HEALTHCARE™

Patient Registration Form

MRN #:

Patient Name: DOB:

Address _____

Home Phone _____ Cell Phone _____ Work _____

Social Security Number _____ Date of Birth _____

☐ Male ☐ Female E-mail Address _____

Is your visit today due to a job related injury? _____ A Motor Vehicle Accident? _____

Primary Care Physician _____ Marital Status: S___ M ___ D___

Primary Health Insurance

Insurance Company Name _____ Effective _____

Insurance Policy ID Number _____ Group Number _____

Subscriber/Policy Holder _____

Subscriber's Address (If different than the above) _____

Subscriber Social Security Number _____ Date of Birth _____

Patient's Relationship to Insured _____

Secondary Health Insurance

Insurance Company Name _____ Effective _____

Insurance Policy ID Number _____ Group Number _____

Subscriber / Policy Holder _____

Subscriber's Address (If different than the above) _____

Subscriber Social Security Number _____ Date of Birth _____

Patient's Relationship to Insured _____

EMERGENCY CONTACT

Name _____

Phone _____ Relationship _____

Signature _____ Date _____

PATIENT MEDICAL HISTORY

Allergies

❑ NONE/Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Contrast ❑ Latex ❑ Morphine ❑ Penicillin

OTHER:

FAMILY HISTORY – **Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.**

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid Disorder		

SOCIAL HISTORY

□**Yes** □**No** - Do you drink alcohol? □ Daily □Weekly □Infrequently □ Recovering Alcoholic
□**Yes** □**No** - Do you smoke? □ Smoke (___ packs per day) □ Chew
□**Yes** □**No** - Do you drink caffeine? □ Daily □Weekly □Infrequently
□**Yes** □**No** – Are you sexually active?
□**Yes** □**No** – Do you wish to be checked for STDs?

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed
❑ Allergies
❑ Anemia
❑ Arthritis conditions
❑ Asthma
❑ Arterial fibrillation
❑ Bleeding problems
❑ BPH
❑ CAD coronary artery disease
❑ Cancer
❑ Cardiac arrest
❑ Celiac disease
❑ Chest pain
❑ Congestive heart failure
❑ Chronic fatigue syndrome
❑ Depression
❑ Diabetes
❑ Drug/alcohol abuse
❑ Erectile dysfunction
❑ Fibromyalgia
❑ Gerd
❑ Heart disease
❑ Hyperinsulinemia
❑ Hyperlipidemia
❑ Hypertension
❑ Hypogonadism male
❑ Hypothyroidism
❑ Infection problems
❑ Insomnia
❑ Irritable bowel syndrome
❑ Kidney problems
❑ Menopause
❑ Migraines/headaches
❑ Neuropathy
❑ Onychomycosis
❑ Organ injury
❑ Osteoporosis
❑ Pulmonary embolism
❑ Seizure disorders
❑ Shortness of breath
❑ Sinus conditions
❑ Stroke
❑ Syndrome X
❑ Tremors
❑ Wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- · The practice reserves the right to change the privacy policy as allowed by law.
- · The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- · The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- · The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____ (PRINTNAME)

Signature: _____ Date: _____

MEDICAL SERVICES AGREEMENT

Medical Consent: I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of The Medical Dock assisting my care.

Financial Agreement: I understand that all charges are due at the time of service. I agree to pay Ramirez Healthcare,LLC for a charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, and American Express. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If The Medical Dock is a participating provider with my insurance company, I understand that my co-pay, coinsurance, deductible, and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company, Ramirez Healthcare is not involved. In order for Ramirez Healthcare to file claims and accept payments from my insurance carrier, I understand that I must present current insurance information at each visit and that Ramirez Healthcare will need to verify my health insurance coverage. In the event that Ramirez Healthcare is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

Self-pay: Patients are expected to pay $120 at time of the visit. Fee will include injections, EKG, in the house labs. Patient will be responsible for any lab or imaging done outside of the clinic.

Insurance Authorization and Release: I request the payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans to be made to Ramirez Healthcare for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Ramirez Healthcare to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of Ramirez Healthcare charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize Ramirez Healthcare to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Ramirez Healthcare any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Release of Medical Information: I hereby authorize Ramirez Healthcare to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize Ramirez Healthcare to provide a copy of my medical records to my Primary Care Physician (PCP) to allow for continuity of care.

Notice of Privacy Practices: By signing this form, you acknowledge receipt of the "Notice Of Privacy Practices" of Ramirez Healthcare. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Ramirez Healthcare at 318-737-7334.

Personal Valuables: Ramirez Healthcare shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.

Ramirez Healthcare, A medical corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature: _____ Date: _____

Ramriez Healthcare
3001 Armand Street Suite L
Monroe, La 71201
Ph: (318) 737 -7334
Fax: (318) 737-7130

CONSENT TO RELEASE MEDICAL INFORMATION

Name: _____ Date of Birth: _____

Last First MI

Address: _____

Street or PO Box City State Zip Code

I authorize: _____

Physician/Facility Mailing Address

_____ To Release To or _____ Obtain Information From

_____

Name of Facility

I authorize to release the following protected health information:

_____ Entire Record _____ History & Physical _____ Hospital Records

_____ Lab _____ X-ray _____ Immunizations

I give special permission to release otherwise privileged information:

_____ Substance Abuse _____ Mental Health _____ HIV Information

This authorization shall expire on: _____.

I understand that if I do not specify an expiration date, this authorization will expire six months from the date which it was signed.

_____ _____

Signature of Patient or Personal Representative Date