Physician Group of Louisiana, Inc. [ ]

PATIENT INFORMATION (Patient Being Seen today)

Date	Patient Name (Legal Name): Last	First (Legal Name)	Middle (Legal Name)	
Address (Permanent Residence)		City	State	Zip
Address (Temporary Address)		City	State	Zip
Gender	Date of Birth	Status: [ ] Married [ ] Widowed [ ] Single [ ] Divorced [ ] Separated	Home Phone	
Social Sec.#	Occupation	Employed By	Business Phone	
Employer Address	City	State	Zip	
Driver License #	E-mail Address	Cell Phone #		

RESPONSIBLE PARTY INFORMATION (If patient is under 18 person responsible must be present)

Relationship To Patient	Name Last (Legal Name)	First (Legal Name)	Home Phone	
Home Address	City, State	Zip	DOB	
Social Sec.#	Occupation	Employed By	Business Phone	
Company Address	City	State	Zip	
Spouse First Name (and last if different)	Employer	Phone		

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY FOR VERIFICATION PURPOSES) DO YOU HAVE INSURANCE? YES ☐ No ☐

Insurance Company	Copay Amount	Policy holder	Policyholder Date of Birth / /	Patient Relationship to Insured: Self	Spouse	Child	Other
Insurance Company Address				Phone			
Social Sec.#		Policy /ID #	Medicare #	Medicaid #			
2nd Insurance Company	Copay Amount	Policy holder	Policy holder Date of Birth / /	Patient Relationship to Insured: Self	Spouse	Child	Other
Social Sec.#	Policy /ID #	Insurance Company Address	Phone				

INJURY INFORMATION (Must be filled out completely)

What type of injury are we seeing you for? (indicate right or left if appropriate)

Is this employment related? Yes [ ] No [ ] If so, Who is your company's industrial carrier?

Accident or Injury (Please circle one)	Date of accident or Injury	Place of Accident: [ ] Work [ ] Auto [ ] Home [ ] School [ ] Other
Name of School	Sport	How was injury sustained?

NAME AND ADDRESS OF PLACE OF INJURY:

EMERGENCY CONTACT / REFERRING PHYSICIAN INFORMATION:

EMERGENCY CONTACT (FULL NAME /RELATION TO PATIENT):	Phone (REQUIRED)
REFERRING PHYSICIAN (NAME & ADDRESS):	Phone (REQUIRED)

ETHNICITY	RACE
☐ Hispanic or Latino	☐ American Indian or Alaska Native ☐ Asian
☐ Not Hispanic or Latino	☐ Black or African American
☐ Declined to Specify	☐ Native Hawaiian or Other Pacific Islander
☐ Unknown Not Reported	☐ White

Authorization for telephone, cell phone and/or electronic communication:
I hereby authorize for **Physicians Group of Louisiana** and all third-party providers and practitioners who provide health care services to me, along with their billing and collection agents to contact me on my cell phone and/or home phone, including the use of pre-recorded messages, artificial voice messages, automatic telephone dialing services, or other computer assisted technology, or by electronic mail, text messaging or any other form of electronic communication for the purposes of payment for services or for health care related notice.

( ) Agree ( ) Disagree

To Opt in to receive text messaging notifications, please text the following word LAMD to 622622. You may Opt out from the text messaging notifications by sending a text with the word STOP to 622622.

REFERRAL SOURCE (How did you hear about us?)

□ Billboard/Signage □Direct Mail □Family/Friend □Hospital □ Insurance Plan □ Internet/Web
□ Newspaper/Magazine □ Radio □Seminar □TV □Yellow Pages

CONSENT TO TREATMENT

1. **I hereby voluntarily consent to outpatient care at Physician Group of Louisiana clinics, encompassing routine diagnostic procedures, examinations and medical treatment including (but not limited to) routine laboratory work (such as blood, urine, and other studies), taking of X-rays, heart tracings and administration of medications prescribed by the physicians.**
2. **I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by Physician Group of Louisiana clinics, and its physicians and physician assistants as is necessary in the medical staff's judgment.**
3. **I understand that this consent form will be valid and remain in effect as long as I (he/she) attend any Physician Group of Louisiana clinic.**
4. **I hereby authorize my insurance carrier(s) to pay Physician Group of Louisiana clinics, all benefits due me, if any, by reason of service described in the statements rendered and as provided for in the policy contract with my insurance carrier(s).**
5. **This form has been explained to me and I understand its contents.**

_____ _____
Signature of Patient or Person Authorized to Consent for Patient **Date**

If patient is a minor or is unable to consent, _____
Patient Name

A. Patient is a Minor _____ years of age.

Name of Father _____ Name of Mother _____

B. Patient is unable to consent because _____

_____ _____
Signature of Person Authorized to Consent for Patient **Relationship**

****REQUIRED** RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize the release of medical information necessary to process my claim. As a courtesy to our patients we will file the claim with their insurance carrier with the understanding that the patient/guarantor, not his/her insurance company is responsible for payment of this account

Signature Of Patient (or Responsible Party): _____ Date Signed_____
Printed Name_____

PERSONAL PAY PATIENTS

As a courtesy to our personal pay patients we extend a 25% discount for payments received at the time of services at our facility.

