing business as a part of MLFH and may be enforced under the practice name, provider name or as MLFH.

Patient Photographs

I understand that a facial photograph may be taken at the first visit and periodically thereafter for identification purposes only and that it will be part of my medical record and will be subject to all the protection that other personal health information receives.

Patient Name (PRINT)_____ DOB _____

Patient/Personal Representative Signature: _____ Date: _____

PRINT Name and Relationship if Personal Representative: _____

MISS LOU FAMILY HEALTH

FINANCIAL POLICY

Patient Full Name (PRINT) _____ DOB _____

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided by MISS LOU FAMILY HEALTH, and the various entities and providers affiliated with them each individually and collectively referred to as MISS LOU FAMILY HEALTH for the patient whose name appears above.

Payment for Service: Our office will inform you of the amount due when you check out. This amount is due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A $25.00 service charge will be added on all checks returned to us for insufficient funds.

No-show Appointments: A fee of $25.00 for a follow up visit and $50.00 for a new patient visit may be charged for all missed appointments not cancelled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling the number listed above during normal office hours.

Payment for Services Provided by Certain Non-MLFH: If you are having laboratory and/or diagnostic services by providers other than this office or other practices, you may be billed separately by that service provider.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at 318-414-2315 to make a payment arrangements. We will attempt to contact you by letter before your account is forwarded.

Questions: We are here to help should you have any questions regarding your statement or insurance.

Signatures: I have read and understand these financial policies.

Patient/Personal Representative Signature: _____ Date: _____

PRINT Name of Personal Representative: _____

Relationship of Representative to Patient: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Full Name (PRINT)_____ SS# _____ DOB _____

Patient listed above is requesting that the following be realeased to Miss Lou Family Health.

From: _____

_____

_____

_____

To: Miss Lou Family Health
ph: 318-414-2315
fax: 318-414-5250
email: info@missloufamilyhealth.com

The information to be disclosed relates to service dates beginning _____ and ending _____

❑ Entire medical record	❑ Medication List	❑ Physical Therapy notes
❑ Demographic Information	❑ Immunizations	❑ Occupational Health Record
❑ History & Physical	❑ Test Results (lab, X-ray, etc.)	❑ Other: (specify)
❑ Medical/Surgical History	❑ Other Assessments	❑ Other: (specify)
❑ Physician Office Visits	❑ Discharge Summary	❑ Other: (specify)

The purpose of the disclosure: *("Request of the Individual" is sufficient for patient-initiated releases)*

❑ Request of Individual	❑ Change of Doctor	❑ Legal Investigation
❑ Referral to Specialist	❑ Insurance	❑ Other: (specify)
❑ Continuing Care	❑ Workers Comp	

CONDITIONS and NOTIFICATIONS:
This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Supervisor at the address listed above. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to the MLFH group practice identified above and to MLFH and each practice and entity affiliated with it.

Note: There may be a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

SIGNATURES:
I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: _____ Date: _____

PRINT Name of Personal Representative: _____

Relationship of Representative to Patient: _____

Released by: _____ Date: _____
(Department Representative Name)