Baton Rouge Clinic Urgent Care

7479 Perkins Road
Baton Rouge, LA 70808
(225) 246-9997

Dear Prospective Patient:

Thank you for your interest in Baton Rouge Clinic Urgent Care. 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.

To help speed your visit at BRCUC and return you on the road to good health as quickly as possible, we ask that you print out and complete this entire document prior to your arrival. We also ask that you be prepared to provide a driver's license and insurance identification card when you arrive.

We look forward to seeing you.

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Patient Billing Acknowledgement

Insurance/Billing

On August 21, 1996, President Clinton Signed the Health Insurance Portability and Accountability Act, known as HIPAA. This law impacts all areas of the health care industry and was designed to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality and security or heath care information.

A major concern in the law was the security and privacy of electronic health records and their transmission between health care entities. The security consists of more than just firewalls – organizations must ensure the confidentiality and integrity of their health records, and transmission of data must be authenticated and have the property of non–repudiation. Additionally, security policies and procedures must be documented and implemented. Baton Rouge Urgent Care has taken a number of technological and administrative steps in order to protect such data. Baton Rouge Clinic Urgent Care has a policy requiring all employees to read and sign a confidentiality agreement. This agreement states that the employee understand that we process confidential data and that the employee agrees not to directly or indirectly disclose any information in an inappropriate manner. Baton Rouge Clinic Urgent Care aggressively enforces this and other agreements applicable to confidential data. Confidentiality obligations are also an integral part of our business and trading partner agreements with entities to which we transmit transactions or from which we receive transactions, such as clearinghouses. Baton Rouge Clinic Urgent Care will neither pursue not knowingly retain a customer relationship with an entity that is either unwilling or unable to concur with reasonable privacy and confidentiality obligations.

Baton Rouge Clinic Urgent Care recognizes that the transfer of medical data must be carried out in a manner that minimizes the risks of inappropriate disclosure and that safeguards the privacy and confidentiality of data that may identify individuals in their roles as patients and consumers. Baton Rouge Clinic Urgent Care corporate policy is to observe all existing state and federal laws and regulations relating to the transmission, storage, and access to records and other health care data, and to maintain the security and confidentiality of patient-specific information.

The physicians of this office are contracted with many of the local and national managed care plans. However, there are some plans that we don 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.

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 Baton Rouge Clinic Urgent Care, 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.

Patient Information Sheet

Patient Information

MRN (Epic) _____

Legal Name _____ Preferred Name _____ Date of Birth # _____
Last *First* *Middle*

Sex: M F Social Security # _____ Other Known Name(s) _____
Please list names used in the past 24 months.

Mailing Address _____ City _____ State _____ Zip _____

Parish _____ Country _____ □ Permanent Address □ Temporary Address

Please mark the box (□) next to the phone number you wish to use as your primary contact number for automated calls and appointment notifications.

Home Phone □ _____ Work Phone □ _____ Mobile Phone □ _____

I wish to receive notifications in the form of a text message (SMS) to the mobile number listed above. □ Yes □ No

Email address _____

Primary Care Physician Name _____ Location _____ Office Phone _____
City, State

If Patient is a minor, list person(s) to contact regarding medical information.

Name _____ Hm Ph _____ Wk Ph _____ Mobile _____ Relationship _____
Name _____ Hm Ph _____ Wk Ph _____ Mobile _____ Relationship _____

Emergency Contact: Person to contact in case of emergency.

Name _____ Hm Ph _____ Mobile _____ Relationship _____

Patient Employment Status *(circle one)* Disabled | Full Time | Part Time | Not Employed | Self Employed | On Active Military Duty | Retired
Student – Full Time | Student – Part Time | Unknown

Employer _____ Employer Phone _____ Employer Fax _____

Employer Address _____ City _____ State _____ Zip _____

Marital Status: *(circle one)*
Married
Divorced
Legally Separated
Significant Other
Single
Widowed
Other_____

Language: *(circle one)*
English
Spanish
Other _____

Hearing Impaired Patients-Interpreter Needed: *(circle one)*
No
Yes

Ethnicity: *(circle one)*
Hispanic or Latino
Not Hispanic or Latino
Unknown
Decline to Answer

Race: *(circle one)*
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian
White or Caucasian
Decline to Answer
Other_____

Responsible Party Information (*Guarantor*)

□ The Responsible Party (Guarantor) for the account is the same as the patient above.

