RED RIVER SLEEP CENTER

Paul Guillory, MD | Renick Webb, MD | Christian Wold, MD | Ernesto Garcia, MD

Ph: 318.443.1684 ● Fax: 318.427.3303 ● 221 Windermere Blvd. Alexandria, LA

AASM ACCREDITED

Date _____

Patient Information

Legal Name _____ Age _____ Date of Birth _____ Race _____
Last First Middle

Marital Status: ☐ single ☐ married ☐ other _____ Employed: ☐ Yes | ☐ No Student: ☐ full-time ☐ part-time

Sex: ☐ male ☐ female Social Security # _____ Drivers License # /State _____

Mailing Address _____ APT# _____

City / State / Zip _____Email_____

Phone: Home # _____ Work # _____ Cell # _____ Fax # _____

Preferred method of contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ Other _____

Employer _____ Employer's Address _____
PO Box/Street City/State/ZIP

Nearest relative not living with you _____ Phone # _____ Relationship _____

Allergies (list all): _____

Special needs (list all): _____

Primary Doctor _____ Cardiologist _____
CITY / STATE CITY / STATE

Other Doctor (s) _____ _____
(PLEASE INDICATE TYPE OF DOCTOR/SPECIALTY, AND CITY / STATE

Emergency Contact: _____ Relationship: _____

Home # _____ Cell # _____ Address _____

GUARDIAN/PARENT INFORMATION (If patient is under 18) ☐ Spouse ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Name _____ Social Security # _____ DOB _____ Employer _____

Address _____ Phone: work # _____ other # _____

*** <u>PLEASE FILL OUT & SIGN THE BACK OF THIS FORM</u> ***

Red River Sleep Center, Inc.

PATIENT INSURANCE INFORMATION

Patient Name _____ DOB _____

Name of Insurance Policy Holder _____ Relationship _____ DOB _____

Social Security Number of Policy Holder _____

Insurance card/information must be provided prior to signing this form.

I hereby instruct and direct my Insurance Company, as indicated by the insurance card/information I provided to RRSC, to pay by check/Credit Card/EFT **Or** if my current policy prohibits direct payment to my doctor/service provider, to make the check to me to be mailed to any of the following providers: Paul A. Guillory, MD; Renick P. Webb, MD; Christian J. Wold, MD; and/or Red River Sleep Center, Inc. for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee(s), and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize that my doctor and/or the service provider may release a copy of my sleep reports to the physicians I have listed on the front of this form. I authorize my doctor and/or the service provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that (regardless of my insurance) I am ultimately responsible for the balance of my account for any professional services rendered. I have read and completed all the information on both sides of this sheet. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

By signing below I understand that, as a courtesy, Red River Sleep Center will be contacting my insurance to verify benefits concerning coverage of the services expected to be received. I understand that this is not a guarantee of payment by my insurance. Decisions about payment are made by the insurance company once the claim is received. Benefits and payment are based on review of the patient's contract with the insurance company and are decided at the time the claim is reviewed by the insurance company. I understand that I am responsible for contacting my insurance company and verifying the benefits for services to be performed. I also understand that I am financially responsible for all charges due to Red River Sleep Center based on services received regardless of payment by insurance. It is my responsibility to make sure my coverage is active and up-to-date. I understand that I am to inform Red River Sleep Center of any changes in my policy or changes in insurance coverage.

_____ _____

Signature of Patient or Representative Date

DISCLOSURE OF FINANCIAL INTEREST

As Required by R.S. 37:1744 and LAC 47:XLV.4211-4215

Louisiana law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to another health care provider or facility in which the physician has a significant financial interest. Dr. Renick Webb and/or Dr. Paul Guillory are referring you, or the named patient for whom you are the legal representative to: Red River Sleep Center, Inc. - 221 Windermere Blvd. - Alexandria, LA 71303 to obtain a diagnostic procedure. Dr. Renick Webb and/or Dr. Paul Guillory have a financial interest in the health care provider to which you are being referred. The nature and extent of the financial interest is that these physicians own the sleep center to which you are being referred.

PATIENT ACKNOWLEDGEMENT

I, the above named patient (or a legal representative of such patient), hereby acknowledge receipt, on the date indicated and prior to the described referral, a copy of the foregoing Disclosure of Financial Interest.

