**Welcome to our Office!**

Coastal URGENT CARE
*Convenient Quality Care*

1411 St. Charles St.
Houma, LA 70360
Ph. 985-709-0136
Fax 985-709-0527
www.coastalurgentcarehouma.com

Dear Patient:

Thank you for your interest in Coastal Urgent Care of Louisiana. It is our primary goal to provide a high-quality, cost-effective alternative to traditional emergency room medicine and a time saving and after-hours alternative to your family doctor.

We ask that you be prepared to provide a driver's license and insurance identification card when you return to the check-in desk.

Patient Last Name _____ First Name _____ M. Name + Suffix _____

Sex ◯ M ◯ F Date of Birth: _____ _____ _____ SSN _____ - _____ - _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Your Preferred Method of Contact ☐ Email ◯ Mobile Phone ◯ Home Phone ◯ Work Phone _____

Street Address / P.O. Box _____ Apt. / Lot # _____

City _____ State _____ Zip _____

Marital Status ◯ S ◯ M ◯ D ◯ WD

Email _____ ☐ No Email

Place of Employment _____ Phone: _____

Primary Care Physician _____ Phone: _____

How did you hear about us? ◯ Brochure ◯ Pharmacy ◯ Mail ◯ Friend/Family ◯ Sign ◯ Internet ◯ Other _____

Emergency Contact _____ Relationship _____ Phone _____

**RESPONSIBLE PARTY INFORMATION** (Parent, if patient is a minor)

Last Name _____ First Name _____ M. Name + Suffix _____

Street Address / P.O. Box _____

City _____ State _____ Zip _____

Date of Birth _____ SS # _____ Relationship _____

**PRIMARY INSURANCE** Name of Ins. _____

Patient's Relationship to Policy Holder ◯ Self ◯ Spouse ◯ Child ◯ Other _____

Last Name _____ First Name _____ M. Name + Suffix _____

Date of Birth _____ _____ _____ SS # _____

Address _____ City _____ State _____ Zip _____

Phone _____ Mobile _____ Email _____

**SECONDARY INSURANCE:** Name of Ins. _____

Patient's Relationship to Policy Holder ◯ Self ◯ Spouse ◯ Child ◯ Other _____

Last Name _____ First Name _____ M. Name + Suffix _____

Date of Birth _____ SS # _____ Phone # _____

Is this visit the result of an accident? ◯ Yes ◯ No Did this accident occur at work? ◯ Yes ◯ No

I consent to treatment for myself or above minor child. I understand that the examination and/or medical treatment I will receive is NOT intended to replace complete medical care by my personal primary care physician. I am aware that I will be responsible for co-payment or full payment at the time of services. Any pre-certification requirement that my insurance company requires is my responsibility to make. Furthermore, I allow Coastal Urgent Care of Louisiana to release to my insurance company treatment and billing information, as requested, to process my claim. I allow Coastal Urgent Care of Louisiana to accept assigned payments made by my insurance company on my behalf. I understand that by my lack of payment or if my insurance denies payment, I am responsible for payment in full for services rendered. I am aware that Coastal Urgent Care of Louisiana does not accept Medicaid or file claims to Medicaid on my behalf. My failure to pay may result in collection proceedings. In addition, I authorize Coastal Urgent Care of Louisiana to release to my primary care physician or specialty referral, any and all information related to my treatment at this clinic.

_____ _____

Patient Signature (if minor, signature of parent/guardian) Date

POS® Reorder # 1309890

HIPAA / Financial Policy

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## Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Coastal Urgent Care of Louisiana, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

**Name, relationship and a personal identification method of persons you wish to allow access – for example:**

| **Name:** | **Relationship:** | **Personal Identification:** |
|---|---|---|
| **John Doe** | **Father** | **Date of Birth, Address or last 4 of SS #** |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Restriction Request: _____

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Coastal Urgent Care and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

**I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.**

_____ Date _____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

Date of Birth of Personal Representative _____ Last 4 of SS # _____

If not signed by the patient, please indicate relationship and describe authority to act:

Name of Patient: _____ ☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient

## Financial Policy

The providers of this office are contracted with many of the local and national managed care plans. However, there are some plans that we do not currently have contracts with. If you belong to a plan that we are not contracted with, our insurance/billing office will be glad to file a claim for you with the understanding that full payment is due at the time of service. Your claim will probably be applied to an out-of-network deductible or totally rejected. We do not file claims to or accept Medicaid.

