FUSELIER
HEALTHCARE SERVICES
Wendy Fuselier PA-C
1525 East Bridge Street · (337) 442-1131
Fax: (337) 442-1223

NEW PATIENT WELCOME LETTER

The entire staff of Fuselier Healthcare Services, LLC want to warmly welcome you to our practice. Our desire is to provide comprehensive medical care for you and your family. We want your experience with us to be a positive one. By completing the following forms, we can get a better understanding of your health care needs, which in turn will enable us to provide you with the best possible medical care.

For your upcoming visit, please remember to bring:

- Your Completed Forms
- Driver's License or Government-Issued Picture ID
- Health Insurance Cards
- Current Medications

We look forward to your visit and would like to thank you for giving us the opportunity to serve you and your family.

Sincerely,
Fuselier Healthcare Services, LLC

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1525 East Bridge Street - (337) 442-1131

Date: _____ Home Phone: _____
Cell Phone: _____

Patient Name (Last, First, M): _____

Name of Spouse: _____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Date of Birth: _____ Age: _____ Sex: _____ Social Security Number: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer Name: _____ Phone: _____

Employer Address:_____

City: _____ State: _____ Zip:_____

GUARANTOR (If different from above)

Name (Last, First, M): _____

Mailing Address: _____ Phone: _____

City: _____ State: _____ Zip:_____

Date of Birth: _____ Social Security #: _____

EMERGENCY CONTACT

Name: _____Relationship: _____ Phone: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Fuselier Healthcare Services, LLC / Warren J Degatur, Jr., M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I understand there is a $25.00 charge for all NSF checks.

AUTHORIZATION FOR RELEASE OF INFORMATION:

For the purposes of expediting payment of my account and processing of benefit claims resulting from my visit and for the assessment of damage claims or potential claims against Fuselier Healthcare Services, LLC / Warren J. Degatur, Jr. (said clinic), the hereinafter listed Health Care Providers, my attending or consulting physicians and their insurers, I hereby expressly waive my rights and privilege under Louisiana Revised Statute 13:3734 (said Statute) and authorize the release of my patient information directly to my insurer(s), workers' compensation carrier or other medical compensation benefit provider(s) as well as to insurer(s) of said clinic, or the legal representatives of any of them as well as to any collection agency or attorney if my account is not paid within a reasonable time. This authorization includes all medical, administrative and financial records, information and transactions, including all personal and insurance data, photographs, drawings or other graphic representations contained therein, as well as the "communication" of such information as defined by said Statute, regardless of whether such payment information is in oral, written or printed form or is mechanically stored on microfilm, magnetic tapes or other audio and/or visual media. I further authorize, and agree to be bound by the use of carbon or photo static reproductions of this agreement.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____

(For minor in non-emergent situation)

Release of Information

Last 4 digits of Social Security: _____ Date of Birth: _____

Patient Name: _____

I authorize the disclosure and use of health information as described below:

1. Who may receive this information on your behalf? (List the names of family members or friends that you would allow to get any information on you from this office, including picking up scripts)

   _____

   _____

   _____

2. What information may be disclosed?

   _____Entire Medical Chart

   _____Drug Screening

   _____Labs and X-Rays

   _____Doctors Notes

   _____Other: _____

   I understand that:

   - I may revoke this authorization at any time by notifying, in writing, the facility listed above.
   - Revoking this authorization does not apply to information that has already been released under this authorization.
   - If the disclosed information goes to a health care provider or a health plan

_____ _____

Patient Signature Date

MEDICAL HISTORY

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Who referred you to us? ☐ Doctor ☐ Friend ☐ Family Member ☐ Other _____

Reason for today's visit: _____

Length of time you have had it: _____

List any symptoms you are experiencing: _____

(Past & Present) Please check all that apply.	Personal Medical History Explain all checked answers
___ Lung Disease	
___ Emphysema	
___ Tuberculosis	
___ Pneumonia	
___ Bronchitis	
___ Asthma	
___ Allergies	
___ Heart Disease / Heart Attack	
___ Stroke	
___ High / Low Blood Pressure	
___ Elevated Cholesterol	
___ Unexplained Weight Loss/Gain	
___ Dental Problems	
___ Diabetes	
___ Venous Thrombosis	
___ Phlebitis	
___ Liver Disease	
___ Hepatitis A, B, C	
___ Cirrhoris	
___ Anemia	
___ Bleeding Disorder	
___ Thyroid Trouble	
___ Gallbladder Disease	
___ Ulcers	
___ Urinary Tract Infections	
___ Prostate Trouble	
___ Kidney Trouble	
___ Cancer	
___ Arthritis	
___ Gout	
___ Osteoporosis	
___ Fractures	
___ Seizures	
___ Migraines	
___ Depression	
___ Mental Illness	
___ Anxiety / Panic Disorder	
___ Alcohol / Substance Abuse	
___ Autoimmune Disorder	
___ Other: _____	

Surgical Procedures & Hospitalizations			
List all surgical procedures	Date:	List all hospitalizations:	Date:

Medications			
Medicine:	Strength: (mg)	Dosage: (# of tablets)	Frequency: (# of times per day)

Allergies

Are you allergic to any medications or substances? ☐ Yes ☐ No

If Yes, please list below:

Medication/Substance:	Reaction

Social History

Hobbies and Special Interests: _____

Marital Status: ☐ Never Married ☐ Married ☐ Widowed ☐ Divorced

Number of Children: _____

Occupation: _____

Smoker: ☐ Yes ☐ No If yes, number of packs a day? _____ for how many years?_____ If applicable, Year Quit: _____

Alcohol Use: ☐ Never ☐ Occasional ☐ Moderate How many drinks per week? _____

Blood Transfusions: ☐ Yes ☐ No If yes, date: _____

Family Medical History	
Please check all that apply.	Type of Illness & Relationship to person
___ Autoimmune Disease	
___ Lung Disease	
___ Tuberculosis	
___ Heart Disease/Heart Attack	
___ Stroke	
___ High Blood Pressure	
___ Low Blood Pressure	
___ Elevated Cholesterol	
___ Diabetes	
___ Liver Disease	
___ Anemia	
___ Bleeding Disorder	
___ Kidney Trouble	
___ Gastrointestinal Issues	
___ Cancer	
___ Arthritis	
___ Gout	
___ Seizures	
___ Mental Illness	
___ Alcohol Abuse	
___ Substance Abuse	
___ Sudden Death before 50	
___Other: _____	

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____DOB: _____

I authorize the custodian of records of _____
to
(Doctor/Physician or Office we are obtaining records from)

DISCLOSE/RELEASE the following information:

_____ All Records _____Abstract/Summary

_____Lab/Path Reports _____Pharmacy/Prescription Records

_____Xray/Radiology Records _____Billing Records

_____Other: _____

*NOTE: IF THESE RECORDS CONTAIN ANY INFORMATION FROM PREVIOUS PROVIDERS OR INFORMATION ABOUT HIV/AIDS STATUS, CANCER DIAGNOSIS, DRUG/ALCOHOL ABUSE, OR SEXUALLY TRANSMITTED DISEASE, YOU ARE HEREBY AUTHORIZING DISCLOSURE OF THIS INFORMATION.

These records are for services provided on the following date(s): _____
Please send the records listed above to:

Fuselier Healthcare Services, LLC
1525 East Bridge Street
Breaux Bridge, La 70517
Telephone: 337-442-1131
Fax: 337-442-1223

The information may be used/disclosed for the purpose of: _____ At my request
_____Other: _____

This authorization shall expire on _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of Patient Date