Registration Form

Date:_____ Primary Physician ___ Michael McCormick, MD

Name:_____ ___ Steven McMahan, MD

First Middle Last Suffix (Jr., Sr., etc) ___ Mark Dollar, MD

What name do you go by?_____ ___ Joe Byron Henry, MD

Home phone:_____ **Date of birth**:_____

Cell phone:_____ **Social Sec #**:_____ **Sex:** Male / Female

Email:_____ (necessary to set up access to online portal)

Address:_____

Street/PO City State Zip

Employer:_____Phone:_____Position:_____

Emergency contact:_____

Name work phone Other phone

How would you like to be reminded of appointments? (Text, call, email)_____

Insured Name _____ **Insured DOB** _____

Insured Social Security number _____ **Insurance name** _____

Insured Employer_____

Additional Information (optional): please circle

Race: American Indian/Alaska native, Asian, Native Hawaiian/Pacific Islander, Black/African american, White, Hispanic, Other, Refuse to answer

Ethnicity: Hispanic, Non-Hispanic, Refuse to answer

Language: English, Indian, Spanish, Russian, Other

Insurance Assignment and Release

I certify that I have given and will continue to update the clinic with correct insurance information and assign directly to West Monroe Family Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of my signature on all insurance submissions. The above-mentioned clinic may use my healthcare information and may disclose such info to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date below.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to West Monroe Family Clinic for any services furnished to me by this provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine benefits or benefits related services.

_____ _____

Signature of Patient or Representative Printed name of Patient or Representative

_____ _____

Date today Relationship to Patient

West Monroe Family Clinic, A.M.C.
PO Box 1260
West Monroe, LA 71294-1260

1900 N 7th St, West Monroe; 318-651-7000
1117 Cheniere Drew Rd., West Monroe; 318-329-4370
3995 Sterlington Rd, Monroe; 318-329-9447

Policy Statement and Acknowledgement

Our goal is to provide and maintain a good physician patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to better serve you.
Please read each section carefully and initial, and ask staff if you have any questions. Thank you.

Appointments:

1) We set aside time to evaluate and treat just you, and do not double book appointments. Because we also value our time, we ask for a **24hr notice if you are unable to keep your appointment.** We reserve the right to institute a $25 charge for missed appointments.
2) If you are late for your appointment, we will attempt to accommodate you with advancing you to the next available open slot, if exists.
3) We will strive to minimize any wait time, but ultimately we will provide the best care to our patients, and occasionally we will run later if priorities dictate. You, as always, may inquire about any wait.

Initials_____

Insurance Plans:

1) We will estimate your benefits and file to insurance as a courtesy, but it is your responsibility to make sure we **have all the correct insurance information** to do so (card copy, SS#, address, name, etc). We will make every attempt to collect the applicable copay/deductible portion at the time of service, but know that this estimate may be adjusted by the insurance company resulting in a refund or billed balance.
2) If we do not participate in your insurance plan, payment will be assessed in full at the time of service, and you will be provided with an invoice to submit to insurance requesting reimbursement.
3) It is your responsibility to know your benefits. Please call ahead to see if your desired service is covered (mole removal, xray, etc.), if there is a pre-authorization or preapproval required, and if there is a preferred vendor (what laboratory is preferred).
4) We will make an effort to guide you, but it is your responsibility to know which specialists participate in your plan.

Initials_____

Financial responsibility:

1) $25 additional service fee for "insufficient funds" on checks.
2) Any remaining balance will be billed to you upon our receiving of an EOB from insurance, and bill will be mailed to you. Payment remittance will be due within 10 business days.
3) If no payment or correspondence after 3 mailed statements, we will attempt to call you. If unable to resolve, we reserve the right to use a collection agency, which will charge an additional collection fee of 50%, to resolve the matter. This letter will be our final attempt to contact you directly.
4) **Your estimated copay/deductible payment is due at the time of service without exception.** For non-covered services or self-pay, this will be 100% of charges.
5) We reserve the right to refuse any/all further service (including office visits) until outstanding balances are paid.

