206 McMillan Rd
W Monroe, LA 71291
Phone: 318.350.6644
Fax: 318.600.4135

Diabetes Care Center of Louisiana

823 W. California Avenue
Ruston, LA 71270
Phone: 318.224.3044
Fax: 318.232.2978
www.diabetescarela.com

## PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____

Address: _____ City: _____ St: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ DOB: _____ Sex: Male Female

Email Address: _____ Marital Status: Married Single Widowed Divorced

Employer/School Name: _____Pharmacy: _____

RESPONSIBLE PARTY

Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

DOB: _____

Social Security #: _____

Email: _____

Employer: _____

Relationship to Patient: Self Spouse Parent Other

INSURANCE INFORMATION

Name of Insurance Company: _____

Name of Policyholder: _____

Policyholder Address: _____

_____

Home Phone: _____

Work Phone: _____ Cell Phone: _____

Policyholder DOB: _____ SS#: _____

Employer: _____

Policyholder ID#: _____

Group #: _____

Relationship to Patient: Self Spouse Parent

EMERGENCY/ALTERNATE CONTACT NUMBERS

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

How did you hear about us: ☐ Word of Mouth_____ ☐ Physician Referral _____

☐ Advertising/Newspaper ☐ Search Engine/Website ☐ Insurance Provider List

Assignment of Insurance Benefits: I hereby authorize Diabetes Care Center to provide medical care that is deemed necessary. I hereby authorize payment of benefits directly to Diabetes Care Center. I hereby authorize Diabetes Care Center to release any information necessary to process my claims. I acknowledge/understand that I am responsible for any charges incurred that my insurance does not pay for or cover for any reason whatsoever. I also acknowledge that if my account is turned over to a collection agency that I will be responsible for the collection fee towards my account. I also attest that the information that I have provided above is correct and truthful to the best of my knowledge.

Patient's/Guardian's Name: _____ Date: _____

# Diabetes Care Center

**AUTHORZATION AND CONSENT FOR MEDICAL TREATMENT, PAYMENT GUARANTEE, AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**CONSENT FOR MEDICAL TREATMENT**: As a patient of Diabetes Care Center, I understand that the office has an obligation to provide screening and emergency medical treatment when appropriate and to provide appropriate care and treatment of all patients. I hereby authorize DIABETES CARE CENTER, and its affiliated physicians and mid-level providers in charge of my case to administer any and all necessary or advisable treatments as may be deemed necessary or advisable in the diagnosis and treatment of any disease, disorder, or condition.

**ASSIGNMENT OF BENEFITS AND PAYMENT GUARANTEE:** I authorize DIABETES CARE CENTER to bill my insurance company or other designated third-party payer for the services provided as related to my care. I acknowledge that DIABETES CARE CENTER will file claims on my behalf as a courtesy and that I as guarantor of the account remain responsible for payment of services. I acknowledge that I am also responsible for deductibles, co-insurance amounts, co-payment amounts, and non-covered services. I/we agree to pay the established rates of the clinic for all services rendered for the patient named below. I also acknowledge that I am aware that DIABETES CARE CENTER may have policies for financial counseling and assistance.

**RELEASE OF MEDICAL INFORMATION FOR TPO**: I do hereby authorize DIABETES CARE CENTER to release medical or other information to any insurance companies involved or any other agency assisting in the payment for the patient's care. I understand that my information may be released by law for any activity related to the treatment, payment and operation activities related to my care. I also authorize the healthcare providers of DIABETES CARE CENTER to release medical and other information to other healthcare providers or facilities as needed for emergency treatment or continuity of care. Unless otherwise restricted by me, as patient or guardian, health information may also be released to immediate family members who are actively engaged in the management of my care. I acknowledge that I will need to authorize a more specific release of information if the HPI is to be used for reasons other than emergency treatment, payment and business operations.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT**: By signing this form, you acknowledge receipt of the notice of privacy practices of DIABETES CARE CENTER. Our notice of privacy provides information about how we may use and disclose your protected health information. We are required by federal law to obtain your acknowledgement that you have received this Notice. If you have any questions about our notice of privacy practices, please contact us at the above telephone number.

***THE UNDERSIGNED CERTIFIES HE/SHE HAS READ AND UNDERSTANDS THE ABOVE INFORMATION/AUTHORZATION. IT ALSO CERTIFIES YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES. THIS AUTHORIZATION/ACKNOWLEDGEMENT REMAINS IN FORCE UNTIL SUCH DATE THAT IT IS REVOKED OR REPLACED.***

Patient Signature:_____ DOB: _____

Print Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____