PRIMARY CARE PROVIDERS FOR A HEALTHY FELICIANA

PATIENT INFORMATION REVIEW/UPDATE

Name: _____ Preferred Name_____ Social Security Number_____
(First Name, Middle Initial, Last Name)

Mailing Address _____ Home Phone _____

City, State, Zip _____ Cell Phone _____

Birth Date _____ Head of Household: _____ Number in Household _____

Student: ☐ Full Time ☐ Part-Time School _____Grade _____

Gender: ☐Male ☐Female	Sexual Orientation: ☐Straight ☐Bisexual ☐Choose not to disclose ☐Lesbian / Gay ☐Something else	Gender Identity: ☐Choose not to disclose ☐Female ☐Male ☐Female to Male/Trans Male ☐Male to Female/Trans Female	Race: (Check all that apply) ☐American Indian ☐Asian ☐Black ☐White ☐Other_____	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic
Migrant Work Status ☐ Migrant ☐ Seasonal ☐ Not a Farm Worker	Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Partner ☐Separated	Housing Status: ☐ Not Homeless ☐ Doubling Up ☐ Permanent Supportive Housing ☐ Shelter ☐ Street ☐ Transitional	Primary Language: ☐ English ☐ French ☐ Spanish; Castilian ☐ Other ☐ Refused	Household Income: $ _____ ☐ Weekly ☐ Monthly ☐ Annually

Are you a Veteran? ☐ YES ☐ NO Email Address:_____

Emergency Contact Name_____ Relationship to Patient_____Phone_____

GUARANTOR INFORMATION (LEGAL GUARDIAN FOR MINOR)

Person Responsible for account_____ Driver License #_____
(First Name, Middle Initial, Last Name)

Relation to Patient _____ Date of Birth _____Soc. Sec. _____

Mailing Address _____ Phone _____

Person Responsible is Employed by_____ Occupation_____

Business Address Business Phone

INSURANCE INFORMATION Is this patient covered by an insurance? **☐Yes ☐No**

Insurance Co. Name_____ Insurance Ph. _____

Insurance Co. Address _____ Subscriber Name _____

Relation to Patient _____ Date of Birth _____ Soc. Sec. #_____

Subscriber Address if different from patient's_____

Policy# _____Group # _____

Is this patient covered by an additional insurance? ☐Yes ☐No

ADDITIONAL INS. INFO. (SECONDARY OR TERTIARY INSURANCE)

Insurance Co. Name _____ Insurance Phone_____

Insurance Co. Address _____Subscriber Name_____

Relation to Patient _____Date of Birth_____ Soc. Sec. #_____

Policy# _____Group # _____

ASSIGNMENT AND RELEASE

I certify that if I (or my dependent) have insurance I will assign Directly to Primary Care Providers For A Healthy Feliciana, Inc d/b/a RKM Primary Care all insurance benefits, if any, otherwise payable to me for services rendered. **I am financially responsible for all charges whether or not paid by the insurance.** I hereby authorize RKM Primary Care to release all information necessary to secure payment of benefits. I authorize the use of the signature on all insurance submissions. Authorization is granted to release medical information to any physicians or entities to which I may be referred.

_____ _____ _____
Signature Relationship to patient Date

Primary Care Providers for a Healthy Feliciana

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)
(May be obtained over the phone.)

In my absence, I authorize the following individual(s) to act on my behalf in seeking treatment for:

_____ _____

(Patient Name) (Date of Birth)

This includes dental treatment and medical treatment, including lab work, injections, immunizations, treatments or procedures, etc. deemed necessary for the patient. At the time of service, medical and/or billing information may be relayed to the individual present with the patient. This person must provide proof of identification.

Authorized persons' name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

It is the responsibility of the patient's parent(s) or legal guardian(s) to keep this form updated with any additions and/or deletions. I understand that this consent will remain in effect until I request otherwise in writing.

_____ _____

Parent/Legal guardian name (print) Parent/Legal guardian (sign)

Effective Date: _____

This form expires one year from the effective date.

If permission obtained via phone:

_____ _____

Relative or Friend with Patient Relationship to Patient

_____ _____

PCPFHF Staff Witness of phone conversation PCPFHF Staff Witness of phone conversation

Primary Care Providers for a Healthy Feliciana

CONSENT FOR TREATMENT

_____ _____

Print Patient Name *Patient Date of Birth*

State law requires Primary Care Providers for a Healthy Feliciana, Inc. (PCPFHF) to obtain your consent for treatment. By signing this form, I authorize and direct the providers of PCPFHF, Inc. to treat the patient listed above.

I understand that all PCPFHF locations may participate in one or more Health information Exchanges (HIEs), whereby PCPFHF, Inc. may share health information with my mutual health care providers for treatment, payment or health care operations purposes. Opt-out information is available at www.rkmcare.org.

I understand that PCPFHF Clinics may provide services via Tele–Health electronic media. I understand that such services will be used only for providing necessary services and that the professionals involved will respect and protect the confidential nature of the sessions. I also understand that if I object to the use of any electronic media for use in treatment, it will in no way jeopardize my relationship with PCPFHF Clinics.

I understand that in order to identify patients PCPFHF uses a picture, name and date of birth. PCPFHF may scan a picture ID or take a picture to assist with proper patient identification.

I hereby state that I have read and understood this consent.

_____ _____

Signature of Patient *Date*

If the patient is not able to sign or is a minor, I, the legal guardian or authorized representative of the patient listed above, have read and understood this consent.

_____ _____

Print Name *Relation to Patient*

_____ _____

Signature of Legal Guardian or Relative *Date*

PCP FHF
Primary Care Providers For A Healthy Feliciana, Inc.

~Federally Qualified, Not-For-Profit Health Centers~

Christi Hunt, Chief Executive Officer Darie Gilliam DNP APRN, FNP-C, Chief Clinical Officer

Affiliate Physicians

Monique Attuso, MD; E. Gene Thompson, MD

NOTICE OF FINANCIAL RESPONSIBILITY

Pat. Name:_____DOB_____

Patients:

As a courtesy to you, our facility will bill your insurance plan for services provided. Should your insurance company deny payment for reasons beyond the fault of our facility, then you will ultimately be responsible for any and all charges. This could include out of network charges, non-covered services, deductible balances, and any recoupments of payments due to lack of premium payments. While it is standard practice for this facility to verify coverage ahead of your visit, it is ultimately your responsibility to know if certain services or providers are not covered under your plan. Some visits may take as long as 120 days to collect on from an insurance company. Therefore, any charges denied could be billed to you as late as 120 days or longer past your date of service. It is always recommended that you read Explanations of Benefits (EOB) received from your insurance following a claim that has been filed by us. They will, in most cases, include any balances that may potentially become billable to you. Should you incur any balances for the above reasons, you may apply for our Sliding Fee Discounts. By signing below, you are acknowledging receipt of and understanding of your financial responsibility. Should you have any questions concerning this notice, please see the Practice Manager.

_____ Date_____

Printed Patient Name (Responsible Party if minor)

_____

Patient Signature (Responsible Party if minor)

PCPFHF

PRIMARY CARE FOR A HEALTHY FELICIANA

NOTICE OF PRIVACY PRACTICES

PURPOSE: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after **September 23, 2013** we must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post this Notice in our office in a clear and prominent location where it is reasonable to expect any patient seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

I acknowledge receipt of the Notice of Privacy Practices:

Patient's Name _____ **Patient's Date of Birth** _____

Patient/Guardian Signature _____ **DATE** _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Rev. 11/2013