PLAQUEMINES MEDICAL CENTER
27136 HIGHWAY 23, PORT SULPHUR, LA
70083 PH: 504-564-3344 FAX: 504-564-0174
PLAQUEMINESMEDICALCENTER.COM

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:	Age:	Race:	Sex: ☐ M ☐ F
Mailing Address:		Social Security No.:			Home/Cell Number: ( )
City:	State:	ZIP 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: / /	Age:	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 friend or relative	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I CONSENT TO TREATMENT FOR MYSELF OR ABOVE MINOR CHILD. I AM AWARE THAT I WILL BE RESPONSIBLE FOR CO-PAYMENT OR FULL PAYMENT AT THE TIME OF SERVICE. ANY PRE-CERTICATION REQUIREMENT THAT MY INSURANCE COMPANY REQUIRES IS MY RESPONSIBILITY TO MAKE. FURTHERMORE, I ALLOW PLAQUEMINES MEDICAL CENTER TO RELEASE MY INSURANCE COMPANY TREATMENT AND BILLING INFORMATION 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 BY 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 MAY RESULT IN COLLECTION PROCEEDINGS. IN ADDITION, I AUTHORIZE PLAQUEMINES MEDICAL CENTER TO RELEASE ANY INFORMATION PERTAINING TO MY TREAMENT TO A SPECIALITY REFERRAL FOR FURTHER TREATMENT. IN THE EVENT OF NON PAYMENT OF PATIENT RESPONSIBILITY, LATE FEES MAY APPLY.

Patient/Guardian signature *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 over eating	☐	☐	☐	☐
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	☐	☐	☐	☐

Total Score: ☐

PLAQUEMINES MEDICAL CENTER

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been offered a copy of the Notice of Privacy Practices for the Practice of Plaquemines Medical Center, which describes how health information about myself may be used or disclosed and how I can obtain access to this information.

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

Documentation of Failure to Obtain Signed Acknowledgement:

On _____, this Acknowledgement of Receipt 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