Initials_____

Non insurance covered items:

1) All forms not covered by insurance (physicals, DOT/CDL, merchant marine, handicap placard, FMLA, etc.) will be subject to a cash pay charge. Please inquire if applicable.
2) Letters written will also incur a charge, and vary in price based on the detail and research needed.

Initials_____

Transfer of records

1) We will provide you with a summary of the last office visit free of charge if needed, upon 7 day notice.
2) A copy of entire record is available for $1/pg for first 25pgs, and %0.50/pg for pages 26-500.

Initials_____

Patient name_____ Date of Birth_____

Signature _____ Date_____

Responsible party name and relationship_____

Responsible party signature_____

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Patient Medical History (2 pages)

Patients name:

Date of birth:

Past Medical history:

- ◯ AIDS/HIV
- ◯ Alcoholism
- ◯ Anemia
- ◯ Anorexia
- ◯ Arthritis
- ◯ Asthma
- ◯ Bleeding disorder
- ◯ Breast lump
- ◯ Bulimia
- ◯ Cancer type:_____
- ◯ Cataracts
- ◯ Diabetes

Year diagnosed:_____

- ◯ Emphysema/COPD
- ◯ Epilepsy/Seizures
- ◯ Glaucoma
- ◯ Gout
- ◯ Heart disease
- ◯ Heart attack

when:_____

Stents: #__, when_____

- ◯ Hepatitis
- ◯ Hernia
- ◯ Herpes
- ◯ High cholesterol
- ◯ Kidney disease
- ◯ Liver disease
- ◯ Migraines
- ◯ Multiple Sclerosis
- ◯ Pacemaker
- ◯ Recurrent pneumonia
- ◯ Polio
- ◯ Prostate problem
- ◯ Psychiatric problem

what:_____

- ◯ Stroke when:_____
- ◯ Suicide attempt
- ◯ Thyroid problems
- ◯ Tuberculosis
- ◯ Stomach Ulcers
- ◯ High Blood Pressure

Questionnaire: Do you have any of the following symptoms?

- ◯ ear fullness
- ◯ chest congestion
- ◯ cough
- ◯ dizziness
- ◯ chest pain
- ◯ palpitations
- ◯ shortness of breath
- ◯ weight gain
- ◯ fever
- ◯ rash
- ◯ weight loss
- ◯ sore throat
- ◯ sinus pain
- ◯ abdominal pain
- ◯ diarrhea
- ◯ constipation
- ◯ blood in stool
- ◯ low back pain
- ◯ joint stiffness
- ◯ joint pain
- ◯ joint swelling
- ◯ headache
- ◯ tingling/numbness
- ◯ eye irritation
- ◯ blurring of vision
- ◯ depression
- ◯ anxiety
- ◯ frequent urination
- ◯ urinary incontinence

Medications:

Name	dose	Times per day	Name	dose	Times per day
1)			8)		
2)			9)		
3)			10)		
4)			11)		
5)			12)		
6)			13)		
7)			14)		

Pharmacy info:_____

Allergies: _____

Surgical History

Date	Surgeon	Type of surgery

Family history:

	Age (now or at death)	Medical problems (heart, cancers, strokes, diabetes, etc.) and/or cause of death
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

Women: Last menstrual cycle:___/____/____ ; # pregnancies:_____ ; Contraceptive use:_____

Social History: Smoking Yes/No/quit If so: how long_____ packs per day_____
If quit: when_____ how much and how long did you smoke_____
Dipping Y/N
Alcohol Y/N on average week, how much_____
Employer: _____ Job Descript:_____
Are you: Married/Single/Divorced/Widowed(er)

Preventative Measures: (Some not applicable to everyone) (ok to approximate dates)
When was your last flu shot? _____
Tetanus shot_____
Pneumonia shot _____
Shingles shot (>54 only) _____
Colonoscopy: date_____ ; who did it_____; when scheduled next _____
Prostate exam: date_____; who_____
Mammogram: date_____; where done_____; result ok? (Yes / No)
Pap smear: date_____; by who_____; result ok? (Yes / No)
Bone density: date_____; where_____; result_____

Medicare patients only: Do you have a living will? (Yes / No)
Do you fall recurrently, or does your medical condition put you at high risk (Yes / No)