# Hebert Medical Group, APMC

LOC: EU JE LA OE AE AJ AS PT

Acct #: _____ ☐ ABN Form ☐ Accident/Injury Information Form Completed Date: _____

P-INS Code: _____ S-INS Code: _____ F/C: _____ ☐ Request for Confidential Communications Attached

## PATIENT INFORMATION

Prefix:
Mr./Mrs./Other: _____ Patient*⇕: _____ (Last) _____ (First) _____ (Middle)

Suffix: Jr./Sr./Other: _____ Previous Name: _____

Mailing Address: _____ (If PO Box, complete Street Address Below) _____ (City) _____ (State) _____ (Zip)

Street
Address: _____ _____ (City) _____ (State) _____ (Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

*Circle the preferred phone #/email contact.* Leave message at what phone number? ☐ Home ☐ Work ☐ Cell ☐ None

Email: _____

Marital Status*: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Date of Birth*: _____ Social Security#: _____

Employer: _____ Occupation: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired _____ (MMDDYY) ☐ Military Active ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A Patient & Responsible Party are the same*? ☐ Yes ☐ No (complete below)

Race*: ☐ African American ☐ Caucasian/White ☐ Other: _____

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Preferred Language*: ☐ English ☐ Spanish ☐ Other: _____

☐ Provide copy of insurance card(s) to be scanned⇕ Do you have well care/preventative coverage for annual exams: ☐ Yes ☐ No
(if not, complete below)

Primary Insurance: _____ Secondary Insurance: _____

Primary Ins Policy #: _____ Secondary Ins Policy #: _____

Group #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

## RESPONSIBLE PARTY INFORMATION

*ONLY COMPLETE IF OTHER THAN PATIENT (NOT SELF), THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION*

Prefix: Mr./Mrs./Other: _____ Responsible Party: _____ (Last) _____ (First) _____ (Middle)
(Employer Info if work related)

Suffix: Jr./Sr./Other: _____ Relationship to Patient: _____ Social Security #: _____

Mailing Address: _____ (If PO Box, complete Street Address Below) _____ (City) _____ (State) _____ (Zip)

Street Address: _____ _____ (City) _____ (State) _____ (Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Date of Birth*: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Email: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Employer: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Disabled ☐ Retired ☐ Military Active ☐ Not Employed

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Patient Name: _____ Date of Birth: _____

How were you referred to our practice: ☐ Friend/Relative ☐ Newspaper ☐ Radio ☐ Healthsource ☐ Other: _____

☐ Referred Physician: _____ Phone #: _____

Primary Care Provider (PCP): _____ Address: _____ Phone: _____

Is this an Accident or Injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No

If 'Yes' to either question, request and complete an Accident/Injury Information Form (Rec'd by): (Date):

Do you have an Advanced Directive (living will, durable power of attorney)? ☐ Yes ☐ No

If 'Yes', provide copy. Rec'd by: Date:

Are you or have you been incarcerated within the last year? ☐ Yes ☐ No

If 'Yes', please provide: Facility Name: _____ Release Date: _____

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By signing this form, I hereby acknowledge Hebert Medical Group (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the Notice of Privacy Practices for Protected Health Information (NOPP). I understand I have the right to restrict how my PHI is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

If below is not signed by the patient, please indicate relationship:
☐ Parent or Guardian of minor patient; ☐ Power of Attorney, Turix, Curator or Designated Personal Representative

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_____ (Initial) I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of HEBERT MEDICAL GROUP, APMC.
Acknowledgement refused:
Efforts to obtain: _____
Reason for refusal: _____

_____ (Initial) I hereby acknowledge I have been provided with, read and understand the practice's 'No Show' policy and I understand that I will be charged the current fee for each no show appointment.

_____ (Initial) I hereby authorize Hebert Medical Group to evaluate and recommend any testing and/or additional treatment from other facilities, i.e., labs; who will in turn bill me for their services. I understand I have the right to refuse any such recommendations/treatment.

_____ (Initial) I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify all above information is true and accurate as of the below indicated date.

_____ (Initial) I hereby authorize the listed insurance companies to pay directly to Hebert Medical Group benefits due on my behalf, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance, i.e., my Out of Pocket (OOP) share.

_____ (Initial) I understand that any payment(s) made by me to Hebert Medical Group in the form of a check may be processed as an electronic check transaction; therefore, the funds will be debited immediately from my checking account.

_____ (Initial) I agree that Hebert Medical Group may contact me via any means that I have provided on the prior page of this form including but not limited to land lines, cell phones (text and mobile applications), and email, etc.

_____ _____
Signature ☐ Patient ☐ Responsible Party Date

**OFFICE USE ONLY** Provide ABN for all potentially non covered services

HMG Staff: Scan to patient demographics 'eCW/INS' folder with copy of Insurance Card/Birth Certificate/Drivers License.

* = *Required for eCW* ¡t = *Interfaces to MEDPM*

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Patient Name: _____ Date of Birth: _____

**EMERGENCY CONTACT:** _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Email: _____

Any special instructions: _____

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? ☐ Yes ☐ No

If 'Yes', office staff to assist in completing a Hospice/HHA/NH/SNF Facility Information Form.

☐ Hospice/HHA/NH/SNF Facility Info Form

## PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

*Note: If request initiated, assign Account Status: R - HIPAA Restricted (in MEDPM); send copy to MEDDATA.*

Please list any person(s) other than yourself, and their relationship to you, that we may discuss your medical information with:

| Person: | Relation: | Phone #: |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |
| 4) | | |
| 5) | | |

Signature: _____ Date: _____