ACADIANA CENTER

2501 W. Pinhook Road ♦ Lafayette, LA 70508
Phone: 337-269-0136 ♦ Fax: 337-233-8525

URGENT CARE PATIENT REGISTRATION

(Patient to complete all shaded areas)

Patient Information

Patient Name: Last _____ First _____ MI _____

Date of Birth: _____ Social Security #: _____ Gender: ☐ Male ☐ Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Other: _____

Email: _____

Emergency Contact (not living with you): _____ Phone Number: _____

Relationship: _____

Guarantor Information

(Please complete this section if patient is under 18)

Last Name: _____ First Name: _____ MI: _____

Relationship to patient: _____

Date of Birth: _____ Guarantor Social Security #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Other: _____

Guarantor's Employer: _____

Primary Insurance Coverage

Insurance Company: _____ Name of Insured: _____

Relationship to Patient: _____ Insured D.O.B. _____ Insured Social Security #: _____

Secondary Insurance Coverage

Insurance Company: _____ Name of Insured: _____

Relationship to Patient: _____ Insured D.O.B. _____ Insured Social Security #: _____

Verification of Information: I verify that the above information provided is true and correct to the best of my knowledge.

_____ Date: _____

Signature of Patient/Guardian/Accompanying Adult

CONSENT/CHIEF COMPLAINT

(Patient to complete all shaded areas)

Patient Name: Date of Birth:

Did this company treat you in the past year? ☐ Yes ☐ No

Do you have a Living Will/Power of Attorney for Healthcare that you will provide a copy of today? ☐ Yes ☐ No

Primary Care Physician:

CHIEF COMPLAINT: (Reason for today's visit)

Are you pregnant? ☐ Yes ☐ No

Is this complaint related to an Accident? ☐ Yes ☐ No Date Accident Occurred:

Type of Accident: ☐ Work Related ☐ Auto ☐ Other

Accident Details:

How did you hear about us? ☐ Friend/Relative ☐ Internet ☐ Billboard ☐ Radio ☐ Location ☐ Other

AUTHORIZATION FOR EVALUATION AND TESTING AND RELEASE OF MEDICAL INFORMATION

I hereby authorize any provider of Acadiana Center Urgent Care to evaluate and or treat the patient. I authorize the release of my medical records to any doctor, employer/employer representative, potential employer, insurance company(s), Voc. Rehab, Rehab nurse(s) all information they may request associated with my medical care. I also request that you release my medical records to the physicians of Acadiana Center Urgent Care.

The opinions rendered in this case are the opinions of the physicians of Acadiana Center Urgent Care. This evaluation is being conducted on the basis of the medial examination and the documentation provided, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment, examination, and documentation. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

I hereby authorize the physicians and/or the employees of Acadiana Center Urgent Care to perform any procedures necessary to perform appropriate drug and alcohol screen tests, including but not limited to the drawing of bodily fluids, the testing of my breath, obtaining hair samples, or other tissue from my body. I further consent to drug and alcohol testing on these fluids and/or tissues, and I further consent that same may be sent to outside laboratories, and that the results may be released to my employer, and any other individuals who by law may receive reports regarding the drug and alcohol screening referenced above.

I herby authorize the performance of diagnostic x-rays, which have been requested by the Acadiana Center and/or the current/prospective employer. I understand that exposure to radiation will be minimized through the use high-speed films, only necessary views, collimation, and protective shields over reproductive organs as feasible. At this time, I am aware of no condition for which the taking of x-rays would further complicate.

I have been advised that the ten (10) days following the onset of a menstrual cycle are generally considered to be safe for X-rays. I understand that certain X-rays - especially those of the abdomen/pelvis/lumbar spine/hips - can be hazardous to an unborn fetus.

I have been presented with a copy of this provider's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and will list any restriction(s) concerning my personal medical information: List any restriction(s)

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Date:

Signature of Patient/Guardian/Accompanying Adult

(Continued on back)