Lake Charles
Memorial Health System

DBA Memorial Medical Group

PATIENT INFORMATION (PLEASE PRINT)

Last Name (Jr, Sr, etc.)	First Name	Middle Initial	Social Sec #

Date of Birth	Home Phone No.	Work Phone No.	Cell Phone No.
	( )	( )	( )

Address	City	State	Zip Code

Sex Assigned at Birth:	Gender Identity	Marital Status:
■ Male □ Female		▣ Married □ Single □ Divorced □ Widowed

Email	Employer	Primary Care Physician

Language:	Ethnicity:	Race (mark all that apply):
□ English □ Spanish □ Other _____	▣ Hispanic or Latino □ Unknown □ Not Hispanic or Latino	□ American Indian □ Asian □ African American □ Native Hawaiian □ White □ Other

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account (if different)	Home Phone No.	Cell Phone No.
	( )	( )

Address	City	State	Zip Code	Sex
				☐M ☑F

Date of Birth	Social Sec #	Employer	Email

PRIMARY INSURANCE (CARD MUST BE PRESENTED TO RECEPTIONIST)

Insurance Co.	Policy No.	Group No.

Policy Holder Name	Policy Holder Address (if different from patient)

Policy Holder DOB	Policy Holder SS#	Relationship to Patient	Effective Date

SECONDARY INSURANCE (CARD MUST BE PRESENTED TO RECEPTIONIST)

Insurance Co.	Policy No.	Group No.

Policy Holder Name	Policy Holder Address (if different from patient)

Policy Holder DOB	Policy Holder SS#	Relationship to Patient	Effective Date

WORKER'S COMP INFORMATION (IF APPLICABLE)

Worker's Compensation Company	Date of Injury	Verification Call Phone No.

EMERGENCY CONTACT INFORMATION

Name	Phone No.	Relationship to Patient
	( )	
Name (Not living in same household)	Phone No.	Relationship to Patient
	( )	

ADVANCED CARE PLAN (65 or older, do you have one of the following?)

Living Will?	Healthcare Proxy?	Healthcare Power of Attorney?
□ Yes □ No	□ Yes □ No	□ Yes □ No

If yes to any of the above, who is your Surrogate Decision Maker?

Name: Phone No. ( )

I understand that I am responsible for supplying Memorial Medical Group, Inc. with my current insurance coverage, including presenting my insurance cards, and to inform Memorial Medical Group, Inc. of any changes to my insurance coverage. Failure to comply with the above will change my status to a self-pay account. I understand I will receive services performed through the Lake Charles Memorial Health System. In the event of any overpayment or credit to any of my accounts for any hospital, clinic, and/or physician services within the Lake Charles Memorial Health System, I do hereby authorize and consent to the transfer and application by the Lake Charles Memorial Health System of said overpayment or credit to any of my accounts with outstanding balances or sums due, if any, which accounts may be within the Lake Charles Memorial Health System. I understand that I am primarily responsible for the payment of this account, subject to the terms noted below:

PRIVATE INSURANCE – As a courtesy to me, Memorial Medical Group, Inc. may file my claims with my insurance carrier. I agree that my insurance benefits may be paid directly to Memorial Medical Group, Inc. If my insurance plan is in network with Memorial Medical Group, Inc., I agree to be responsible for the deductible, any patient portion as determined by my insurance plan, as well as, any services that are deemed not covered under my insurance policy. If my insurance plan is out of network, I agree to be responsible to Memorial Medical Group, Inc. for the full balance of Memorial Medical Group, Inc.'s charges that are not paid by my private insurance carrier, including any deductible and/or copayment.

MEDICARE – Memorial Medical Group, Inc. accepts Medicare assignment (Medicare approved charges). I understand that I am responsible for any deductible(s), coinsurance(s) or copayment(s). If there is a Medicare supplement insurance policy, Memorial Medical Group, Inc. will file my claims as a courtesy to me, and the benefits may be sent directly to Memorial Medical Group, Inc. If there is no supplemental policy, I am responsible for the payment of the balance of the assignment (Medicare 20% coinsurance).

MEDICAID – I understand that some providers in Memorial Medical Group, Inc. accept Medicaid and that I must present a current Medicaid card at each visit. If Medicaid discontinues or my visits are exhausted, I agree to be responsible for payment of the account.

WORKERS' COMPENSATION – I agree to allow Memorial Medical Group, Inc. to verify my Workers' Compensation coverage with my employer or my employer's insurance carrier. The employer or insurance carrier may request medical information in order to process claims. Any such information so requested will also be provided to the patient. I agree to be responsible for payment of all charges which are not paid by my employer or its Workers' Compensation insurance carrier.

