Daniel R. Bourque, M.D., A.P.M.C.

Jennifer B. Pugliese, M.D. **Nicole P. Harper, M.D.**

Please Print Clearly

Patient Information Form

Chart #	***Date***

First_____ Last _____ Middle _____

Address _____ City _____ St. _____ Zip _____

Birth Date _____/_____/_____ Social Security # _____/_____/_____ Driver's License # _____

Home # _____/_____/_____ Work # _____/_____/_____ Ext. _____ Cell # _____/_____/_____

Employer _____ Occupation _____

Marital Status _____ Race _____ Language _____

Hispanic/Latino/Spanish - YES or No Referred By _____

Email: _____

Insured's Information

Name _____ Social Security # _____/_____/_____

Address _____ City _____ St. _____ Zip _____

Birth Date _____/_____/_____ Employer _____

Emergency Contact Information

Name _____ Phone _____/_____/_____

Address _____ City _____ St. _____ Zip _____

If you are 18 or older, please list names(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.

	Name	Relationship	Date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

_____ _____

Signature of Patient Date

OB/GYN Associates of Lafayette

Daniel R. Bourque, M.D. - Jennifer B. Pugliese, M.D. - Nicole P. Harper, M.D.

Important Information

Please read carefully, sign and date all areas that apply

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.

_____

Signature of Patient/Guardian Date

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.

_____

Signature of Patient/Guardian Date

CONSENT FOR MEDICAL TREATMENT

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

_____

Signature of Patient/Guardian Date

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.

_____

Signature of Patient/Guardian Date

ASSIGNMENT OF INSURANCE BENEFITS

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

_____

Signature of Patient/Guardian Date

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 beneftis.

_____

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.