SWLA Center for Health Services

Patient Registration Form

Check one: ☐ Lake Charles ☐ Lafayette ☐ Crowley ☐ Oberlin ☐ Sowela

DATE: _____/_____/_____ **INTAKE SIGNATURE: _____**

Patient's First Name:	**Middle:**	**Last Name:**	**Social Security Number:** _____/_____/_____	**Sex at birth:**

Date of Birth: _____/ _____ /_____	Physical Address City / State / Zip:	Mailing Address City/State/Zip:

Home/Cell Number: ( ) _____-_____	Work Number: ( ) _____-_____	Email Address:

Primary Insurance: _____ ☑ Medicaid ☑ Medicare ☐ Other

Pharmacy: ☐ **SWLA Pharmacy** ☐ **Other** _____ **Phone** _____

PRIMARY LANGUAGE SPOKEN	***ETHNICITY***	***RACE***
Check One: ☐ English ☐ Spanish Other _____	***Check One:*** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Refuse to report	***Check all that apply:*** ☐ Asian ☐ White ☐ Black/African American ☐ Native Hawaiian ☐ American Indian / Native Alaskan ☐ Pacific Islander ☐ Other ☐ Refuse to report

SEXUAL ORIENTATION	***GENDER IDENTITY***
Check One: ☐ Straight/Heterosexual ☐ Lesbian / Gay ☐ Bisexual ☐ Something else ☐ Don't Know ☐ Choose not to disclose	***Check One:*** ☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male ☐ Other ☐ Choose not to disclose

EMPLOYMENT INFORMATION

Employer:	Address:	City / State / Zip:

EMERGENCY CONTACT

Name of Emergency Contact:	Relationship to Patient:	Home Number:	Cell Number:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Phone Number: ( ) _____

As a Federal Program we are required to capture financial information. This information is used for ***statistical data only.***

Are you interested in the Sliding Fee Discount Program? ☐ **YES** ☐ **NO** **Do you live in Public Housing?** ☐ **YES** ☐ **NO**

ADDITIONAL INFORMATION - CHECK ALL THAT APPLY

☐ Homeless—Street, Shelter, Doubling or Transitional

☐ Permanent Supportive ☐ Migratory Agricultural worker ☐ Seasonal Agricultural Worker ☐ Veteran ☐ Other

I hereby certify that all answers and statements on this document and all the information provided is true and accurate. I understand that any misrepresentation or omission of facts. I hereby authorize SWLACHC permission to obtain insurance verification and information from parties outside of SWLA Center for Health Services.

Signature _____ Date _____

PLEASE FILL THIS FORM OUT COMPLETELY

Revised 03/22

Patient Name: _____ DOB: _____

Consent, Release and Statement to Permit
Payment of Medicare/Private Insurance Benefits of Provider

I voluntarily consent to routine medical treatment by SWLA Center for Health Services for myself or the above named minor, for whom I am parent/guardian. I understand that specific and separate consent will be requested from me prior to any non-routine, hazardous or major treatment that is not of any emergency nature.

I authorize the release of information from the medical records of the above named person only to the extent necessary to carry out the following purposes, fiscal and accounting use, consultation and referral, quality assurance, educational programs and research maintaining confidentiality and previously approved by the Board of Directors of SWLA Center for Health Services.

I request payment of authorized Medicare/Private Insurance benefits for me or on my behalf for any service furnished me by or in SWLA Center for Health Services, including physician services, to SWLA Center for Health Services. I authorize any holder of medical or other information about me to release to Medicare/Private insurance and its agents any information needed to determine these benefits for related services.

I understand that if I do not qualify or apply for the Sliding Fee Discount, I am responsible for the Medicare co-payments and Private Insurance co-payments and deductibles.

I declare that the information listed above is accurate and complete. I understand that I may be asked for evidence to verify the statement of income and family size.

_____ _____
Signature of Patient, or Patient's Representative Date

……

Patient Confidentiality

Due to patient confidentiality, we are unable to relay any information regarding your healthcare to anyone but you, including husband and wife. Therefore, when a question arises regarding your appointments, billing, test results, or medical advice in general, we will only respond to you unless we are given prior permission to give information out to other people as indicated below. Should you choose that we do not disclose any information regarding you, your condition, your financial or medical records please indicate that by writing NONE. You have my permission to discuss any information held in my medical record to:

Name: Relationship:

_____ _____

_____ _____

_____ _____
Signature of Patient, or Patient's Representative Date

……
……

Patient Acknowledgment of Receipt

I, _____, hereby acknowledge that I have received a copy of the following:

- Patient Bill of Rights
- Patient Responsibilities
- Notice of Privacy Practices

_____ _____
Signature of Patient, or Patient's Representative Date

PATIENT/PARENT ATTESTATION

LOUISIANA HEALTH INFORMATION EXCHANGE OPTION

(please check one option)
[ ] Opt-In to LaHIE
When you seek medical treatment at an organization participating in LaHIE, your health information is accessible.

[ ] Opt-Out of LaHIE
If you choose to opt out of LaHIE, your health information cannot be accessed through LaHIE, even in an emergency.

[ ] No Option selected
If you have a health emergency, and your consent has not been obtained, your electronic health information may be accessed for emergency treatment purposes only.

_____ Date: _____
Signature of Patient

_____ Date: _____
Printed Name of Patient

_____ Relationship: _____
Signature of Parent/Legal Guardian

_____ Date: _____
Printed Name of Parent/Legal Guardian

This consent may be withdrawn or modified at any time with written permission of the patient or parent/guardian to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

SWLA WITNESS

_____	_____	_____
Printed Name	Signature	Date

PATIENT RESPONSIBILITY FORM

It is important that you read and acknowledge our patient responsibility policy in full.