NO INSURANCE – If there is no insurance or other such coverage for the charges of this account, I agree to pay the full balance of all charges in accordance with payment terms as agreed upon by Memorial Medical Group, Inc.

RELEASE OF INFORMATION – Should my insurance carrier, Medicaid, or Medicare request medical information and/or copies of my medical records in order to process my claim(s), Memorial Medical Group, Inc. has my permission to furnish same. Unless otherwise noted by me, I also give Memorial Medical Group, Inc. permission to furnish medical information and copies of my medical records to my referring and/or family physician.

If I fail to make any payment due as outlined above or as agreed upon, Memorial Medical Group, Inc. may turn this account over to a collection agency and/or attorney for handling. If this occurs, I may be subject to dismissal from Memorial Medical Group, Inc. If such action is taken on this account, I agree to pay the reasonable fees of said collection agency and/or attorney.

_____ _____

Patient/Responsible Party (Signature) **Date**

CONSENT FOR TREATMENT - I, the undersigned, do hereby authorize Memorial Medical Group, Inc. to provide medical care as deemed necessary in the judgment of the provider. This treatment may include, but is not limited to: laboratory procedures, non-invasive diagnostic and therapeutic procedures and treatments, administration of pharmaceutical products, such as injections and intravenous medications or other therapeutic solutions, and minor surgical procedures.

_____ _____

Signature **Date**

Lake Charles
Memorial Health System

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HIPAA Consent

Patient Name: (Please print) _____ Patient Date of Birth: _____

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES

I, individually or on behalf of the patient, authorize Memorial Medical Group (MMG) to use and disclose my health information as required for treatment, payment, and healthcare operations as described in MMG's Notice of Privacy Practices. I hereby acknowledge that I was given a copy of the Notice of Privacy Practices.

(Please sign only one)

-Hereby acknowledge that I was given a copy of the Notice of Privacy Practices but declined to accept.

Signature: _____ Date: _____

-Hereby acknowledge that I was given a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Relationship (if not signed by patient): h_____

METHOD OF COMMUNICATION

-May we leave a message with any person answering your telephone if you are not available? □Yes □No

-May we reach you by cellular phone? □Yes □No Cellular # (_____) _____ - _____

-May we call your place of employment? □Yes □No Work # (_____) _____ - _____

-May we confirm your appointment via text message? □Yes □No

-May we confirm your appointment on your answering machine? □Yes □No

-May we confirm your appointment with someone other than yourself? □Yes □No
If yes, please specify below.

Name	Relationship to patient	Phone Number
_____	_____	(_____) _____ - _____
_____	_____	(_____) _____ - _____

RELEASE OF MEDICAL/BILLING INFORMATION

Please list any persons authorized to have access to billing, appointment, and medical/treatment records.

Name	Relationship to patient	Phone Number
_____	_____	(_____) _____ - _____
_____	_____	(_____) _____ - _____

RELEASE OF PRESCRIPTIONS

****List individuals you designate to pick up your written prescriptions from this office on your behalf. The individual must present ID at time of pick up:**

Name	Relationship to patient	Phone Number
_____	_____	(_____) _____ - _____
_____	_____	(_____) _____ - _____

_____ _____

Signature Date

Memorial Medical Group

Medical Record Release Form

Patient Information

Full Name: _____ Date of Birth: _____/_____/_____

Maiden or Other Names Used: _____ Social Security #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone #: (_____) _____ - _____ Cell Phone #: (_____) _____ - _____

Treatment Dates

From: (date) _____ To: (date) _____

Information to Be Released

- ☐ Complete health record
- ☐ EKG
- ☐ Operative
- ☐ Billing Records
- ☐ History and physical exam
- ☐ X-ray Report
- ☐ ED Report
- ☐ Cardiac Studies
- ☐ Laboratory
- ☐ Consultation
- ☐ Discharge Summary

☐ Other (please be specific): _____

Purpose of Request

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal

☐ Other (specify): _____

Release To

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: (_____) _____ - _____ Fax #: (_____) _____ - _____

Requesting Records From

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: (_____) _____ - _____ Fax #: (_____) _____ - _____

Signature of Patient or Personal Representative

I Understand That:

- Without my express revocation, this authorization will automatically expire 180 days from the date signed below, unless I request an expiration date less than 180 days.
- I may **revoke** this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
- Information disclosed pursuant to the authorization may be subject to **redisclosure** by the recipient and is no longer protected by the HIPAA Privacy rule.

Signature: _____ Date: _____/_____/_____

Signing Authority (if not patient): _____ Relationship: _____