*******NOTE ****NOT APPLICABLE FOR THE FOLLOWING:***

- ***SURGICAL WT. LOSS SURGERY***
- ***FAA EXAMINATIONS***
- ***PLATELET RICH PLASMA INJECTIONS***

PAYMENT ARRANGEMENTS

Services are payable upon date performed or upon receipt of monthly statement. If extended terms are required on balances, Office Manager of our clinics will need to be contacted to establish a payment schedule. For your convenience we accept VISA, MASTER CARD, American Express and DISCOVER CARD.

FINANCE CHARGE

The finance charge is an annual percentage rate of 18% applied to the 90 day balance after deducting payments and credits.

ATTORNEY/ COLLECTION FEE'S

In the event it becomes necessary to refer the account to an ATTORNEY, or OUTSIDE COLLECTION AGENCY, you hereby agree to pay all attorney fees, court costs, and a 25% COLLECTION FEE.

YOUR BILLING RIGHTS (A copy of this notice may be provided upon request)

This notice contains important information about your rights and our responsibility under the Fair Credit Billing Act.

Patient is responsible to notify us in case of Errors or Questions regarding your bill:

If you think your bill (statement) is wrong, or if you need more information about a transaction on your bill, write or phone us as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared. **You can telephone us, however you must speak with a member of the business office, leaving a message will not preserve your rights.**

In your letter, the following information must be provided:

- Your Name and account number
- The dollar amount of the suspected error.
- Describe the error and explain, if you can, why you believe there is an error.

Your Rights and our Responsibilities After We Receive Your Written Notice:

We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 60 days we must correct the error or explain why we believe the bill was correct.

After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount NOT in question, including finance charges, and we can apply any unpaid amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. If we find that we made a billing error on your account, you will not have to pay any finance charges related to any questioned amount. IF WE FIND YOUR ACCOUNT CHARGES TO BE CORRECT, YOU MAY HAVE TO PAY FINANCE CHARGES, AND YOU WILL HAVE TO MAKE UP ANY MISSED PAYMENTS ON THE QUESTIONED AMOUNT. In either case, we will send you a statement of the amount you owe and the date that it is due.

IF AT THAT TIME, YOU DO NOT PAY THE BALANCE OF YOUR ACCOUNT, WE MAY REPORT YOU AS DELINQUENT.

MANAGED CARE/COMMERCIAL INSURANCE

PATIENT'S ARE RESPONSIBLE FOR ANY CO-PAYS, DEDUCTIBLES OR NON COVERED SERVICES AS DICTATED BY THEIR MANGED CARE PLAN. **IT IS THE PATIENTS RESPONSIBILITY BEFORE MAKING AN APPOINTMENT, TO CONFIRM WITH THEIR INSURANCE COMPANY WHETHER THE PHYSICIAN IS COVERED AS AN IN-NETWORK PROVIDER FOR THEIR PLAN. THE PATIENT IS RESPONSIBLE FOR SERVICES RENDERED BY PHYSICIAN GROUP OF LOUISIANA, INC. PHYSICIAN'S THAT ARE NOT PROVIDERS OR IN-NETWORK PROVIDERS FOR THEIR PLAN.**

If an overpayment occurs, Permian Premier Health Services, Inc. will refund the patient or the insurance company, whoever is due, within a reasonable length of time.

I declare that the above answers and statements are true and correct to the best of my knowledge and belief. I hereby acknowledge that I have read this entire document, and agree to all of the terms herein.

_____	**X** _____
Date:	**Signature**
_____	**X** _____
Date:	**Signature of responsible party/Patient**

NOTICE OF PRIVACY PRACTICES

We are required to provide you with our "Notice of Privacy Practices." Please review this information. Return the completed coversheet to the receptionist. You may keep the attached Notice or return it along with the coversheet.

Please provide the information below.

Your Name (Patient) please print _____Date of Birth _____

I have been provided with a copy of the "Notice of Privacy Practices." Yes / No

Your signature (Patient or Personal Representative) _____

If a personal representative description of personal representative's authority:

_____ Date _____

May we leave medical information on your "home" answering machine? _____Yes _____ No
May we leave appointment information on your "home" answering machine? _____ Yes _____ No

Please list below the names, relationship, and phone number of any authorized individuals (spouse, family members, friends, caregivers, etc.) that we may discuss your medical or financial information with.

	Name	**Relationship**	**Phone Number**
1.			
2.			
3.			

_____
Signature of Patient/Parent/Legal Guardian Date

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself please sign below.

_____
Signature of Patient/Parent/Legal Guardian

THE ABOVE INFORMATION IS PRIVATE AND CONFIDENTIAL AND WILL BE PLACED IN YOUR CHART.

