ST. CHARLES URGENT CARE

13100 River Rd, Suite 100
Destrehan, LA 70047
PH# (985) 235-0010 Fax: (985) 764-1310
Email: stcharlesurgentcare@gmail.com

Patient Registration

Where did you hear about St. Charles Urgent Care?

____ Friend	____ Letter	____ Website	____ Mailer	____ Dr. Referral	____ Other
____ Phone Book	____ Radio	____ Insurance Directory	____ Signage	____ Television	
____ Existing Patient	____ Facebook	____ Relative	____ Work	____ Newspaper	

Patient Last Name _____

Patient First Name _____ Middle Initial _____

Social Security Number _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Race: _____ Preferred Language: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Primary Care Physician: _____ E-mail (optional): _____

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Preferred Pharmacy: _____
Name City State

Primary Insurance: _____ Secondary Insurance: (If Applicable) _____

- Person financially responsible for bill (Guarantor) is the same as above: ☐ Yes ☐ No
- Insurance Card Holder is the same as above: ☐ Yes ☐ No

If you answered "No" to either question, please provide information below:

Primary Insurance Card Holder / Guarantor: _____
Last Name First Name M.I.

Guarantor's Street Address: _____

Guarantor's City: _____ State: _____ Zip: _____

Guarantor's Social Security Number: _____ Date of Birth: _____

Guarantor's Phone Number: _____ Gender: ☐ Male ☐ Female

Relationship to Patient: ☐ Parent ☐ Spouse

Secondary Insurance Card Holder / Guarantor: _____
(If Applicable) Last Name First Name M.I.

Guarantor's Street Address: _____

Guarantor's City: _____ State: _____ Zip: _____

Guarantor's Social Security Number: _____ Date of Birth: _____

Guarantor's Phone Number: _____ Gender: ☐ Male ☐ Female

Relationship to Patient: ☐ Parent ☐ Spouse

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New Patient: Yes No

Patient Name: _____

Date of Birth: _____ **Age:** _____

PLEASE NOTIFY STAFF IMMEDIATELY If you are experiencing **CHEST PAIN, SHORTNESS OF BREATH, WORSE HEADACHE OF YOUR LIFE or SEVERE ABDOMINAL PAIN.** Also, if reason for today's visit is **HEAD INJURY** or **LOSS OF CONSCIOUSNESS,** please alert staff prior to continuing.

1. Reason for today's visit: _____

2. When did your symptoms begin? _____

3. Symptoms: Please check all that you are currently experiencing:

☐ Fever	☐ Cough	☐ Dizziness	☐ Back pain
☐ Chills	☐ Congestion	☐ Laceration/Cut	☐Burning with urination
☐ Body aches	☐ Shortness of Breath	☐ Rash	☐ Frequent urination
☐ Sore Throat	☐ Wheezing	☐ Abdominal Pain	☐ Other:
☐ Earache	☐ Chest Pain	☐ Nausea/Vomiting	
☐ Vision changes	☐ Headache	☐ Diarrhea	

4. Allergies to Medications: _____

5. Medications: ☐ I do not take any medications ☐ I have a list I will provide for copying

Name of Medication:	Dose:	How often taken:

6. Preferred Pharmacy: _____

Name **Street** **City** **State**

7. Social History: Occupation _____

8. Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

9. Smoker: ☐ Yes ☐ No ☐ Former Smoker (Quit _____) If yes, ___ packs per day

10. Alcohol: ☐ Never ☐ Occasionally ☐ Daily

11. Drug Use: ☐ Never ☐ History of drug use ☐ Current drug use

12. Past Medical History (check all that apply): ☐**No past medical history**

☐ Acid Reflux	☐ Asthma	☐ Heart Disease	☐ Migraines
☐ Anemia	☐ Cancer	☐ High Cholesterol	☐ Seizures
☐ ADHD	☐ COPD/Emphysema	☐ High Blood Pressure	☐ Skin Disease
☐ Anxiety/Depression	☐ Diabetes	☐ Kidney Disease	☐ Stroke
☐ Arthritis	☐ Heart Attack	☐ Liver Disease	☐ Thyroid Disease
☐Other:			

13. Past Surgical History (check all that apply): ☐**No past surgeries**

☐Appendix	☐Heart Stents	☐Hysterectomy	☐Tonsils/Adenoids
☐Gallbladder	☐Heart Bypass	☐C-section	☐Tubes in Ears
☐Hernia Repair	☐Pacemaker	☐Back	☐Thyroid
Other:			

14. Family History: _____

Staff Use Only: Room#: _____ Pain: ___/10 Height: _____ Weight: _____ LMP: _____

Vitals: Temp: _____ Pulse: _____ BP: _____ Respirations: _____ Pulse ox: _____

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Medical Information Release Form (HIPAA Release Form)

Patient Name: _____ Date of Birth: _____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

For Proper Identification	Names:	Date of Birth:
➢ Spouse:	_____	_____
➢ Child(ren):	_____	_____
➢ Parent(s):	_____	_____
➢ Employer:	_____	_____
➢ Other:	_____	_____

☐ Information is **not** to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Patient Receipt of HIPAA Privacy Notice

St. Charles Urgent Care is committed to maintain the integrity of your protected health information and complies with all applicable state and federal regulations. I give St. Charles Urgent Care my consent to use or disclose my protected health information, for purpose of treatment, payment activities and healthcare operations.

I understand that I may preview a copy of St. Charles Urgent Care's notice of Privacy Practices before signing this consent by asking a staff member for assistance. The Notice of Privacy Practices provides a complete description of uses and disclosures of my health information.

As described in our Notice of Privacy Practices, we reserve the right to change our privacy practices. I understand a copy of the revised notice will be made available to me.

_____	_____	_____
Printed Patient Name	Patient/Guardian Signature	Date

Office Use Only: To be completed only when a patient declines to sign acknowledgment.

☐ Check here if patient declines to sign acknowledgment

Staff Signature: _____ Date: _____

Refusal to sign acknowledgment does not prevent the patient from continuing to be treated.

(To be filed in patient's records)

ST. CHARLES URGENT CARE

Consent Information:

You expressly consent and agree that, in order to discuss or service your account(s) or to collect amounts you may owe, St Charles Urgent Care/Lafourche Medical Group, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any their-party debt collection agency associated therewith collectively. We may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-ordered or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- You may become responsible for the medical costs of treatment for your illness or condition filed by St. Charles Urgent Care as a Worker's Compensation claim or employer paid service claim if; (1) you fail to pursue the claim for workers compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease of (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law 32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.
- By my signature below, I hereby authorize assignment of financial benefits directly to St. Charles Urgent Care and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient's Name (Please Print) _____

_____ _____

Patient/Guardian Signature Date