PRIMARY CARE PROVIDERS FOR A HEALTHY FELICIANA

PATIENT INFORMATION REVIEW/UPDATE

Name: ________________________________ Preferred Name_______________ Social Security Number____________________
(First Name, 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 Gender Identity: ☐ Female ☐ Male ☐ Female to Male / Trans Male ☐ Male to Female / Trans Female ☐ Choose not to disclose	Sexual Orientation: ☐ Straight ☐ Bisexual ☐ Lesbian / Gay ☐ Something else ☐ Choose not to disclose	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partner ☐ Separated	Ethnicity: ☐ Mexican / Mexican American / Chicano ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic / Latino / Spanish ☐ Not Hispanic / Latino / Spanish ☐ Choose not to disclose
Migrant Work Status: ☐ Migrant ☐ Seasonal ☐ Not a Farm Worker	Housing Status: ☐ Not Homeless ☐ Doubling Up ☐ Permanent Supportive Housing ☐ Shelter ☐ Street ☐ Transitional	Household Income: $ ___________ ☐ Weekly ☐ Monthly ☐ Annually	Primary Language: ☐ English ☐ French ☐ Spanish; Castilian ☐ Other ☐ Refused

Race:
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawai'ian
☐ Guamanian / Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ American Indian / Alaska Native
☐ Black / African American
☐ White
☐ More than one
☐ Choose not to disclose

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 __________________

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

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE: ____

Insurance Co. Name ____ Insurance Phone_____________________

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 INSURANCE INFORMATION (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

Advance Directive Notification Form

___________________________________ ______________________
Printed Patient Name Birth Date

I understand that I am being given the option to notify my provider if I have an Advance Directive currently in place.

Please select one of the following:

☐ I currently have active Advance Directive (DNR, Living Will or Power of Attorney for Healthcare).

* If you select this option please provide a copy to the registration desk.

☐ I do not have an active Advance Directive.

Note: In the event of an emergency at one of our locations, RKM staff will call 911 and stabilize you for transport to a hospital. If a copy of your Advance Directive is on file, we will provide the form to the ambulance service. If a copy of a DNR is on file, RKM staff will not resuscitate you in the event that you enter cardiac arrest but will call 911 and stabilize you for transport to a hospital, we will provide a copy of the form to the ambulance service.

______________________________ ______________________
Patient Signature Date

If a Power of Attorney for Healthcare is active, please provide the name of the person(s) assigned to make healthcare decisions for you if you choose not to or become unable to do so.

The Louisiana medical power of attorney form is a legal document that will permit the Principal to assign an Agent to attend to their medical decisions in the event of incapacitation or disability. A copy of the medical power of attorney must be provided for PCPFHF to honor the directive.

_________________________________ ______________________________________
Power of Attorney Agent Name (print) Additional Power of Attorney Agent (if applicable)

Advance Directive Related Policies:
PR 008 Advance Directives for Life Sustaining Procedures
CLI 004 Patient Assessments/Reassessment
CLI 005 Coordinated Managed Care

Feb 2020

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*

~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