It is important for you to understand that the patient is ultimately responsible for the fees that are not covered by the provider in this case. If you have any questions concerning the coverage your plan has with Coastal Urgent Care of Louisiana, please call the patient relations department of your provider.

The responsible party will also be responsible for any durable medical equipment (splints, crutches, ace wraps, etc.) and medications not covered by the insurance plan or applied towards the deductible.

Thank you.

POS® Reorder # 1309891

Coastal URGENT CARE of Houma

**Staff Only**
**Room: ____**
**Triage Time: _____**
**MR #: _____**

**Patient Name:** _____ **Date of Birth:** _____ **Age:** _____

**Medication Allergies:** _____

**Medications Taking:** _____

**Is this visit a result of a work related accident? Yes / No** **Have you been a patient here before? Yes / No**

STOP **Please NOTIFY STAFF if you have an emergency such as: CHEST PAIN, a HEAD INJURY, SHORTNESS OF BREATH, SEVERE ABDOMINAL PAIN, or the WORST HEADACHE OF LIFE before continuing.** STOP

**Past Medical History (please check all that apply)**

| | | |
|---|---|---|
| ☐ Acid Reflux | ☐ Diabetes | ☐ Migraines |
| ☐ Anemia | ☐ Down Syndrome | ☐ Seizures |
| ☐ ADHD | ☐ Heart Attack | ☐ Skin Disorder |
| ☐ Anxiety/Depression | ☐ High Cholesterol | ☐ Stroke |
| ☐ Asthma | ☐ High Blood Pressure | ☐ Thyroid Disease |
| ☐ Cancer | ☐ Kidney Disease | ☐ Other _____ |
| ☐ COPD | ☐ Liver Disease | ☐ Other _____ |
| ☐ **NO PAST MEDICAL HISTORY** | | |

**Past Surgeries**

| | | |
|---|---|---|
| ☐ Appendectomy | ☐ Gall Bladder removal | ☐ Hysterectomy |
| ☐ Cardiac Stent | ☐ Tubes in ears | ☐ Thyroidectomy |
| ☐ Heart Bypass | ☐ Hernia Repair | ☐ Tonsillectomy/Adenoidectomy |
| ☐ C-Section | ☐ Other _____ | |
| ☐ **NO PAST SURGERIES** | | |

**Social History**

| | | |
|---|---|---|
| ☐ Nonsmoker | ☐ Do not drink alcohol | ☐ No Drug Use |
| ☐ Former Smoker | ☐ Occasional Drinker | ☐ History of Drug use |
| ☐ Circle: Occasional/Daily Smoker | ☐ Daily Drinker | ☐ Current Drug user |
| **Please Circle:** Employed/ Student/ Retired/ Disabled/ Homemaker/ Unemployed | | |

**Current Symptoms (please check all that apply)**

| Constitutional | Pulmonary | Pain |
|---|---|---|
| ☐ Fever | ☐ Shortness of breath | ☐ Back pain |
| ☐ Chills | ☐ Cough | ☐ Other _____ |
| ☐ Body Aches | Cardiovascular | GU |
| HEENT | ☐ **Chest Pain** | ☐ Burning with urination |
| ☐ Eye Problems | ☐ Passed out | ☐ Frequent Urination |
| ☐ Ear Problems | ☐ Skin Problems | ☐ Other _____ |
| ☐ Sore Throat | ☐ Laceration | ☐ Other _____ |
| ☐ **When did symptoms start? ____minutes ago _____hours ago _____days ago ____weeks ago** | | |

**Vital Signs (staff Only)**

BP-_____ Pulse-_____ RR- _____ Temp-_____

Pulse Ox-_____

WT: _____ LBS / KG

Immunizations up to date: YES or NO

Tetanus up to date: YES or NO

Last Menstrual Period: _____