PHYSICIAN GROUP OF LOUISIANA

Patient Questionnaire

In order to best care for you, please fill out the following information. This form only needs to be completed once so we can enter the information in our new electronic medical record. If you are unsure of a question or do not feel well enough to complete this form, you may leave it blank and ask for assistance from a member of the office staff when you are called into an exam room.

Name:

_____

Date of Birth: ___ / ___ / _____ **Sex (circle one): Male / Female**

Relationship status (married, single, life partner, separated, widowed): _____

Medications:

Please list the name and dosage of any medications you are currently taking (include any over the counter medications, vitamins, supplements, eye drops, topical creams, nebulizer treatments, investigational drugs, etc.). Please bring in your medication bottles or detailed medication list

Name	Dose	Frequency	Name	Dose	Frequency

Allergies:

Please list any allergies, side-effects from medications, or intolerances you have experienced. Include allergies and reactions:

Allergy	Reaction	Allergy	Reaction

☐ No known allergies

Chronic Conditions

Please indicate if you currently have any of the following conditions

	Condition	Onset Date		Condition	Onset date
☐	Asthma		☐	High cholesterol	
☐	Atrial fibrillation		☐	High blood pressure	
☐	COPD (chronic lung disease)		☐	HIV	
☐	Coronary artery disease		☐	Osteoporosis	
☐	Congestive Heart Failure		☐	Thyroid disease	
☐	Diabetes Type I Type II				

☐ Other: _____

Past Medical History

Please check any illnesses you have had and list the date of onset (approximate dates are acceptable)

Condition	Date	Condition	Date
☐ Allergies		☐ GERD	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable bowel disease	
☐ Asthma		☐ Liver disease	
☐ Atrial fibrillation		☐ Migraine headaches	
☐ Cancer		☐ Myocardial infarction/Heart attack	
Type: _____		☐ Osteoarthritis	
☐ Cerebrovascular accident		☐ Osteoporosis	
☐ COPD		☐ Peptic ulcer disease	
☐ Coronary artery disease		☐ Renal disease	
☐ Crohn's disease		☐ Seizure disorder	
☐ Depression		☐ Thyroid disease	
☐ Diabetes Type I Type II			

☐ Other: _____

Past Surgical History

Please indicate any of your past surgical history below

Condition	Date	Condition	Date
☐ Angioplasty		☐ Gastric bypass	
☐ Angioplasty w/ stent		☐ Hernia repair	
☐ Appendectomy		☐ Hip replacement	
☐ Arthroscopy knee		☐ Knee replacement	
☐ Back surgery		☐ LASIK	
☐ CABG (Coronary Artery Bypass Graft)		☐ Pacemaker	
☐ Carpal tunnel release		☐ Small bowel resection	
☐ Cataract extraction		☐ Pacemaker	
☐ Cholecystectomy		☐ Small bowel resection	
☐ Colectomy		☐ Thyroidectomy	
☐ Colostomy		☐ Tonsillectomy	

☐ Other: _____

Female	Year	Male	Year
☐ Breast biopsy		☐ Prostate biopsy	
☐ Cesarean section		☐ TURP	
☐ Hysterectomy		☐ Vasectomy	
☐ Mastectomy			
☐ Reduction mammoplasty			

☐ Other: _____

Family History

☐ **Are you adopted?** If you are not aware of your birth family's medical history, skip the section below.

Has anyone in your family ever had any of the following conditions? (please indicate if the condition was the cause of death)

	Condition	Family Member	Age
☐	ADD/ADHD		
☐	Alcoholism		
☐	Alzheimer's		
☐	Asthma		
☐	Blood disease		
☐	Heart disease		
☐	Cancer: Type: _____		
☐	Diabetes		
☐	High cholesterol		
☐	Hypertension		
☐	Inflammatory bowel disease		
☐	Kidney disease		
☐	Mental illness		
☐	Migraines		
☐	Obesity		
☐	Osteoporosis		
☐	Peripheral Vascular Disease		
☐	Seizures/epilepsy		
☐	Stroke (CVA)		
☐	Thyroid disease		
	Other:		
☐			
☐			
☐			
☐			
☐			
☐			

Social History

Smoking status: Never / Former / Current

If current: Quantity/frequency: _____ Date started: ___ / ___ / _____

If former: Quantity/frequency: _____ Date started: ___ / ___ / _____
Date quit: ___ / ___ / _____

Do you use any other tobacco products? Never / Former / Current

If current: Type: _____ Quantity/frequency: _____
Date started: ___ / ___ / _____

If former: Type: _____ Quantity/frequency: _____
Date started: ___ / ___ / _____ Date quit: ___ / ___ / _____

Do you drink alcohol? No / Yes

Type: _____ Quantity: _____ How often? _____

Do you drink caffeine? (circle all that apply): Coffee / Tea / Soda / Other: _____

Quantity: _____

Pharmacy

Name: _____ Address: _____
Phone: (____) _____ - _____

Referring Physician:

Name _____ Specialty _____ Phone number ( ) -

_____

Signature: _____

Date of office visit: ____ / ____ / _____