DEMOGRAPHICS INTAKE FORM

Hebert Medical Group, APMC

LOC: EU JE LA OE AE AJ AS PT

Acct #: ____________ ☐ ABN Form ☐ Accident/Injury Information Form Completed Date: ____________

P-INS Code: ________ S-INS Code: ________ F/C: ________ ☐ Request for Confidential Communications Attached

PATIENT INFORMATION

Prefix: Mr./Mrs./Other: ________ Patient*: ____________ (Last) ____________ (First) ____________ (Middle)

Suffix: Jr./Sr./Other: ____________ Previous Name: ____________

Mailing Address: ____________ (If PO Box, complete Street Address Below) ________ (City) ________ (State) ________ (Zip)

Street Address: ____________ ________ (City) ________ (State) ________ (Zip)

Home #: ________ Cell #: ________ Work #: ________ Ext: ________

Circle the preferred phone #/email contact. Leave message at what phone number? ☐ Home ☐Work ☐ Cell ☐ None

Email: ____________

Date of Birth*: ________ Marital Status*: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Social Security#: ________

Employer: ____________ Occupation: ____________

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ________ (MMDDYY) ☐ Military Active ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A Patient & Responsible Party are the same*? ☐ Yes ☐ No (complete below)

Race*: ☐ African American ☐ Caucasian/White ☐ Other: ________

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Preferred Language*: ☐ English ☐ Spanish ☐ Other: ________

☐ Provide copy of insurance card(s) to be scanned (if not, complete below) Do you have well care/preventative coverage for annual exams: ☐ Yes ☐ No

Primary Insurance: ____________ Secondary Insurance: ____________

Primary Ins Policy #: ____________ Secondary Ins Policy #: ____________

Group #: ____________ Group #: ____________

Policy Holder's Name: ____________ DOB: ________ SS#: ________

RESPONSIBLE PARTY INFORMATION

ONLY COMPLETE IF OTHER THAN PATIENT (NOT SELF), THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION

Prefix: Mr./Mrs./Other: ________ Responsible Party: ____________ (Last) ____________ (First) ____________ (Middle)
(Employer Info if work related)

Suffix: Jr./Sr./Other: ________ Relationship to Patient: ____________ Social Security #: ________

Mailing Address: ____________ (If PO Box, complete Street Address Below) ________ (City) ________ (State) ________ (Zip)

Street Address: ____________ ________ (City) ________ (State) ________ (Zip)

Home #: ________ Cell #: ________ Work #: ________ Ext: ________

Date of Birth*: ________ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Email: ____________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ________

Employer: ____________

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Disabled ☐ Retired ☐ Military Active ☐ Not Employed

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☐ Request for Confidential Communications Attached

Patient Name: ____ Date of Birth: ____________________

How were you referred to our practice: ☐ Friend/Relative ☐ Newspaper ☐ Radio ☐ Healthsource ☐ Other: ______________

☐ Referred Physician: ______________________________ Phone #: ______________________

Primary Care Provider (PCP): ____________________ Address: ______________________ Phone: ______________

Is this an Accident or Injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No

If 'Yes' to either question, request and complete an Accident/Injury Information Form (Rec'd by): (Date):

Do you have an Advanced Directive (living will, durable power of attorney)? ☐ Yes ☐ No

If 'Yes', provide copy. Rec'd by: Date:

Are you or have you been incarcerated within the last year? ☐ Yes ☐ No

If 'Yes', please provide: Facility Name: ______________________________ Release Date: ____________

By signing this form, I hereby acknowledge Hebert Medical Group (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the Notice of Privacy Practices for Protected Health Information (NOPP). I understand I have the right to restrict how my PHI is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

If below is not signed by the patient, please indicate relationship:

☐ Parent or Guardian of minor patient; ☐ Power of Attorney, Turix, Curator or Designated Personal Representative

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_________ (Initial) I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of HEBERT MEDICAL GROUP, APMC.
Acknowledgement refused:
Efforts to obtain: ____
Reason for refusal: ____

_________ (Initial) I hereby acknowledge I have been provided with, read and understand the practice's 'No Show' policy and I understand that I will be charged the current fee for each no show appointment.

_________ (Initial) I hereby authorize Hebert Medical Group to evaluate and recommend any testing and/or additional treatment from other facilities, i.e., labs; who will in turn bill me for their services. I understand I have the right to refuse any such recommendations/treatment.

_________ (Initial) I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify all above information is true and accurate as of the below indicated date.

_________ (Initial) I hereby authorize the listed insurance companies to pay directly to Hebert Medical Group benefits due on my behalf, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance, i.e., my Out of Pocket (OOP) share.

_________ (Initial) I understand that any payment(s) made by me to Hebert Medical Group in the form of a check may be processed as an electronic check transaction; therefore, the funds will be debited immediately from my checking account.

_________ (Initial) I agree that Hebert Medical Group may contact me via any means that I have provided on the prior page of this form including but not limited to land lines, cell phones (text and mobile applications), and email, etc.

______________________________ ______________
Signature ☐ Patient ☐ Responsible Party Date

OFFICE USE ONLY Provide ABN for all potentially non covered services

HMG Staff: Scan to patient demographics 'eCW/INS' folder with copy of Insurance Card/Birth Certificate/Drivers License.

** = Required for eCW # = Interfaces to MEDPM*

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Patient Name: ______________________________ Date of Birth: ____________

EMERGENCY CONTACT: ______________________________ Relationship: ____________

Home #: ____________ Cell #: ____________ Work #: ____________ Ext: ______

Email: ______________________________

Any special instructions: ______________________________

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? ☐ Yes ☐ No

If 'Yes', office staff to assist in completing a Hospice/HHA/NH/SNF Facility Information Form.

☐ Hospice/HHA/NH/SNF Facility Info Form

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Note: If request initiated, assign Account Status: R - HIPAA Restricted (in ***MEDPM****); send copy to MEDDATA.*

Please list any person(s) other than yourself, and their relationship to you, that we may discuss your medical information with:

Person:	Relation:	Phone #:
1)		
2)		
3)		
4)		
5)		

Signature: ______________________ Date: ____________