OB/GYN Associates of Lafayette
Chart # _____
Date: _____

Daniel R. Bourque, M.D., A.P.M.C.
Charles E. Padgett, Jr., M.D.
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 the 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 have accepted assignments for my Medical benefits.

_____

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 has ownership interest in Park Place Surgical Hospital (PPSH). You will be notified of the existence of the ownership interest by Dr. Daniel R. Bourque'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.