OB/GYN Associates of Lafayette
Chart # ____________________
Date:______________________

Daniel R. Bourque, M.D., A.P.M.C.
Jordan M. Forsthoff, WHNP

Please Print Clearly

Demographic Information

Last ________________________ First _________________________ Middle _________

Maiden __________________________

Address ____

Zip __________ - ________ City ____________________________ St.______________

Birth Date ______/______/______ Social Security # ______/______/______

Student Status ______________________ Marital Status ______________________

Contact Information

Home # _______________ Cell # _______________ Work # ________________, Ext ___

Email Address ____

Language ____________________

Preferred Contact Method - (circle one) → Text Email Mail

Preferred Contact Number - (circle one) → Home Cell Work

Employment Information

Employer ____

Employer Phone # ____ Ext. _____________

Employment Status - Full-time Part-time Occupation ____________________________

Other Information

Race _____________________ Hispanic/Latino/Spanish - Yes or No

Emergency Contact ____

Emergency Phone ______________________________ Relationship _________________

Insured's Information

Last ________________________ First _________________________ Middle _________

Address ____

Zip __________ - ________ City ____________________________ St.______________

Gender ___ Date of Birth _____/_____/______ Social Security # ______/______/______

Marital Status ________ Home Phone ________________ Cell Phone ________________

Employer ____

Employer Phone ________________________ Ext ______ Employer Status ____________

Occupation____

HIPAA Information

If you are 18 or older, please list name(s) of individuals who may inquire about your healthcare and treatment. *(Note: This can be updated or changed at any time.) If none, please write NONE below and sign.*

Name________________________________ Relationship ____________________

Name________________________________ Relationship ____________________

Name________________________________ Relationship ____________________

Signature of Patient ___________________________ Date _________________

Please read carefully, sign and date

Acknowledgement of Notice of Privacy Practice - A copy of OB/GYN Associates of Lafayette's Notice of Privacy Practices is available to review at all times.

Consent For Use & Disclosure Of PHI for TPO - I hereby give my consent for OB/GYN Associates of Lafayette to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). This consent is valid until revoked by me in writing.

Consent For Medical Treatment - I authorize OB/GYN Associates of Lafayette to treat me for any illness related to my health and well-being.

Financial Agreement - I assume all responsibility for all obligations. I agree to pay all amounts for services rendered at time of service. I further agree that in the event it becomes necessary to place this account in the hands of a collection agency and/or attorney, I agree to pay any collection fee on the balance due and owing.

Assignment of Insurance Benefits - I authorize payment of medical benefits to Daniel R.Bourque, M.D., A.P.M.C. & Associates for services rendered.

State of Louisiana Medicare/Medicaid Programs - I authorize payment of medical services to Daniel R. Bourque, M.D., A.P.M.C. & Associates who has accepted assignment for my Medical benefits.

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Signature of Patient/Guardian Date

Physician Ownership Disclosure

In accordance with La.R.S.37:1744 and 42 CFR 489.20, please be advised that Dr. Bourque, Dr. Pugliese and Dr. Harper have ownership interest in Park Place Surgical Hospital (PPSH). You will be notified of the existence of the ownership interest by Dr. Daniel R. Bourque, Dr. Jennifer B. Pugliese and Dr. Nicole P. Harper's staff when the referral is made. If you have any questions about receiving care at PPSH, or objections to receiving treatment at PPSH, please let a nurse or your physician know.