Lake Charles
Memorial Health System

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	Sex ☐ M ☐ F

	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Employer

Referring Physician	Primary Care Physician

RESPONSIBLE PARTY INFORMATION

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

Address	City	State	Zip	Sex ☐ M ☐ F

Date of Birth	Social Sec #	Employer	Email

PRIMARY INSURANCE (CARD MUST BE PRESENTED TO RECEPTIONIST)

Insurance Co.	Policy Holder Name	Employer Employment Status

Effective Date of Coverage	Policy Holders Address (if different from patient)

Group No.	Home Phone No.	Policy Holder's DOB	Policy Holder SS#

Policy No.	Cell Phone No.	Relationship to Patient

SECONDARY INSURANCE (CARD MUST BE PRESENTED TO RECEPTIONIST)

Insurance Co.	Policy Holder Name	Employer Employment Status

Effective Date of Coverage	Policy Holders Address (if different from patient)

Group No.	Home Phone No.	Policy Holder's DOB	Policy Holder SS#

Policy No.	Cell Phone No.	Relationship to Patient

EMERGENCY CONTACT INFORMATION

Name	Home Phone No.	Relationship to Patient

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

WORKER'S COMP INFORMATION (IF APPLICABLE)

Worker's Compensation Co.	Date of Injury	Verification Call #

ADDITIONAL INFORMATION

Language ☐ English ☐ Spanish ☐ Other:	Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	Race ☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ White ☐ Other:

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

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HIPAA Consent

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.

Patient Name: _____ (Please print.) Patient DOB:_____

Signature: _____ Date: _____
Hereby acknowledge that I was given a copy of the Notice of Privacy Practices and refused to accept.

Signature: _____ Date: _____
Hereby acknowledge that I was given a copy of the Notice of Privacy Practices.

Relationship (if not signed by patient):_____

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.

_____

Name	Relationship to patient	Phone No. Including Area Code
Name	Relationship to patient	Phone No. Including Area Code

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 No. Including Area Code
Name	Relationship to patient	Phone No. Including Area Code

Signature _____ Date _____

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FINANCIAL POLICY

In order for our medical staff to be able to deliver the quality of care that you expect, we have established this financial policy. In order for us to continue to provide high quality care and to ensure that your visit is as pleasant as possible, it was necessary to establish the following list of guidelines.

Please read all information and acknowledge by signing below:

1. We ask that you present your insurance card and a picture ID at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist.
3. We will collect your deductible, co-payment, or charge from non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, MasterCard, American Express, and Discover.
4. If we do not participate with your insurance company, you will be expected to make payment in full at the time service is rendered.
5. If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to turn your account over to a collection agency.
6. **MEDICARE PATIENTS:** We are participating providers with Medicare and will bill Medicare for all of your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your deductible is met.
7. **HMO-PPO PATIENTS:** If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service-**NO EXCEPTIONS**. If you plan requires you to choose a primary care physician, it is ***your*** responsibility to make sure your insurance company has the Physician you are seeing in our office as your PCP. If your plan requires you to have an authorization to see a specialist, you still need to obtain that from our office prior to seeing the specialist. Retroactive referrals are allowed for up to five days after services are rendered. If we do not participate with your plan, we will verify your out-of-network benefits, and will expect payment of your portion of the charges at the time of service.
8. **SELF-PAY PATIENTS:** Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements. You will be allowed to apply for financial assistance to see if you qualify for UCC or Medicaid.
9. No/show or missed appointments: When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not canceled in advance and the patient "no-shows," another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there *may* be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel the appointment. If ***two*** appointments are missed without cancellation, you will be charged a fee of $25.00. If ***three*** appointments are missed, you may be considered for dismissal from the practice for non-compliance.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (337) 494-2776.

I have read and have a full understanding of the financial policy.

Printed Name	Signature	Date