GRETNA MEDICAL CENTER

MDC# _____
(For office use only)

IMMIGRATION I-693
NEW PATIENT CHECK IN WORKSHEET

First Name:_____ Middle:_____ **Last:**_____

Date of Birth: ____/____/____ **SSN:**_____ **Sex:** ☐ Male ☐ Female

Home #: _____ **Cell #:** _____ **Email:** _____

By providing my email address, I authorize Gretna Medical Center to contact me via email regarding my medical care. I acknowledge the risk involved if my email is not secure.

Address: _____ **Apt/Suite:**_____ **City:**_____ **State:**_____ **Zip Code:**_____

Emergency Contact: _____ **Phone #:** _____ **Relationship:** _____

ATTORNEY INFORMATION

How did you hear about us? Friend/Family Attorney Drive-by Yelp Facebook Google Insurance Radio Ad

Attorney Name/Law Firm: _____

Law Firm Contact Name: _____

Phone #: _____

Email: _____

PARENT/ LEGAL GUARDIAN FOR PATIENTS UNDER 15

The patient's parent/legal guardian *(full name)* _____

Parent/legal guardian phone #: _____ Email: _____

GUARANTOR*(PERSON FINANCIALLY RESPONSIBLE FOR MINOR)*

Name: _____ DOB: _____ Relation:_____

Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip Code: _____

AUTHORIZATION & AGREEMENT

HIPAA Patient Consent

By signing below, I have read and fully understand the Patient Consent for Use and Disclosure of Protected Health Information, rev. 7/ 2016. I consent and agree to all of its terms and conditions. I understand copies of Gretna Medical Center's full Notice of Privacy Practices are available on request.

Patient Responsibility and Financial Policy Clause

By signing below, I have read and fully understand Gretna Medical Center's Patient Responsibility and Financial Policy. I accept and agree to all of its terms and conditions. Specifically, I understand that I am responsible for any medical treatment and medical equipment not covered by my insurance plan or applied towards my copay, coinsurance, and/or deductible. These services include, but are not limited to: Injections (administration fee & medicine), IV treatments and fluids (initial IV treatment, hydration, medicine, etc.), and durable medical goods (crutches, walking boots, splints, slings, ace wraps, etc.) I understand that balances may be assessed interest and collection fees. I understand that any overpayments may remain as a credit balance on my account, to be applied to future charges, unless I request a refund. Credit balances remaining will be handled per the Patient Responsibility and Financial Policy may be assessed inactivity fees and/or processing fees if sent to the Louisiana Secretary of State LSA R.S. 9:151 et seq.

Consent for Treatment

By signing below, I understand that I have a choice to be seen at Gretna Medical Center. I authorize Gretna Medical Center to provide medical treatment and services to me. I understand I am authorizing Gretna Medical Center to treat me while I seek care from Gretna Medical Center or until I withdraw my authorization in writing. I authorize Gretna Medical Center to request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Patient Signature: _____ **Date:** ____/____/____

I declare the above information is true. I authorize my insurance benefits to be paid to Gretna Medical Center. I understand that I am financially responsible for any charges that may not be covered by my insurance plan. I authorize my medical information to be released to my insurance company/ any of its affiliates for medical purposes and/or physician payments.