Pelican State Outpatient Center
1525 Dickory Ave. Harahan, LA 70123
Phone: (504) 818-0006 Fax: (504) 818-0095

Patient Information Form

PATIENT INFORMATION

Please save and print after filling out this form

Last Name	Suffix:	Date of Birth MM/DD/YYYY	Gender
First Name	MI	Prefix:	Social Security #
Address Line 1	Apt No.	Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced	
City	State	Zip	Country
Employer Name			
Home Ph#	Cell Ph#	Employment ☐ Full-Time ☐ Part-Time ☐ Retired	
Email Address		Student ☐ Full-Time ☐ Part-Time ☐ Not a Student	
Work Ph#	Ext #	Emergency Contact Name	
Pharmacy	Pharmacy Ph#	Emergency Contact Ph#	
		Emergency Contact Relationship	

INSURANCE INFORMATION

Primary	Secondary
Primary Insurance	Secondary Insurance
Policyholders Name	Policyholders Name
Date of Birth MM/DD/YYYY — Gender:	Date of Birth MM/DD/YYYY — Gender:
Phone Number	Phone Number
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

AUTHORIZATION FOR TREATMENT I hereby certify that the personal medical information submitted is correct and that I seek medical treatment from Pelican State Outpatient Center and its staff. I hereby authorize such treatment so deemed appropriate and necessary by the physician. All payments for medical services are expectedin full with no cancellation/refunds once the service(s) is provided.

WORKER'S COMPENSATION We must be able to verify and obtain authorization for all services rendered to patients covered by a worker's compensation insurer. If we are unable to verify coverage, you will be notified prior to the visit or procedure and full payment at time of service is expected.

LEGAL CASES You must pay before services are rendered, unless other arrangements are made in advance.

RELEASE OF INFORMATION I authorize Pelican State Outpatient Center to furnish information to insurance carriers, employers, referring physicians, or other medical consultants concerning the illness and treatments for myself or my dependents. I hereby authorize the above-listed insurance companies to pay directly to PSOC benefits due me, if any, as provided in the above unexpired policy. **I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENTS ON COPAYS, DEDUCTIBLES, CO-INSURANCE, ANY CHARGES AND/OR CLAIMS THAT ARE NOT COVERED AND/OR NOT PAID BY THE INSURANCE COMPANY WITHIN 60 DAYS.**

SIGNATURE ____________________ PRINTED NAME ____________________ DATE ____________

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HIPAA
Notice of Privacy Policy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

(See below for copy of HIPAA Policy)

Notice of Privacy Practices
This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty
We use and disclose health information about you for treatment, payment, and healthcare operations.
For example:

Treatment: We may use or disclose your health information to a physician or other healthcare providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, or with payment for your healthcare, but only if you agree that we may do so. Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (Including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person' involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

This acknowledges that I was given a copy of our Notice of Privacy Practices. Our Notice of Privacy Practices explains how we will use and/or disclose your health information. I have read the Notice and had the information of the Notice explained to me. At any time, you may request another copy of the Notice by contacting this office.

PATIENTS SIGNATURE	PELICAN REPRESENTATIVE
______________________________	______________________________