

HAYDEL ASTHMA & ALLERGY CLINIC

Robert D. Haydel, Jr., M.D.

4752 Hwy 311 Suite 108

Houma, LA 70363

(985) 857-8271- (985)655-8271 Fx.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone # () _____ Cell # () _____

Date of Birth: ____/____/____ Social Security Number: _____

Driver's License State: ____ Number: _____

Patient's Employer: _____

Employer Telephone #: () _____ Can We call you at work? _____

Check one: _____

Patient (if a minor) lives with: ____ Mother ____ Father ____ other: _____

Sex: ____ Male ____ Female Race: ____ Caucasian ____ African American ____ Asian other: _____

Status: ____ Single ____ Married Spouse's Name: _____

Spouse's Employer: _____ Spouse's Employer # () _____

Can we call your spouse at work if we need to get in touch with you? _____

Please list at least one emergency contact for us to call in case we cannot get in touch with you.

Emergency Name (not in your home): _____ Relation: _____

Emergency # () _____ () _____

IF THE PATIENT IS A MINOR. PLEASE FILL OUT BELOW:

Father's Name: _____

Date of Birth: ____/____/____

Cell # () _____

Is it OK to call? _____

Employer: _____

Employer #: () _____

Is it OK to call? _____

Social Security # ____/____/____

Driver's License State: ____ #: _____

Mother's Name: _____

Date of Birth: ____/____/____

Cell # () _____

Is it OK to call? _____

Employer: _____

Employer #: () _____

Is it OK to call? _____

Social Security # ____/____/____

Driver's License State: ____ #: _____

E-MAIL ADDRESS: _____

Your e-mail address will remain confidential and will not be sold or shared. It will be used to provide important information on a timely basis.

Name of the patient's Primary Care Physician (PCP): _____

Did a physician refer you to us? ____ NO ____ Yes, Physician's Name: _____

Physician's phone number: _____

How did you hear about this office? ____ patient ____ Physician Referral ____ Telephone Directory
____ friend ____ Insurance Manual

INSURANCE INFORMATION (Please provide the office with a copy of your insurance card with every visit)

Primary Insurance Company Name: _____
Policy #: _____ Group: _____
Employer Name: _____
Insured's Full Name: _____
Insured's Date of Birth: _____
Insured's Phone #: _____
Insured's Social Security #: _____
Insured's Address: _____
Relationship to Insured: _____

Please READ the following information carefully before signing.

Privacy Notice

Our Notice of Privacy Practices (notices) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by request from the receptionist.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format are confidential and cannot be disclosed without my prior written authorization; except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

Date: _____

Patient, Parent, or Guardian Signature

Please read the following carefully before signing.

Patient Insurance/Responsibility

I understand that Dr. Haydel's Office relies on the insurance information given to them by my carrier, which cannot be guaranteed. It is up to each patient to know their insurance benefits and ensure that what is relayed to you is also your understanding with your carrier. PLEASE NOTE: We must check your insurance card at every visit. The slightest change could result in unnecessary expenses. This will be done at every visit and we would appreciate your willingness to comply. INITIALS: _____

I request payment of authorized insurance/Medicare benefits be made on my behalf to Haydel Asthma & Allergy Clinic, Inc. for any services furnished me by that provider. I authorize Dr. Haydel to release to my insurance carrier/health care financing administration and its agents any information needed to determine the benefits payable for related services. I understand that the office policy is: all co-pays or any amounts not payable by insurance are due at the time of service. I also understand that the "verification of benefits" obtained by Dr. Haydel's office is not a guarantee of payment and circumstances such as pre-x riders we are not made aware of, etc. may result in denials. I am financially responsible for any remaining covered charges not paid by insurance or Medicare and that balance is to be paid in full within 30 days after insurance

payment or denial is made. Should an insurance company withhold payment "pending patient info", account will be considered a self-pay account until resolved. Individual payments will be refunded if deemed payable by insurance. I understand that I will be responsible for any collection fees and court cost necessary should my account exceed the 60 days and I have not made agreeable arrangements. Re. my account. INITIALS: _____

I understand that there will be a \$25 charge for failure to give at least a 24-hour notice for a canceled appointment. To avoid being charged for a cancelled appointment, I will be responsible for obtaining the name and/ or code from the person canceling my appt. INITIALS: _____

I agree to have lab & diagnostic tests done in a timely manner and will personally contact Dr. Haydel's office for all results. Patient assumes risks for remaining on medications if labs are not performed as ordered. INITIALS: _____

Patient Financial Responsibility

I understand that I am fully responsible for any bills incurred from my office visit or allergy immunotherapy. I agree to pay a \$25.00 service charge for each NSF check issued. If the patient is a minor, financial responsibilities lie with the parent/guardian of the child.

**Louisiana law requires physicians and other health care providers to make certain disclosures to patient when refer a patient to another health care facility in which the physician has a significant interest in; (Physicians Medical Center Hospital), 218 Corporate Drive, Houma, LA 70360. (4%) ownership interest and immediate family (0%).

Date: _____

Patient, Parent, or Guardian Signature