Payment is due in full at the time services are rendered. As the patient/guarantor, you are financially responsible for any fees and costs associated with any services you received from our office. This includes any medical/dental visits, ultrasounds, labs and any other services ordered by the doctor or staff.

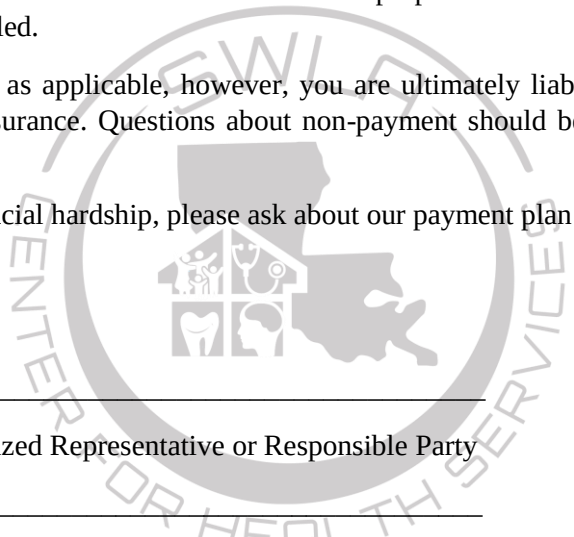
Co-payments /Sliding Fee payments will be collected at the time of service.

As a patient/ guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. If you arrive for an appointment and your insurance is inactive, you have the option to reschedule the appointment, be placed on our Sliding Fee discount program or pay in full for all services rendered.

If you are a patient with a secondary insurance to your primary plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary will not be billed.

We will bill your insurance as applicable, however, you are ultimately liable for any fees and cost not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company.

If you are experiencing financial hardship, please ask about our payment plan agreement.



_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

Revised 03/22

Sliding Fee Application

Name _____ DOB _____ Date _____/_____/_____

Completion of this form must be accompanied by proof of eligibility for a sliding fee discount. This application is available to ALL persons without regard to race, creed, color, age, and religion, country of origin, sexual orientation, any disability, or ABILITY TO PAY. ALL SLIDING FEE APPLICATIONS WILL BE PREPARED BY THE ELIGIBILITY STAFF TO DETERMINE THE DISCOUNTED AMOUNT ACCORDING TO THE INCOME AND FAMILY SIZE. A copy of application will be filed and the information documented in the patients HER and on their account entry in SWLA's database. SUBMITING FALSE INFORMATION ON THIS APPLICATION MAY RESULT IN YOUR BEING DENIED THE SLIDING FEE DISCOUNT.
____ (patient initials)

Names of Family members	**D.O.B.**	**Names of Family members**	**D.O.B.**

Signature _____ Date _____

Statement of No Income

I am applying of the SWLA Center for Health Services Sliding Fee Discount Program on _____ (date). I affirm that I have no income and I am currently unemployed. I acknowledge that it is my responsibility to return once I secure gainful employment and provide proof of my income and update my sliding fee application. If there is no change in my income status, I will need to reapply for the program at each visit.

Signature _____ Date _____

++FOR OFFICE USE ONLY++

Sliding Fee Scale Assignment: SFA _____ SFB _____ SFC _____ SFD _____ SFE _____

STAFF signature _____ Date _____

**** This completed application is valid for 12 months***

Revised 03/22

TELEMEDICINE PROGRAM

TELEMEDICINE PATIENT CONSENT FORM

I _____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session. I understand that a physician/healthcare provider will review this information and other persons involved in my medical or mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider inappropriate or unwilling to have heard by others. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause delay in my care and that I may still pursue face-to-face consultation.

I understand I will be receiving health care services through interactive video conferencing equipment. I understand that the equipment will be shown to me and I will see how it works before I receive any services. I understand that my participation in telemedicine is voluntary and I may refuse to participate or decide to stop participation at any time, verbally or in writing. I understand that my refusal to participate or decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of my revocation of informed consent to treatment.

I understand that my privacy and confidentially will be protected. I understand that medical records of telemedicine services will be kept electronically at both the referring site facility and the consulting site facility. I also understand that the health care provider and both locations and the remote video site will have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

I have read this document and I hereby consent to participate in receiving healthcare services via telemedicine under the terms described above. I understand this document.

Signature of (or parent/guardian) _____ Date _____

Print Name _____

Signature of witness: _____ Date _____

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MEDICATION HISTORY CONSENT

Medication History:

Up-to-date medication history information is very important in helping us provide the highest quality medical care and avoid potentially dangerous drug interactions.

A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources including your pharmacy and/or insurance company and may include medications used to treat mental health conditions or HIV.

By signing this consent form, you give permission for SWLA Center for Health Services to use e-prescribing tools to obtain your medication history. You may cancel this consent at any time. However, any medication information already added to your medical record due to this consent will remain as part of your record.

Accepted: _____ (initial)

Printed Name: _____ DOB: _____

Signature: _____ Date: _____
Patient, Parent or Guardian (if patient 17 years of age or under)

Relationship to patient (if applicable): _____

……

Request to Withdraw Consent

Printed Name: _____ DOB: _____

Signature: _____ Date: _____

Patient, Parent or Guardian (if patient 17 years of age or under)

Relationship to Patient (if applicable): _____