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 (_____)_____-_____

ACADIANA AFTER HOURS
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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: _____ Date Started _____
(Sore Throat, Fever, Cough, Physical Exam, ect.)

(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: _____ Type of Reaction: _____
(Medication, Food, ect.) (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 (Circle One) (Packs/Cans)

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)

ACADIANA
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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: _____

3. ACADIANA AFTER HOURS
WALK-IN CLINIC

Authorization to Release Medical Information to Individuals/Family Members

In accordance with Federal government privacy rules implemented thought 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: _____

ACADIANA
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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 C0-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:_____