HAYDEL ASTHMA & ALLERGY CLINIC

Robert D. Haydel, Jr., M.D.
4752 Hwy 311 Suite 108
Houma, LA 70363
PH: (985) 857-8271 FX: (985)655-8271

PATIENT INFORMATION

Last Name: _____________________ First Name: ___________________ Middle Initial: ______________

Mailing Address: ____________________________ Street Address: ______________________________

City: __________________________ State: _________ Zip Code: _________________

Home Telephone # (   ) ______________ Cell # (   ) ______________________

Date of Birth: _______/_______/_______ Social Security 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 Date of Birth: __________________________Spouse's SS#_____________________________

Spouse's Employer: __________________________________ Spouse's Employer # (   ) ____________

Please list at least one emergency contact that **does not** live in your house for us to call in case we cannot get in touch with you.
Emergency Name (not in your home):_______________________________ Relation: _______________
Emergency # (   ) __________________ (   ) ___________________

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

Father's Name: _________________________	Mother's Name: _________________________
Date of Birth: _______/_______/_______	Date of Birth: _______/_______/_______
Cell # ( ) __________________________	Cell # ( ) _____________________________
Is it OK to call? ____________	Is it OK to call? ____________
Employer: ______________________________	Employer: ______________________________
Employer #: ( ) _______________________	Employer #: ( ) _______________________
Is it OK to call?	Is it OK to call?
Social Security # _______/_______/_______	Social Security # _______/_______/_______

____

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 thru our patient portal.

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 provides the office with a copy of your insurance card with every visit

Primary Insurance Company Name: ______________________________________

Employer Name: ____

Insured's Full Name: ____

Insured's Phone #:____

Insured's Social Security #:________________________D.O.B_______________

Insured's Address: ____

Relationship to Insured: ____

Please read the following carefully before signing.

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.

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 of 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.
4. If you have and questions or comments concerning your HIPPA rights please feel free to contact us to speak with

____ Print:________________________________

Patient, Parent, or Guardian Signature Date: _________________________________

Please read the following carefully before signing.

APPOINTMENT CANCELLATION POLICY

I understand that there will be a $25.00 charge for failure to give at least a 24-hour notice for a canceled or missed appointment, and that it is my responsibility to obtain the name of the person canceling my appointment.
INITIALS: __________

LABS

I agree to have lab & diagnostic test done in a timely manner and will personally contact Haydel Asthma & Allergy Clinic for all results. Patient assumes risks for remaining on medications if labs are not performed as ordered. **INITALS: ________**

PATIENT FINANCIAL/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.
INITALS: ________

I request payment of authorized insurance benefits be made on my behalf to Haydel Asthma & Allergic Clinic for any services furnished to me by that provider. I authorize Haydel Asthma & Allergy Clinic the release of my information to my insurance carrier and its financing administration for determination of my benefits. I understand that the office policy is that all co-pays or any amounts not payable by my insurance company are due at the time services are rendered. I also understand that the "verification of benefits" obtained by the office of Haydel Asthma & Allergy Clinic is not a guarantee of payment. I am financially responsible for any remaining charges not covered or denied by my insurance company and that the balance is to be pain in full within 30 days. Should my insurance company withhold payment "pending patient information," my account will be considered self pay until resolved. Individual payments will be refunded if deemed payable by insurance.
INITALS: ________

I understand that I will be responsible for any court cost and collection fees should my account exceed 60 days and I have not made any arrangements with the billing department.
INITALS: ________

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 responsibility lies with the parent/guardian of the child.
INITIALS: ________

____ Print:______________________________
Patient, Parent, or Guardian Signature Date: ______________________________

Request for confidential Communications

Patient's Name: ___________________________________
Patients DOB: _______/______/________
Parent/Guardian Name: _____________________________

Please list below people to whom we can disclose medical information of the patient. (This list should include people we may call if we cannot get in touch with you or who may call the office on the patient's behalf to schedule an appointment, check on an appointment, or get medical information.)

Person's name	Relationship to the patient	Phone Number

- When calling your home phone, can we leave a message for you? _____________
- Can we call your cell phone? _____________
- Can we call you at work? _____________

Please list any special instructions:

____

____

____

______________________________ ______/______/________

Patient or Guardian Date

4752 Hwy. 311 Suite 108
Houma, La 70360-4635

Office (985) 857-8271
Fax (985) 655-8271

Robert D. Haydel Jr., M.D.

Authorization to Disclose Protected Health Information (PHI)

This form is for all record requests.

I, ____________________ herby authorize my Health Care Provider to disclose the following protected health information to Haydel Asthma & Allergy Clinic:

___ Entire Medical Records ___Laboratory/Radiology
___ SPT ___ Other: ____________________

My PHI may be disclosed by fax, or email to: Haydel Asthma & Allergy Clinic
Fax: 985-655-8271 Email: rec1@haydelasthma.com

Disclosure of PHI is authorized to help in the evaluation and management of the
Patients full name: ____
Date of Birth: _____/_____/_____ Medical Records # __________________

1. I understand that I have the right to revoke this authorization at any time, I understand that if I revoke this authorization I must do so in writing and present my written revocation to the to the provider of care. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim.

2. I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

3. Haydel Asthma & Allergy Clinic, its employees, and physicians ore hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorization herein.

____ ____/_____/_______
Signed: Patient- Parent or Legal Guardian Relationship if not Patient Date