# ACADIANA URGENT CARE CENTER
## Reason for Visit and Medical History

*We can not see any motor vehicle accidents! (Including automobiles, motorcycles, ATV's, dirt bikes, and golf carts)*

Patient Name: _____ Reason for Visit: _____

Date of Birth: ____/____/____ **Outside of the Country in the last 6 weeks?** Y/N **Work Related Injury?** Y/N

Please check all that apply to you (conditions you have been diagnosed with and/or being treated for):

____ Acid Reflux ____ Depression ____ Heart Attack ____ Kidney Disease

____ Asthma ____ Diabetes: Type I Type II ____ High Blood Pressure ____ Stroke

____ Cancer Type: _____ ____ High Cholesterol ____ Hypothyroid

Drink Alcohol (amount/freq) ____/____ Smoke (amount/freq) ____/____ Do you use an E-cigarette? Y / N

Current Medication? Y / N (list) _____

Preferred Pharmacy & Location _____

Previous Surgeries & Dates? Y / N (list) _____

Medication Allergies? Type of reaction (rash, itching, etc.)
(list) _____

Other Medical History: _____

*****WE CANNOT SEE ANY MOTOR VEHICLE ACCIDENTS*****

**Please circle all that apply for TODAY'S visit**

| CONSTITUTIONAL | LYMPH | RESPIRATORY | MUSCULOSKELETAL |
|---|---|---|---|
| Change in Appetite | Bleeding | Chest Congestion | Joint Pain |
| Chills | Bruising | Cough | Muscle Pain |
| Fatigue/weakness | Frequent Infection | Shortness of Breath | Swelling |
| Fever | Nodes/Glands | Snoring | Aches/Pains |
| Sweating | **EYES** | Wheezing | Back Pain |
| **CARDIO** | Blurry Vision | **GI** | **SKIN** |
| Chest pain/pressure | Contact Lens/Glasses | Abdominal pain | Itching |
| Fainting | Double Vision | Blood in Stool | Laceration |
| Fluttering/palpitation | Eye Discharge | Constipation | Redness |
| Leg Swelling | Eye Pain | Diarrhea | Skin Sores |
| **NEURO** | Eye Redness | Nausea | Bruised |
| Headache | Eyelid Swelling | Urinary/Bowel Changes | **ALLERGY/IMMUNOLOGY** |
| Loss of consciousness | **ENT/MOUTH** | Vomiting | Itchy Eyes |
| Light-headedness | Loss/Change in Taste/Smell | **GU** | Lip Swelling |
| Numbness | Difficulty Swallowing | Blood in Urine | Tongue Swelling |
| Poor Balance | Dizziness | Urinary Frequency | Postnasal Drip |
| Weakness | Ear Pain | Painful Urination | Rash |
| **PSYCHIATRIC** | Hoarseness | Vaginal Itching/Discharge | Sneezing |
| Anxiety | Mouth Pain | | |
| Depression | Nasal Congestion | | |
| Sleep Difficulties | Nasal Discharge | | |
| | Sore Throat | | |

**Rapid Lab Results**

| STREP | FLU A | FLU B | COVID |
|---|---|---|---|
| | | | |

**Females Only**: Date of last menstrual cycle: _____ Taking birth control? Y / N Are/Could you be pregnant? Y / N

4906 Ambassador Caffery Parkway
Bldg. C, Suite 350
Lafayette, LA 70508
(337) 981-4675

# ACADIANA URGENT CARE CENTER

## Patient Consent for Treatment

Patient Name: _____ DOB: __/__/__

Phone Number: _____

Emergency Contact Name & Relation to Patient: _____

Emergency Contact Number: _____

I consent to treatment for myself or above minor. I understand that the examination and/or medical treatment I will receive is NOT intended to replace complete medical care by my personal primary care physician. I am aware that I will be responsible for any co-payment, deductible, co-insurance payment in full at the time of service. Any pre-certification requirements that my insurance company requires is my responsibility to make. Furthermore, I allow Acadiana Urgent Care (AUC) to accept assigned payments made by my insurance company on my behalf. I understand that any lack of payment in full and/or if my insurance denies payment, I am responsible for payment in full for all services rendered. My failure to pay may result in collection proceedings. In addition, I authorize AUC to release any and all information related to my treatment at this clinic to my primary care physician or specialty referral.

