Rapides Regional Physician Group
Committed to Care - Dedicated to Quality

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM____/DD____/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number:___-_____-_____ Phone number: _____
Address:_____
City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____
City, State:_____ZIP: _____
Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

Consent to Photograph

I, _____
First Name *Middle Name* *Last Name*

_____understand that photography is a necessary part of planning
Date of Birth

and evaluating cosmetic or reconstructive surgery.

I agree that the images may be: *(Please initial)*

	YES	NO
• Sent to my insurance company for authorization	_____	_____
• Placed in my medical record	_____	_____
• Used for medical seminars, health publications, credentialing and/or certification purposes by The American Board of Plastic Surgery, Inc.	_____	_____
• Placed on the RRPG.com website for viewing (No identifiable features)	_____	_____

By signing below I confirm that I understand this consent form.

Patient Signature:_____

Patient Representative (if a minor):_____

Date:_____

Rapides Regional Physician Group

Business Office Policy

The primary goal of our practice is to provide quality patient care. This goal can be accomplished through sound fiscal management, the practice keeping costs contained, and having the cooperation of our patients implementing the following policies. Please review this document thoroughly and sign below. This will become part of your file.

COSMETIC SURGERY: A nonrefundable deposit of $500.00 is required to secure a surgery date. This is payable in the form of cash, cashier's check, major credit card or money order. Your nonrefundable deposit will be applied to the surgeon's fee and the remaining balance is required 10 business days prior to surgery. If for any reason you have to cancel your surgery, your nonrefundable deposit will be credited to your surgeon's fee if your rescheduled surgery is performed within 12 months of your original surgery date.

INSURANCE CLAIMS: For those patients whose charges may be covered by insurance, we will be happy to file those charges and follow-up with your carrier. We ask that you provide our staff with all necessary information at the time of your first visit. Although we provide claim filing services as a courtesy to our patients, you will receive a monthly statement and be required to make monthly payments on your account until the balance is resolved. Payments are required monthly on an outstanding balance. Your compliance is necessary to avoid collection referral from a source outside our office.

MANAGED CARE NETWORKS: Our office participates in many managed care programs. If you are a member, you must provide the appropriate identification (insurance card). Co-payments are due at the time of your visit. Our participation in these programs is subject to change.

Dr. Maguire strives to provide excellent health care. We will only release information concerning you to those that are necessary and/or we have permission. Thank you for choosing our practice to provide you medical care. Please feel free to inquire about anything we can assist you with.

_____ _____

Patient Signature *Date*

PATIENT NAME_____**DATE OF BIRTH**_____

Rapides Regional Physician Group PATIENT FINANCIAL AGREEMENT

1. _____**(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **RAPIDES REGIONAL PHYSICIAN GROUP** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____**(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **RAPIDES REGIONAL PHYSICIAN GROUP** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____**(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **RAPIDES REGIONAL PHYSICIAN GROUP** any insurance or other third-party benefits available for health care services provided to me. I understand **RAPIDES REGIONAL PHYSICIAN GROUP** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **RAPIDES REGIONAL PHYSICIAN GROUP**, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____**(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **RAPIDES REGIONAL PHYSICIAN GROUP** by the Medicare or Medicaid program.

5. _____**(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **RAPIDES REGIONAL PHYSICIAN GROUP**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **RAPIDES REGIONAL PHYSICIAN GROUP** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **RAPIDES REGIONAL PHYSICIAN GROUP** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____**(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Guarantor
- ☐ Healthcare Power of Attorney
- ☐ Other (please specify)_____

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
- Lab Corp
- Clinical Pathology Laboratories
- Medical Diagnostic Lab
- Rapides Regional Medical Center

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* _____ *Other*

Here to see:

_____ *H. Stephen Maguire, MD*

Rapides Regional Physician Group

Dr. David Spence, MD Mia Sylvia, PA-C
501 Medical Center Drive Suite 4A
Alexandria, Louisiana 71301
Phone (318) 442-5800 Fax (318) 442-1109

Missed Appointments / No Show Appointments

Missed or no show appointments prevent our ability to care for your healthcare needs, and the needs of other patients who could have been seen in the time set aside for you.

Please note the below:

- **If you must cancel an appointment, please be *considerate and call* at least 24 hours in advance.**

- **It is our office policy to dismiss patients from our practice for repeat failure to keep scheduled appointments; this means 3 missed appointments in a 12 month period.**

Please sign the below acknowledging our policy and as always, thank you for your consideration.

X_____ Date:_____

Rapides Regional Physician Group

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I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

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

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**