_____ _____

Signature of Patient or Representative Date

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Records Permission | Acknowledgement

I give Red River ENT Assoc., Red River Sleep Center, its staff and its members permission to speak with the people/service providers/organizations listed below regarding: my health status (including: diagnosis, treatment options, plans/payment for health services I receive), contact information (including: names, addresses, email, phone/fax numbers), dates (including: DOB, dates of service, other), and personal information (including: social security number, account numbers, codes). This consent is valid until such time as I provide Red River ENT Assoc. and/or Red River Sleep Center written revocation of it. Name and relationship of spouse and parents must be listed to be legally recognized.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

May send records to the following Email address: _____

Fax Number (Grant permission to fax records to this number): _____

Durable Medical Equipment Provider (if applicable) _____

I have been presented with a copy of Red River ENT Assoc./ Red River Sleep Center Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restrictions(s) concerning the use of my personal medical information:

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

_____ _____

Signature of Patient or Representative **Date**

(THIS FORM IS TO BE FILED IN THE PATIENT'S MEDICAL RECORD AND WITH THE INSURANCE/BILLING)

If the patient refuses to sign, indicate your attempt to obtain a signature below.

☐ Patient refused to sign this acknowledgement form.

_____ _____

RRENT/RRSC Representative Date

RED RIVER SLEEP CENTER

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PATIENT BILL OF RIGHTS

If you, the patient, cannot read the Patient Bill of Rights or Patient Responsibilities, it can be read to you or a copy can be given to you in a language you understand. As an individual receiving health care services from our organization, let it be known and understood that you have the following rights:

- To receive the appropriate or prescribed service in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference, or physical/mental handicap.
- To be promptly informed if the prescribed care or services are not within the scope, mission, or philosophy of Red River Sleep Center, and therefore be provided with transfer assistance to an appropriate care or service organization.
- To be dealt with and treated with friendliness, courtesy and respect by each and every individual representing Red River Sleep Center who provides treatment or services for you, and be free from neglect or abuse be it physical, mental, or sexual.
- To have your privacy and your property respected at all times.
- To assist in the development and planning of your health care program that is designed to satisfy, as best as possible, your current needs.
- To be provided with adequate information prior to service/care from which you can give your informed consent for the commencement of service/care, the continuation of service/care, the transfer of service to another health care provider, modifications of service/care, or the termination of service/care. Information provided to include scope of service/care and limitations of service/care to be provided.
- To express concerns or grievances or recommend modifications to services provided without fear of discrimination or reprisal, and have concerns/grievances investigated.
- To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, and risks of treatment within the physician's legal responsibilities of medical disclosure.
- To receive appropriate care and services, without discrimination, within the scope of your health care plan, promptly and professionally, while being fully informed as to Red River Sleep Center's policies, procedures, and charges.
- To refuse care, within the boundaries set by law, and receive professional information relative to the ramifications or consequences that will or may result due to such refusal.
- To request and receive data regarding services or costs thereof privately and with confidentiality.
- To request and receive the opportunity to examine or review your medical records.
- To formulate an advance directive such as a Living Will or a Durable Power of Attorney for Health Care.
- To expect that all information received by Red River Sleep Center shall be kept confidential and shall not be released without written consent.
- To be involved, as appropriate, in discussions and resolutions of conflicts and ethical issues related to your care. You are invited to speak up about your care and discuss issues with our management team and/or accrediting bodies.
- To be informed of any experimental or investigational studies that are involved in your care, and be provided the right to refuse any such activity.
- To the assessment and management of pain and discomfort.
- As a patient of Red River Sleep Center, you can expect that your reports of pain will be believed and our concerned staff will quickly respond to your concerns by contacting and informing the Medical Directors.
- To be able to identify visiting personnel members through proper identification

PATIENT RESPONSIBILITIES

As a patient of Red River Sleep Center, you have the responsibility to:

- Give accurate and complete heath information concerning your past illnesses, hospitalization, medication, allergies, infections, diseases, and other pertinent items.
- Assist in developing and maintaining a safe environment.
- Inform Red River Sleep Center when you will not be able to keep an appointment.
- Request further information concerning anything you do not understand.
- Contact your doctor whenever you notice a change in your condition.
- Contact Red River Sleep Center whenever you have an equipment problem.
- Contact Red River Sleep Center whenever you have received a change in your prescription.
- Give information regarding concerns and problems you have to Red River Sleep Center.
- Ensure that the financial obligation for your equipment is fulfilled as promptly as possible.
- Maintain and repair purchased equipment when equipment is no longer under warranty.
- Follow equipment care procedures as outlined on equipment orientation form.
- Follow the no smoking policy and all patient applicable policies of Red River Sleep Center, without exceptions.