PLAQUEMINES MEDICAL CENTER

27136 Highway 23
Port Sulphur, LA 70083
Phone: 504-564-3344 Fax: 504-564-0174

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Preferred Pharmacy:	Email Address:	Birth Date:	Race:	Age:	Sex: □ M □ F

Street Address:	Social Security No.:	Home/Cell Phone No.: ( )

P.O. Box:	City:	State:	Z Code:

Occupation:	Employer:	Employer Phone No.: ( )

Is this visit the result of an accident? Yes or No Did this accident occur at work? Yes or No Are you a new patient? Yes or No

REASON FOR TODAY'S VISIT:

INSURANCE INFORMATION

Person responsible for bill:	Birth Date: / /	Race:	Home Phone No.: ( )

Address (If different):

Occupation:	Employer:	Employer Address:	Employer Phone No.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance: ❑ Blue Cross/Blue Shield ❑ Medicaid ❑ United HealthCare ❑ LA HealthCare Connections ❑ Amerigroup ❑ Humana ❑ Medicare ❑ Other ❑ Aetna

Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Secondary Insurance:	Subscriber's Name:	Group No.:	Policy No.:

IN CASE OF EMERGENCY

Name of Relative or Friend:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Patient/Guardian signature: *Date:*

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Patient Name: _____ DOB: _____

Phone Number: _____ Email: _____

Is this visit work related? YES NO

I consent to treatment for myself or named minor child. I understand that the examination and/or medical treatment I receive is not intended to replace complete medical care by my personal primary care physician. I am aware that I will be responsible for my co-payment or a down payment at the time of service. Any pre-certification that my insurance company requires is my responsibility to make. Furthermore, I allow Plaquemines Medical Center to release treatment and billing information to my insurance company as requested to process my claim. I allow Plaquemines Medical Center to accept assigned payments made by my insurance company on my behalf. I understand that my lack of payment or if my insurance company denies payment, I am responsible for payment in full for services rendered. My failure to pay my result in collection proceedings. In addition, I authorize Plaquemines Medical Center to release to my primary care physician or specialty referral all information related to my treatment at this facility. I also consent to Plaquemines Medical Center to review my previous prescription history for treatment purposes. This consent is effective on the signature date and will remain in effect for one calendar year.

_____ _____

Patient signature (parent/guardian of a minor) DATE

_____ _____

Witness DATE

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "X" to indicate your answer)

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
	0	1	2	3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking slowly that other people could have noticed; of the opposite, being so fidgety or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Signature: _____ ☐ *Score:*

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that the Notice of Privacy Practices for Plaquemines Medical Center, which describes how health information about myself may be used or disclosed and how I can obtain access to this information is available for viewing and if requested, a copy of the practices will be provided.

_____ Patient/Guardian Signature	_____ Witness
_____ Print Name of Patient	_____ Patient's Date of Birth
_____ Date of Signature	_____ Date

FOR OFFICE USE ONLY:

Documentation of Failure to Obtain Signed Acknowledgement:

On _____, this Acknowledgement of Notice of Privacy Practices was presented to _____ (the Patient/Guardian). The Patient /Guardian refused to provide a signature when requested.

Privacy Officer :
Leslie R. Prest, Administrator
27136 Hwy. 23
Port Sulphur, LA 70083
(504) 564-3344