Acadia Women's Health

527 Odd Fellow Road, Suite B
Crowley, LA 70526
Phone (337)785-2006 Fax (337)785-2016
This information is updated yearly for office purposes

Patients
Legal Name: ____________________/____________________/_____/_____________/_____________
Last **First** **MI** **Maiden Name** **Preferred Name**

DOB_________________ Age_________________SSN_________________DL#_________________

Mailing
Address: _________________________________City________________State_________ZIP_________

Primary Phone No(____)___________ Cell Phone No(____)___________ Marital Status:__M__S__W__D

Patient's Employer:____Phone No(____)_________________

Employer Address:____

Spouse's Name:_______________________________SSN_________________DOB________________

Spouse's Cell No (____)__________________

Emergency Contact____________________Relationship________________Phone No(____)___________
(If other than spouse)

Insurance Information:

1st Insurance Company:_____________________Member/ Contract No__________________Group No_________

2nd Insurance Company:_____________________Member/ Contract No__________________Group No_________

Responsible Party Information: (This is the person who has the insurance, if other than the patient.)

1. Name:____Phone No(____)__________________

Date of Birth___________________SSN___________________Relationship to Patient_______________

2. Name:____Phone No(____)__________________

Date of Birth___________________SSN___________________Relationship to Patient_______________

● How did you first hear about us? Check below all that apply:

Friend___________Website___________Facebook___________Mailer___________Other____________

Revised on
10/26/17

Acadia Women's Health

Patients Name:____Date________________________

I authorize Acadia Women's Health to contact me in reference to any items that will assist the practice in providing optimal care such as appointment reminders, insurance items, billing inquiries, and any information pertaining to my clinical care: including laboratory results. I authorize the following methods of communication for the items listed above.

Mail E-mail Home Telephone Cell phone Voicemail/Answering Machine

Email Address (Please Print)____

Preferred Pharmacy________________________________Pharmacy Phone Number__________________

City_____________________________________Zip Code____

Primary Care Provider____

With my consent, all financial and/or medical information can be given to the following people:

Name	**Relationship**	**Phone Number**

Financial Medical

Name	**Relationship**	**Phone Number**

Financial Medical

Name	**Relationship**	**Phone Number**

Financial Medical

By signing below, I understand that I am allowing Acadia Women's Health staff to speak to the above identified person(s) in reference to any and all of my Personal Health Information (PHI). I also understand that I can change the list at any time by appearing in person or in writing by sending a request to the office:

Acadia Women's Health, 1325 Wright Ave. Suite D, Crowley LA 70526

Patient Signature	Legal Guardian Signature

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Acadia Women's Health

Guarantee of Payment

I, the undersigned, hereby agree to pay all the amounts and charges incurred by members of my family for services rendered by our physician(s). I further agree that it is my responsibility to know and understand the provisions and limitations stated in my insurance policy as well as the current list of providers in my contract. I accept full responsibility for all charges not covered by my insurance. Failure to make payments requested is basis for legal action and the undersigned agrees to pay all costs of collections, including a reasonable fee and waives his/her right of exemption under law of the State of Louisiana and any other state.

Assignment of Benefits

In consideration of care and services rendered to me by physician(s) during this office visit, I assign the benefits payable under my insurances policies for physician's services to the physician furnishing the services or to their authorized billing agent insofar as necessary to cover their charges. I authorize such physician(s) or their billing agent to submit a claim to my insurance carrier for payment for me and authorized payment to be made directly to the physician(s), billing agent or organization.

Assignment of Claims Against Third Parties

In consideration of care rendered to me by physician(s), I hereby assign to the physician(s) rendered services that I may have against third parties who may be liable for any of my medical expenses, to the extent necessary to cover my expenses for physician(s) care and services. Any funds received by me in connection with such claims against third parties, or settlement of such claims shall be paid to said physician(s) to cover my expenses. I hereby authorize payment directly to said physician(s) or their authorized billing agents of any of the above-mentioned funds which are otherwise payable to me but not to exceed the regular reasonable charges for their services.

Medicare Benefits to Physician(s)

I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by physician(s). I authorize that any holder of medical or other information about me be released in order to process claim(s) and request payment of my benefits to the physician(s) rendering services.

Authorization to Release Information

I hereby authorize physicians rendering services to release to my insurers, billing, and certain medical information including final diagnosis and operative procedure(s) relative to this or related hospital claim(s) and/or office claim(s) for the purpose of determining eligibility of coverage and payment of charges for services rendered in connection with the hospitalization and/or office care. I also give permission for my physician to release my medical information to another physician assisting in my healthcare.

Privacy Notice

I hereby acknowledge receipt of your practice's privacy notice and understand that your Privacy Policy is posted in your patient reception area.

(Please complete all information IF person financially responsible is someone other than patient)
Simply sign if you are financially responsible

Name______________________________________Address____

City________________________State___________Zip_________Phone No(____)____________________

____ ____
Signature of Patient Required Date Signature of Financial Guarantor Date

Acadia Women's Health

Financial Policy 2017

Thank you for choosing Acadia Women's Health. Our entire team is committed to providing you with the best possible quality medical care and services. Please understand payment for our services is part of your treatment and care. Our primary concern is to provide you with the highest quality of medical treatment. Knowledge of your individual insurance plan coverage remains your responsibility; therefore, we urge you, as a patient, to check with your insurance company prior to any testing or surgery that is going to be performed.

There may be certain services that are necessary for the maintenance of your good health, (example: laboratory, urinalysis, ultrasound, hemoccult, etc.) that are not covered by your insurance company. Any charges not covered by your insurance company will be your responsibility.

Let us reassure you that we will order only those tests we feel are necessary for your treatment and optimal care. If you have any questions, someone in our office will be happy to assist you. Thank you very much for understanding and trusting us with your medical care.

You are responsible for all required payments, co-payments, deductibles, and co-insurance on the day of your visit.

We accept cash, check, and all major credit cards as forms of payment. Please note we have a $25.00 returned check fee. If we must bill you for four consecutive months for a past due balance, our system will automatically send the account to collections.

No Insurance Coverage
Payment is required at the time of services. Please call your insurance company prior to your appointment for information.

Do I need a referral?
If your health insurance plan requires an authorization, please call your primary care physician. Authorization is needed prior to your appointment.

Minor Patients
The parent/guardian/adult accompanying a minor child is responsible for payment. Any child over 18 is legally an adult and is responsible for all services rendered.

Cancellation Policy/No Show
Your scheduled appointment is reserved exclusively for you. We have a 48 hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if a 48 hour notice is given. If sufficient notice is not given, your account will automatically be charged a $25.00 missed appointment fee. We ask that you make every effort to keep your reserved time.

Signature____Date______________________

Acadia Women's Health

E-prescribing PBM Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions –** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions –** Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that **Acadia Women's Health** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (printed) ________________________________ Date of Birth ___ /___ /_____

Signature of patient (or representative) ____

Revised on
10/26/17