



ACADIANA  
AFTER HOURS  
WALK-IN CLINIC

## PATIENT INFORMATION FORM

### IDENTIFYING INFORMATION

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_  
PATIENT GUARDIAN \_\_\_\_\_  
PHYSICAL ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
E MAIL \_\_\_\_\_  
GENDER ☐ MALE ☐ FEMALE  
HOME PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SSN \_\_\_\_\_

### EMERGENCY CONTACT

CONTACT NAME \_\_\_\_\_ RELATION TO CONTACT \_\_\_\_\_  
PRIMARY PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SECONDARY PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
SUBSCRIBER _____	SUBSCRIBER _____	SUBSCRIBER _____
COMPANY NAME _____	COMPANY NAME _____	COMPANY NAME _____
POLICY NUMBER _____	POLICY NUMBER _____	POLICY NUMBER _____
GROUP NUMBER _____	GROUP NUMBER _____	GROUP NUMBER _____
PHONE NUMBER _____	PHONE NUMBER _____	PHONE NUMBER _____
OTHER INFORMATION	OTHER INFORMATION	OTHER INFORMATION

### GUARANTOR INFORMATION ☐ THE ABOVE STATED "PATIENT" WILL BE RESPONSIBLE FOR ANY AND ALL CHARGES

NAME \_\_\_\_\_ RELATION TO CONTACT \_\_\_\_\_  
DOB \_\_\_\_\_  
PHYSICAL ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_



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Room # \_\_\_\_\_

## Reason for Visit and Medical History

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

(Check **ONLY** if it Applies)

Auto Accident \_\_\_\_\_

Workplace Accident \_\_\_\_\_

Date of Accident \_\_\_\_\_

Chief Complaint: \_\_\_\_\_  
(Sore Throat, Fever, Cough, Physical Exam, ect.)

Date Started \_\_\_\_\_

(Please Check all Conditions you have been **DIAGNOSED** with)

\_\_\_\_\_ Acid Reflux

\_\_\_\_\_ Depression/Anxiety

\_\_\_\_\_ Heart Attack

\_\_\_\_\_ Kidney Disease

\_\_\_\_\_ Asthma

\_\_\_\_\_ Diabetes

\_\_\_\_\_ High Blood Pressure

\_\_\_\_\_ Sleep Apnea

\_\_\_\_\_ Cancer

\_\_\_\_\_ High Cholesterol

\_\_\_\_\_ Hypothyroidism

\_\_\_\_\_ Stroke

\_\_\_\_\_ Other DX \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Known Allergies: \_\_\_\_\_  
(Medication, Food, ect.)

Type of Reaction: \_\_\_\_\_  
(Rash, Itching, ect.)

(Please Check the one that best describes you)

Alcohol use: \_\_\_\_\_ Never \_\_\_\_\_ Rarely \_\_\_\_\_ Occasionally \_\_\_\_\_ Daily \_\_\_\_\_ Amount \_\_\_\_\_  
(Per Sitting)

Tobacco use: \_\_\_\_\_ Never \_\_\_\_\_ Rarely \_\_\_\_\_ Occasionally \_\_\_\_\_ Daily \_\_\_\_\_ Amount \_\_\_\_\_  
Smoke/Smokeless (Packs/Cans)  
(Circle One)

Recreational Drugs: \_\_\_\_\_ Drugs Used: \_\_\_\_\_  
(Check **ONLY** for Yes)

Current Medication: \_\_\_\_\_  
\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

## ***Females Only:***

Date of last Menstrual Cycle: \_\_\_\_\_ Birth Control \_\_\_\_\_ Pregnant \_\_\_\_\_  
(Please Check **Only** for Yes)



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## Patient HIPPA Privacy Notice

Dear Patient,

Acadiana After Hours is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations. The federal privacy regulations of the Health Portability and Accountability Act (HIPPA) took effect April 14, 2003. In support of our policy to comply with all applicable regulations, Acadiana After Hours provides all patients regardless of age, sex, race, or religion with the HIPPA notice of privacy rights. While this is not required to receive treatment at our facility, we are obligated under federal regulations to ask you to sign an acknowledgement of the HIPPA privacy notice being made available to you. A full and detailed copy of our HIPPA policies and regulations are available upon request.

Thank You

I acknowledge receipt of the notice of privacy rights with detailed information about how Acadiana After Hours may use and disclose my protected health information. I understand that Hulin Health reserves the right to change the privacy notice and that a copy of the revised notice will be made to me.

In order to protect your privacy please indicate how we can contact you after your visit to check on how you are feeling,

- ☐ Home number
- ☐ Cell number
- ☐ May speak only to me
- ☐ May leave a message

Signature of Patient or Parent/Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_



## Authorization to Release Medical Information to Individuals/Family Members

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of Acadiana After Hours to discuss your condition with members of your family or individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

\_\_\_\_\_ I **do not** authorize Acadiana After Hours to release any or all information concerning my medical care to any individual except as set for the above.

\_\_\_\_\_ I do authorize Acadiana After Hours to verbally release any or all information concerning my medical care to the following individuals.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

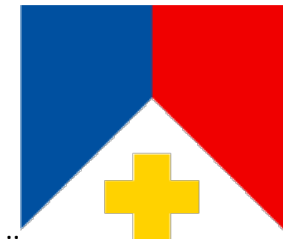
\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_



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## Financial Policy

Acadiana After Hours provides insurance claim submission as a courtesy to our patients. You are directly responsible to Acadiana After Hours for your account irrespective of your insurance schedule. You will be billed for any insurance claims that are outstanding in excess of 60 days.

If you have no insurance, or you carry an insurance that does not reimburse our office, charges for services are due and payable at the time services are rendered.

All CO-Pays's are due before medical services are rendered. We accept cash, personal checks, Visa, MasterCard, and Discover.

I authorize and request my insurance company to pay insurance benefits directly to Acadiana After Hours. I understand that my insurance carrier may pay less than the actual bill for services and that I will be responsible for payment of all services rendered

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_