CONSENT & CHIEF COMPLAINT

Patient Name: _____ Date of Birth: _____ / _____ / _____

Were you treated by this company in the past year? **[ ]** No **[ ]** Yes Will you provide a copy of an Advance Directive today? **[ ]** No **[ ]** Yes
(Living Will/ Power of Attorney for Healthcare)

Chief Complaint: (Primary reason for your visit today)

Vaccine Requested: [ ] No **[ ]** Yes Influenza, Tetanus, Other: _____, _____, _____
(per clinic availability)

□ I understand the benefits, risk and possible side effects of receiving vaccines and that it is my responsibility to provide information relevant to health history, possible medication interactions, allergies and recent vaccine administration.

Is this complaint related to an Accident? **[ ]** No **[ ]** Work Related **[ ]** Auto **[ ]** Other Date Accident Occurred: _____/_____/_____

Accident Details: _____

_____

Location of Occurrence: _____ City: _____ State: _____

Responsible Party: Name Contact Number:

How did you hear about us? **[ ]** Friend/Relative **[ ]** Online **[ ]** TV **[ ]** Physician Referral
[ ] Magazine/Newspaper **[ ]** Billboard **[ ]** Location **[ ]** Other _____

Consent for Treatment*Use of Protected Health Information*Financial Obligation

I hereby consent to medical evaluations, testing, and/or treatment provided to me by the staff of this medical facility.

I understand that this medical facility may use or disclose my Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations or in other instances as permitted. I understand that the address and email I provide may be used to provide me with information on health related benefits and services that may be of interest to me, as well as marketing and fundraising material. I understand that I have the right to opt out or unsubscribe to any information or materials that I may receive.

I hereby authorize the facility to e-prescribe my prescriptions. For treatment purposes, the facility may request and utilize my medication history from other health care providers or third party pharmacy benefit payers.

I understand that if the provider has ordered additional laboratory test that the collected specimens will be sent to a local laboratory for testing. The facility will forward my payer information to the laboratory, but I will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory. I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance company and I will be responsible for the balance.

I hereby authorize the facility to accept assignment of contracted insurance benefits and I understand that I am responsible for co-insurance, co-payments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out-of-network), the facility will courtesy file the claim for services rendered and any monies received by the facility will be reimbursed to me. In the event that I have no insurance coverage, I understand that fees are due at the time of service. I understand that the facility has the right to withhold discharge paperwork and prescriptions in the event of non-payment. I understand that previous balances owed to the facility will be requested at time of registration and any outstanding patient balance will be billed with accrued interest. I understand that the facility may be contracted only with specific Bayou Health Medicaid plans and if my specific plan is not under contract with the facility, I may elect to accept sole responsibility for the payment of services and the facility nor myself may seek reimbursement from Medicaid for charges incurred.

I acknowledge that I have reviewed the facility Notice of Privacy Practices, Patient Rights and Responsibilities, Payment Policy, Resolution of Communication and Education Barriers and Advance Directive information. I have been given the opportunity to ask questions, address concerns and submit written request.

X _____ Date: _____ / _____ / _____
Signature of Patient/Guardian/Accompanying Adult