Complete the following if the patient is under 18 years of age and/or the Responsible Party is someone other than the patient.

Legal Name _____ Preferred Name _____ Date of Birth # _____
Last *First* *Middle*

Sex: M F Social Security # _____ Other Known Name(s) _____
Please list names used in the past 24 months.

Mailing Address _____ City _____ State _____ Zip _____

Home Phone □ _____ Work Phone □ _____ Mobile Phone □ _____
Please mark the box (□) next to the phone number you wish to use as your primary contact number.

Relationship to Patient _____ **Employment Status** *(circle one)* Disabled | Full Time | Part Time | Not Employed | Self Employed
On Active Military Duty | Retired | Student – Full Time | Student – Part Time | Unknown

Employer _____ Employer Phone _____ Employer Fax _____

Employer Address _____ City _____ State _____ Zip _____

Updated 02/15/2017

Policy Holder Information (Subscriber)

□ The Patient is the Policy Holder of the Insurance.
□ The Responsible Party (Guarantor) for the account is the Policy Holder of the Insurance.

Policy Holder Name on Card _____ **Covered Through** *(circle one)* Current Employer | Retirement | COBRA/Cont of Benefits | Other

Complete the following if the Policy Holder for the insurance is someone other than the patient or the responsible party on the reverse side.

Legal Name _____ Preferred Name _____ Date of Birth # _____
Last *First* *Middle*

Sex: M F Social Security # _____ Other Known Name(s) _____
Please list names used in the past 24 months.

Mailing Address _____ City _____ State _____ Zip _____

Home Phone □ _____ Work Phone □ _____ Mobile Phone □ _____
Please mark the box (□) next to the phone number you wish to use as your primary contact number.

Relationship to Patient _____ **Employment Status** *(circle one)* Disabled | Full Time | Part Time | Not Employed | Self Employed | On Active Military Duty | Retired | Student – Full Time | Student – Part Time | Unknown

Employer _____ Employer Phone _____ Employer Fax _____

Employer Address _____ City _____ State _____ Zip _____

Patient Insurance Information

Primary Coverage

Insurance Company _____

Ins Address _____

City _____ State _____ Zip _____

Phone _____ Effective Date _____

Policy Holder _____ Relation to Patient _____

Ins ID # _____ Group # _____

Patient Name on Card _____

Covered Through *(circle one)* Current Employer | Retirement | Other COBRA/Cont of Benefits

Secondary/Supplemental Coverage

Insurance Company _____

Ins Address _____

City _____ State _____ Zip _____

Phone _____ Effective Date _____

Policy Holder _____ Relation to Patient _____

Ins ID # _____ Group # _____

Patient Name on Card _____

Covered Through *(circle one)* Current Employer | Retirement | Other COBRA/Cont of Benefits

Patient / Guarantor Disclosures

By initialing next to each item below and signing and dating the bottom of this form, I agree to the following:

Consent to Treatment
_____ I consent to and authorize treatment by The Baton Rouge Clinic.

HIPAA Acknowledgement
_____ I acknowledge that I have received a copy of the 'Notice of Privacy Practices'.

Authorization and Assignment
_____ I authorize The Baton Rouge Clinic to release medical information that may be necessary to request claim reimbursement from insurance companies to whom claims may be submitted. I also assign claim payments including major medical benefits to be made payable to The Baton Rouge Clinic. I understand The Baton Rouge Clinic will refund to me any overpayment upon request, regardless of insurance. This authorization and assignment may be revoked by me at any time by a written notice.

Financial Responsibility
_____ I understand I am responsible for co-payment and deductible amounts at the time service is rendered as well as any amount not covered by insurance.

Notifications
_____ I consent to receiving automated calls and/or messages for appointment reminders and other pre-recorded notifications.
_____ I consent to receiving text messages for appointment reminders sent to the mobile number listed above.
Note: Email notifications can be set up in the 'Preferences' section of your MyChart account.

Signed _____ Date _____