



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

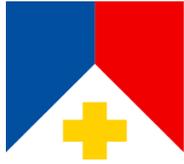
CONTACT NAME _____ RELATION TO CONTACT _____
PRIMARY PHONE (____) _____ - _____ SECONDARY PHONE (____) _____ - _____

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

WALK-IN CLINIC

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)

| | | | |
|---|---|--|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> 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
AFTER HOURS**
— WALK-IN CLINIC —

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.

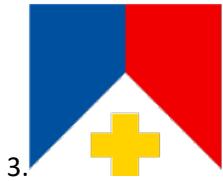
In order to protect your privacy please indicate how we can contact you after your visit to check on how you are feeling,

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

Signature of Patient or Parent/Guardian: _____

Printed Name: _____

Date: _____



ACADIANA
AFTER HOURS
— WALK-IN CLINIC —

Authorization to Release Medical Information to Individuals/Family Members

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), 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

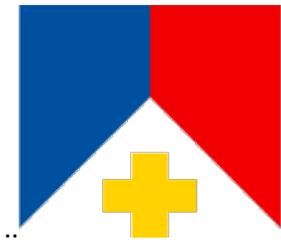
Name

Relationship to Patient

Patient Signature: _____

Date: _____

Witness Signature: _____



ACADIANA
AFTER HOURS
— WALK-IN CLINIC —

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: _____