Patient Signature (parent if minor) _____ Date ____/____/____

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## PLEASE PROVIDE ADDRESS AND INSURANCE POLICY INFORMATION BELOW:

**Patient Address:** _____ **Apt/Lot:** _____ **Home (___) ___-_____**

**City:** _____ **State:** _____ **Zip:** _____ **Cell (_____) _____**

**E-mail:** _____

### Insurance Policy Holder Information

**Policy Holder (Name):** _____ **M / F**

**Relationship to patient:** _____ **Policy Holder's DOB:** _____/_____/_____

**PLEASE FILL OUT PAPERWORK TO ENTIRETY BEFORE TURNING IN TO THE FRONT DESK.**
**WE NEED THIS INFORMATION AT EVERY VISIT.**

**THANK YOU!**

**EMAIL: INFO@ACADIANAURGENTCARE.COM**

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

**Our Legal Duty:** We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect.

**Uses and Disclosures of Health Information:** We use and disclose health information about you for treatment, payment, and healthcare operations.

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you

**Healthcare Operations:** we may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement, activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the patient rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required by law to do so.

# INSURANCE/BILLING POLICY

Our physicians are contracted with many of the local and national insurance plans. However, there are some plans that we do not currently contract with as participating providers. If you belong to such a plan, our 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 denied. It is important for you to understand that the patient is ultimately responsible for the fees that are not covered by the plan in this case. If you have any questions concerning the benefits/coverage your plan provides, please call the member relations department of your plan.

**Insurance Patients**: It is your responsibility to keep us updated with your correct insurance information. It is your responsibility to understand your benefit plan with regard to, covered services and participating providers, including laboratories. For example, not all plans cover annual physicals, sports physicals, or hearing and vision screenings. If these services are not covered, you will be responsible for payment. It is your responsibility to know if a written referral or authorization is required to see a specialist, whether preauthorization is required prior to a procedure, and what services are covered.

**Non-Covered Services:** Your insurance company will only pay for services that it determines to be a covered benefit. If your insurance company determines that a particular service is not a covered benefit, your insurance company will deny payment for that service. The responsible party will be responsible for any durable medical equipment (splints, crutches, ace wraps, and etc.) and medications not covered by the insurance plan or any services applied towards the deductible. If my insurance company denies payment, I agree to be personally and fully responsible for payment to Acadiana Urgent Care **(AUC).**

**Insurance Payments:** If applicable, due to your insurance plan, we will collect a deposit today. We anticipate a discount for our contractual allowance, so this payment today reflects only a portion of your total charges.

Our billing office will file a medical claim for your visit today. If you have a balance due after your claim is processed, you will receive a bill from our office. However, if you are due a refund because of a possible overpayment, you may request to receive a refund. If you have any questions regarding your bill, please contact our billing office, Gulf South Healthcare Management. A representative from the billing office can be reached Monday-Thursday, 8:30am – 4:30pm,
at 504-210-0890 or toll free at 855-899-2455.

**Assignment Of Benefits**: I hereby assign to **AUC** any insurance or other third-party benefits available for health care services provided to me. I understand that **AUC** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **AUC**, I agree to forward to **AUC** all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

**Tricare Referral Requirement:** Urgent Care Services are covered when required for illness or injury that would not result in further disability or death if not immediately treated, but does require professional attention and has the potential to develop into such a threat if treatment is delayed longer than 24 hours. Urgent Care Services for TRICARE Prime, TRICARE Prime Remote (TPR), and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) beneficiaries should be provided by their assigned primary care manager (PCM), unless the beneficiary has obtained a referral prior to the Urgent Care visit.

**Medicaid:** Our facility is not participating with Medicaid, even in the case that it is a secondary insurance. You will be responsible for the remaining balance after the primary insurance has paid.

**I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH A COPY OF NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW HEALTH INFORMATION ABOUT ME, AS A PATIENT OF THE CENTER, MAY BE USED OR DISCLOSED AND HOW I CAN GET ACCESS TO THIS INFORMATION. I HAVE READ AND UNDERSTAND THE ACADIANA URGENT CARE INSURANCE INFORMATION/BILLING POLICIES.**

Patient / Guardian Signature _____ Date _____