## Patient Demographic and Insurance Intake Form

Last Name: _____ First name: _____ MI: _____

DOB: _____ SS #: _____ Sex: _____ Marital Status _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____@_____ Referred by: _____

Primary Care Physician Name and Phone: _____

Pharmacy Name and Phone No.: _____

## Insurance Information

Primary Insurance Co: _____ ID #: _____ Grp #: _____

Secondary Ins Co: _____ ID #: _____ Grp #: _____

Policy Holder name: _____ ID #: _____

Policyholder DOB: _____ Policy holder address: _____

Policyholder SS #: _____ Policyholder Sex: _____ Copay Amount: _____

## Patient Authorization

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services rendered.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor) _____ Date: _____

## Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor) _____ Date: _____

# HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

| | | |
|---|---|---|
| May we phone, email, or send a text to you to confirm appointments? | YES | NO |
| May we leave a message on your answering machine at home or on your cell phone? | YES | NO |
| May we discuss your medical condition with any member of your family? | YES | NO |

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

# Disclosure of Financial Interest Form

Jayme Trahan, MD PLLC
99 West Martial Ave
Lafayette, La 70508

DISCLOSURE OF
FINANCIAL INTEREST
As Required by R.S. 37:1744 and
LAC 46:XLV.4211-4215

Date: _____ Patient Name: _____

Patient Address: _____

Louisiana law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to a facility in which the physician has a significant financial interest. Jayme Trahan, MD is referring you, or the named patient for whom you are legal representative, to:

Lafayette General Surgical Hospital
1000 West Pinhook
Lafayette, La 70503

For the purpose of Surgical Treatment

Jayme Trahan, MD has a financial interest in the facility to whom he is referring you, the nature and extent of which are as follows:

Physician ownership

PATIENT ACKNOWLEDGEMENT

I, the above-named patient, or legal representative of such patient, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

_____
(Signature of Patient or Patient's Representative)