Date: _____

Attached:
❑ Hospice/HHA/NH/SNF Facility Info Form
❑ Accident/Injury Information Form
❑ ABN Form

Acct #: _____
Guar Acct #: _____

PATIENT INFORMATION

Patient: _____ Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____
Last First Middle

Mailing Address: _____ _____ _____ _____
Zip City State

Ph#s: H: _____ W: _____ Ext: ____ C: _____ Other: _____

Email: _____ Date of Birth: _____

Social Security #: _____ Sex: ☐Male or ☐Female (circle one)

Marital Status ☐Married ☐Single ☐Widowed ☐Divorced (circle one) Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ Caucasian ☐ African American ☐ Other: _____ Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Current Employer: _____ Employment Status ☐Fulltime ☐Self Employed ☐ Part Time ☐Disabled (circle one) ☐Not Employed ☐ Unknown ☐ Retired ☐Military Active

Student: ☐Full Time ☐ Part Time (circle one) Prior Name: _____

Emergency Contact (EC) Name: _____ Relationship: _____

EC Ph#s: Home: _____ Work : _____ Cell: _____

Pharmacy: _____ Address: _____ Phone: _____

Notification Method: ☐ Mail ☐ Email ☐Phone (circle one) Patient & Resp Party are the same? ☐ Yes or ☐No (circle one)

Blood Type: _____ Referred By: _____

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: _____

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

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', request a Hospice/HHA/NH/SNF Facility Information Form and ask about an ABN Form.

RESPONSIBLE PARTY INFORMATION

IF OTHER THAN PATIENT, SEND STATEMENT/BILL TO:

Responsible Party: _____ Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____
(Employer Info if work related) Last First Middle

Mailing Address: _____ _____ _____ _____
Zip City State

Ph#s: H: _____ W: _____ Ext: ____ C: _____ Other: _____

Email: _____ Date of Birth: _____

Social Security # _____ Sex ☐Male ☐ Female (circle one) Relationship to Patient: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ Employment Status ☐Fulltime ☐Self Employed ☐ Part Time ☐Disabled (circle one) ☐Not Employed ☐Unknown ☐Retired ☐Military Active

Current Employer: _____

INSURANCE INFORMATION

Scan/Copy Card

PRIMARY: _____

Relationship to Insured: ☐Self ☐Child ☐Mate ☐Other (circle one)
Insured: ☐Patient ☐Rsp Party ☐Other
Insured Name: _____
Social Security #: _____ DOB: _____
Group #: _____ Policy# _____
Eff Date: _____ Exp Date: _____
Contact: _____
Phone: _____
PCP (Name/Phone): _____

SECONDARY: _____

Relationship to Insured: ☐Self ☐Child ☐Mate ☐Other (circle one)
Insured: ☐Patient ☐Rsp Party ☐Other
Insured Name: _____
Social Security #: _____ DOB: _____
Group #: _____ Policy# _____
Eff Date: _____ Exp Date: _____
Contact: _____
Phone: _____
PCP (Name/Phone): _____

By signing this, I hereby acknowledge [PRACTICE] (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 protected health information 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.

_____ _____
Signature Date
Patient/Responsible Party (circle one)

I hereby authorize [PRACTICE] to evaluate and recommend any testing and/or additional treatment. _____Initial _____Date

I understand I have the right to refuse any such recommendations/treatment. _____Initial _____Date

I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify this information is true and accurate as of the below indicated date. I hereby authorize the attached insurance companies to pay directly to [PRACTICE] 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.

_____ _____
Signature Date
Patient/Responsible Party (circle one)

Acct #: _____
Guar Acct #: _____

Date: _____

HOSPICE/HHA/NH/SNF FACILITY INFORMATION FORM

PATIENT INFORMATION

Patient: _____ Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____
Last First Middle

If Hospice/HHA/NH/SNF patient and answered 'Y'es *to same* on Acquaintance Form, complete below data and ask about an ABN Form. Please ask if you have any questions.

FACILITY INFORMATION

Type: (circle one) Hospice Home Health Nursing Home Skilled Nursing Facility

Facility Name: _____ Contact Name: _____
Last First Middle

Mailing Address: _____ _____ _____ _____
City State Zip

Phone: _____

Completed by: _____ Date: _____

OFFICE USE ONLY

Provide ABN form for all services.

If currently a Home Health patient, all charges must be paid for prior to rendering services or the patient must be redirected to the HHA facility for care.

Refer to **User Guide: SNF/Home Health/Hospice Billing Medicare & LA Medicaid**

Acct #: _____
Guar Acct #: _____

Date: _____

ACCIDENT/INJURY INFORMATION FORM

PATIENT INFORMATION

Patient: _____ Title: Mr./Mrs./Other: _____ Suffix: Jr/Sr/Other: _____
Last First Middle

If patient has had an accident or injury and answered 'Y'es *to same* on Acquaintance Form, complete below data. Please ask if you have any questions.

ACCIDENT/INJURY INFORMATION

Type: (circle one) Accident Injury

Date of: _____ Date symptoms began: _____

Motor Vehicular Accident (MVA): Y or N If 'Y', State Code: _____

Give details of accident/injury (Description/Reason): _____

Slip & Fall: _____

Prior Physicians Seen (Treated by, date and Treatment Place): *(List)* _____

❑ Release Form Needed *(Provide Physician Address)* _____

Prior Tests with approximate date: *(List)* _____

❑ Patient is Providing Results OR ❑ Release Form Needed *(Provide Facility and Address)* _____

Prior Surgery (Treated by, date and and Treatment Place): *(List)* _____

WORKERS' COMP INFORMATION

Resp Employer: _____ Work Ph.: _____
Mailing Address: _____
City State Zip

Workers' Comp Ins Co.: _____ Phone: _____
Mailing Address: _____
City State Zip

Adjuster: _____ Approved: _____
Phone: _____ Spoke with: _____
Claim #: _____ Any testing: _____

Patient's Attorney: _____ Phone: _____
Mailing Address: _____
City State Zip

Completed by: _____ Date: _____

OFFICE USE ONLY

Refer to **User Guide: Workers' Compensation Accounts and Claims.**