

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	Rapid Lab Results STREP FLU A FLU B COVID	
Depression	Nasal Congestion		
Sleep Difficulties	Nasal Discharge		
	Sore Throat		

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



PATIENT INFORMATION

(Patient's Information as it Appears on the Insurance Policy)

First Name: _____ Last Name: _____ MI: _____ DOB: ____/____/____
Gender: M / F SSN: _____ - _____ - _____ Home Phone: (____) _____ - _____
Mailing Address: Street: _____ Apt _____ Cell Phone: (____) _____ - _____
City: _____ State: _____ Zip: _____ Email: _____ @ _____
Preferred Language: _____
Race: Native American Indian / Asian / African American / Native Hawaiian / White / Other
Ethnicity: Hispanic or Latino / Not Hispanic or Latino
Emergency Contact Name: _____ Phone: (____) _____ - _____ Relationship: _____

INSURANCE INFORMATION

Policy Holder Information/Responsible Party

Name: _____ Relationship to Insured: _____ M / F
DOB: ____/____/____ SSN: _____ - _____ - _____ Cell Phone: (____) _____ - _____
Address (If different from above): _____

Additional Insurance Information (Secondary Insurance):

Name: _____ Relationship to Insured: _____ M / F
DOB: ____/____/____ SSN: _____ - _____ - _____ Cell Phone: (____) _____ - _____
Address (If different from above): _____

ACADIANA URGENT CARE EMAIL: info@acadianaurgentcare.com

Treatment Consent/Policies and Procedures

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 agency proceedings and fees for which I will be responsible. 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. No refunds on services once they are rendered.

Acadiana Urgent Care is a privately owned Facility with no Hospital/Surgical Center affiliation.

As an independent Urgent Care Facility, our Physician Owners implement their own Medical Policies and Procedures on medical services performed here. **Our policy on any type of COVID testing requires an evaluation/management (office visit) on every lab testing order and will be billed to your insurance carrier.**

We understand many insurance carriers are informing patients that COVID testing is covered at 100%, but that may not include the additional Professional Services fees (office visits).

Some COVID testing is not payable by insurance when determined not medically necessary, such as testing for travel, return to work, and/or pre-operative procedures.

We can never guarantee how a claim will process or determine what will/will not be paid by your insurance carrier. We are happy to file an insurance claim on your behalf to the Carrier you provide to our billing office.

Your health is important to us, and we THANK YOU for choosing Acadiana Urgent Care Center for your medical care!

Patient Signature: _____ (Parent/Guardian if Minor) Date ____/____/____

NOTICE OF PRIVACY PRACTICES – Acadiana Urgent Care

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 your 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 you 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 judgment 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 about 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 by the plan in this case, 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 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, etc.) and medications not covered by the insurance plan, or any services applied toward 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 may reflect 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 billing 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, 8:30 am – 4:30 pm 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 healthcare 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 not 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 THE 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 Signature: _____ (Parent/Guardian if Minor) Date ____/____/____