GREENE FAMILY MEDICINE
&
ELLENDER FAMILY MEDICINE

Date:______________________ Account Number:__________________________

Patient Information

Name: (Last)_____________________ (First)__________________________ (M.I.)_____

Mailing Address:____

City:____________________________ State:_________________ Zip Code:___________

Home Phone #:_________________ Cell:_________________ Work:__________________

Which is primary #: Phone____ Cell___ Work____ Yes/No Text Message for appointments

Email Address:____

Social Security #:_________________________ Date of Birth:________________________

Sex:_______ Marital Status:_______ Race:_________

Emergency Contact:__________________________ Relationship:______________________

Emergency Contact Phone #:____

Were you referred to us:______ If so, by whom:______________________________________

For Minors

Mother's Name :_________________________ Father's Name:__________________________

Required Information

Guarantor's Name:______________________ SS#:_____________________ DOB:__________

Occupation:__________________________ Employer:_________________________________

Insurance Information

Primary:____

Secondary:____

If policy holder other than patient. Policy Holder Name:___________________________________

Policy Holder DOB:_____________________ Relationship:________________________________

For Minor Children

I consent the following people can bring ___________________________ for care:

__________________________________ Relation________________

__________________________________ Relation________________

__________________________________ Relation________________

__________________________________ Relation________________

SIGNATURE:______________________________ Date:______________

Relationship to patient:_______________________

PLEASE CAREFULLY READ THE FOLLOWING STATEMENTS. YOUR SIGNATURE CERTIFIES THAT YOU HAVE READ ALL THE STATEMENTS, AND ARE THE PATIENT, OR ARE DULY AUTHORIZED BY THE PATIENT, AS THE PATIENT'S AGENT TO EXECUTE THE FOLLOWING AND ACCEPT ITS TERMS:

1. **PERMISSION FOR TREATMENT**: I hereby authorize the physicians, nurse practioners and/or the physician assistants for the care of the patient named on this record, to administer any treatment as may be deemed necessary including examination or treatment that may be ordered or performed by the clinical personnel. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examinations or treatments to be performed.
2. **PERMISSION FOR RELEASE OF MEDICAL INFORMATION**: I understand and agree that any of the above information may be used, if necessary, for purpose of communication for appointment changes, accounts receivable, emergencies, etc. Information from my medical records may be released, if necessary, for insurance purposes.
3. **ASSIGNMENT OF BENEFITS**: I hereby authorize my insurance company to make payment(s) as stipulated in my policy(s) for any service furnished and that such payment(s) be paid directly to the provider of the services. I also understand that I am financially responsible for all services provided and agree to pay upon demand or as agreed, for the related charges or remaining charges following my insurance payments. If at any time after 90 days the insurance has not made any attempt to pay for services rendered, the clinic reserves the right to forward that amount to the patient/guarantor for collection.
4. **MEDICARE ASSIGNMENT**: The undersigned certifies that the information given by him/her in applying for payment under Title XVII of the Social Securtiy Act is correct. The undersigned authorizes any holder of medical information or other information about him/her to release to Social Security Administration or its intermediaries or carries or any information needed for this or related Medicare claim. The undersigned requests that payment of authorized benefits made on his/her behalf and assigns that benefits payable for physician services and or other provider services to the furnishing of the service.
5. **FINANICAL AGREEMENT**: The undersigned agrees, whether he/she signs as an agent or a patient, that in consideration of their services rendered to the patient, he/she individually obliges himself/herself to pay the account to the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to collection, the undersigned shall pay reasonable attorney fee and collection expense including but not limited to collection agency cost. If this should occur, the patient can not be seen until balance is paid in full at the collection agency.

Patient's Signature______________________________________ Date_______________

Patient Representative___________________________________ Date_______________

Relationship to patient : ___Mother ___Father ___ Grandmother ___ Grandfather ___ Other

If other, please specify:____

PATIENT:_________________________ DATE OF BIRTH:________________

ADVANCE DIRECTIVE
(LIVING WILL)

I understand that it is my responsibility to furnish Greene Family Medicine and Ellender Family Medicine with a copy of my advance directive, if any, for placement in my medical record.

(patient/representative to INITIAL appropriate section below.)

I DO have a living will and/or power of attorney for medical decisions and:

____copy was furnished to place in my chart.

____copy will be obtained from prior physician and placed in chart.

____did not bring, will restate my wishes or instructed to bring.

I DO NOT have an advance directive/living will and:

____am not interested in any information.

____have received written information.

Patient Signature:____________________________ Date:______________

Patient representative:_________________________ Date:______________

Relationship to patient:________________________

Authorization For Use or Disclosure of Health Information

Patient Name:____

Date of Birth:____

I hereby authorize Greene Family Medicine or Ellender Family Medicine to release medical information including:

to the named individuals:

______________________Relationship:_________________Phone:______________

______________________Relationship:_________________Phone:______________

______________________Relationship:_________________Phone:______________

______________________Relationship:_________________Phone:______________

Signature:______________________________ Date:_____________________

GREENE FAMILY MEDICINE
&
ELLENDER FAMILY MEDICINE
2967 SOUTH UNION ST
OPELOUSAS, LA 70570
Phone: (337) 594-8958
Fax: (877)-756-2975

Request for medical records from your previous physician(s).

Date:____________________________

Requested by: Greene Family Medicine _____
Ellender Family Medicine_____

Previous Physician(s):

____

_ _______________________________________

____

Patient's Name:_____________________________________ Date of Birth:__________________

Address:____

____

____

I herby authorize you to release to Greene Family Medicine and Ellender Family Medicine, at the above address, any information including the date of service, diagnosis, treatment, labs and examination records of service rendered to me in your facility.

_________________________________ Records for these dates of service.

_________________________________ All medical records.

Patient Signature:___________________________________ Date:_________________

NOTICE OF PRIVACY ACKNOWLEDGEMENT
Greene Family Medicine
Ellender Family Medicine
2967 South Union St
Opelousas, LA 70570

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physicians certifications.**

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ________________________________

If minor, relationship:___________________________

Signature:____________________________________ Date:_______________

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OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:____________________ Initials:______________ Reason:______________________