



# PLAQUEMINES MEDICAL CENTER

8712 Highway 23

Belle Chasse, LA 70037

Phone: 504-226-2550 Fax: 504-226-2553

PATIENT INFORMATION							
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital status (circle one)		
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid		
Preferred Pharmacy:	Email Address:		Birth Date:	Race:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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							
<b>REASON FOR TODAY'S VISIT:</b>							
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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance: <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Medicaid <input type="checkbox"/> United HealthCare <input type="checkbox"/> LA HealthCare Connections							
<input type="checkbox"/> Amerigroup <input type="checkbox"/> Humana <input type="checkbox"/> Medicare <input type="checkbox"/> Other <input type="checkbox"/> Aetna							
Subscriber's Name:		Subscriber's S.S. No.:		Birth Date:	Group No.:	Policy No.:	Co-payment:
				/ /			\$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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: Relation to patient:						Date:	



## INFORMED CONSENT

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Is this visit work related?    YES            NO            (if yes, please read the addendum below)

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 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.

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.

**WORK-RELATED:** In the event this encounter is work related and another entity is responsible for the payment, billing statements will be sent accordingly. I am only responsible for work-related visits if Workers' Compensation denies the claim and my employer is not responsible for payment of services rendered. Plaquemines Medical Center may submit a claim to my insurance in this instance.

\_\_\_\_\_  
Patient signature (parent/guardian of a minor)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Printed name of patient or parent/guardian

\_\_\_\_\_  
Relation to patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
DATE



# PLAQUEMINES MEDICAL CENTER

## 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.

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient Signature (parent/guardian if a minor)

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Relation to patient

\_\_\_\_\_  
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  
8712 Highway 23  
Belle Chasse, LA 70037  
(504) 226-2550



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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking slowly that other people could have noticed; of the opposite, being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature: \_\_\_\_\_

Score: