Rapides Regional Physician Group

# Patient Registration Form

| Patient's Demographic Information | | |
|---|---|---|
| Last Name: | First Name: | Middle Initial: |
| Mailing Address: | | |
| City: | State: | Zip: |
| Home Phone: | Mobile Phone: | Alt. Phone: |
| Date of Birth: | SS# | Email: |
| Marital Status: ○Married ○ Single ○Divorced ○Widowed | | |
| Pharmacy Name: | Pharmacy Location: | Pharmacy Phone: |
| Who can we thank for referring you to our clinic? | | |
| Ethnicity/Race: ○Caucasian ○ African American ○Latin American ○Native American ○Asian ○Hispanic ○Other: | | |

## INSURANCE INFORMATION

****Even though we have a copy of your cards, this section must be filled out in completion****

| | |
|---|---|
| **Primary** Insurance Company: | ID# |
| Policy Holders Name: | Relationship: |
| Policy Holders Date of Birth: | Policy Holders SS#: |
| **Secondary** Insurance Company: | ID# |
| Policy Holders Name: | Relationship: |
| Policy Holders Date of Birth: | Policy Holders SS#: |
| **Tertiary** Insurance Company: | ID# |
| Policy Holders Name: | Relationship: |
| Policy Holders Date of Birth: | Policy Holders SS#: |

## Guarantor Information

If the patients is under "18"years of age, we must receive the following information for the person who brought them today

| | |
|---|---|
| Name of Guarantor: | Relationship |
| Guarantor Date of Birth: | Guarantor SS# |
| Mailing address of Guarantor: | |
| Guarantor Home Phone: | Guarantor Cell: |

**Patient Signature:** _____ **Date:** _____

HCA Physician Services Rapides Regional Physician Group

**Patient Consent Form**

*(Please Read and Sign)*

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
  Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
I understand that Rapides Regional Physician Group may include consent at satellite offices under common ownership.
I, the undersigned, acknowledge that Rapides Regional Physician Group will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.
A photocopy of this consent shall be considered as valid as the original

**MEDICARE PATIENTS**: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Rapides Regional Physician Group.
I acknowledge that I have been given the Rapides Regional Physician Group Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initial: _____**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

***Patient (or Responsible Party) Signature*** ***Date:***

**Rapides Regional Physician Group "CLWC"**
**Patient HIPAA Acknowledgment and Consent Form**

Patient Name: _____

Date of Birth: _____

_____ (patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.
Relationship.

**Disclosures to Friends and/or Family Members**

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

| | Name | Relationship |
|---|---|---|
| 1: | | |
| 2: | | |
| 3: | | |

**Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:**
**Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.**
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

*The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

**Prescription Pick-up**. There may be times when you need a friend or family member to pick-up prescriptions from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the prescription, your designee will need to present a valid picture identification and sign for the prescription.
____ (patient initials) I wish to designate the following family member / friend to pick up prescriptions on my behalf:
Name: _____ Date: _____

Name: _____ Date: _____

____ (patient initials) I do not want to designate anyone to pick-up my prescriptions.

Patient Signature _____ Date _____

Rapides Regional Physician Group

Attention Patients:

Please note: The health care providers of Rapides Regional Physician Group utilize outside laboratories for cultures, blood work, pap smears, etc. Our office will provide your insurance information to these outside venders for payment. Although they may file your claim to your insurance, depending on your insurance policy/coverage, a bill may be received from one of the following laboratories:

- Omega Diagnostics
- Clinical Pathology Laboratories
- Medical Diagnostic Lab

As always, please feel free to contact our office for any additional information or with any questions you may have. We value you as a patient and look forward to providing all of your healthcare needs.

_____ _____

Patient/Guarantor Signature Date

Rapides Regional Physician Group

Please take a moment and let us know how you heard about our clinic. We are glad you're here and we hope that your visit is a positive experience. Thank you for your time

○Phone Book

○Television advertising

○Radio advertising

○Newspaper

○Billboard

○Cenla Focus

○Internet

○Friend (please specify) _____

○Physician (please specify _____

○Other (please specify) _____

Reason for visit: ○OB ○GYN

Here to See:

○David Spence, M.D. ○Alex Joseph, M.D. ○Kaylin Corley, WHNP