LSU HEALTHCARE NETWORK

REGISTRATION & CONSENT FORM

PATIENT INFORMATION

Name (Last, First, Middle Initial):		Social Security Number:	Date of Birth:
Address:	City:	State	Zip
Home Phone:	Work Phone:	Cell Phone:	
Email Address:		Employer:	
Primary Physician:		Referring Physician:	
Primary Insurance:		Primary Policy Holder's Name:	
Preferred Pharmacy:		Pharmacy Location (Street or general location and City):	
Legal Guardian (children under 18 and disabled adults):	Relationship:	Phone Number:	
Emergency Contact Name:	Relationship:	Phone Number:	

How did you hear about us?		Referred by Physician		Referred by Friend/Colleague		Web		Employer			
	Health Fair		Radio		Newspaper		TV		Phone Book		Brochure/Flyer		Other

Consent for Examination

I hereby consent to such examination procedures, as in the judgment of my physicians, may be considered necessary or advisable while a patient at the LSU Healthcare Network ("LSUHN"). I recognize that LSUHN manages teaching and research facilities, and that my treatment and care will be observed and in some instances aided by physicians and/or technicians under supervision.

Signature: _____ Date: _____

To Release Medical Information to Pay Insurance Benefits

I hereby authorize LSUHN and its physicians to release any and all information related to my treatment and care to my insurance carrier or carriers including Medicare and Medicaid if applicable. I also authorize and request that all insurance carriers, with which I have coverage, make payment directly to LSUHN for bills covering services rendered by its physicians. I further agree to pay all charges connected with this treatment not covered by any insurance. I may have and understand that insurance coverage does not release me form obligation to pay for non-covered services, co-payments and deductibles at the time of service. Copies of this agreement shall be as valid as the original signature on file at the LSU Healthcare Network.

Signature: _____ Date: _____

LSU
HEALTHCARE
NETWORK

Notice of Privacy Practices Acknowledgement Form

I have been provided with and read a copy of the LSU Healthcare Network's Notice of Privacy Practices.

Print Name of Patient | Date of Birth | Date

Signature of Patient or Legally Authorized Representative

Print Name of Personal Representative's Authority

LSU Healthcare Network Staff Member Witnessing Signature | Date

LSU Healthcare Network

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of the LSU Healthcare Network, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of the LSU Healthcare Network.

Name and relationship of person you wish to allow access – for example, your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:

Name of Person or Entity **Relationship**

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or, if the purpose of the disclosure is related to research, at the end of the research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the LSU Healthcare Network and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the LSU Healthcare Network's Privacy Officer at the Health Information Management Department. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Regardless of whether you provide us with this authorization, we will provide you with medical services or conduct payment operations. However, if your treatment is for any of the following purposes, we have the right not to provide you with medical services:

1. If your treatment is related to research
2. If health care services are provided to you solely for the purpose of creating protected health information for disclosure to a third party

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Send correspondence to:

LSU Healthcare Network
Attn: Health Information Management Department
1340 Poydras St., Suite 1640
New Orleans, LA 70112

PRESCRIPTIONS
INSURANCE INFORMATION

NAME: _____ DOB: _____

PLAN: _____

GROUP: _____

MEMBER ID: _____

RELATIONSHIP: _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE: _____

MAIL NAME: _____

MAIL ADDRESS: _____

MAIL PHONE: _____