DOCTORS
After Hours
URGENT CARE AND WALK-IN CLINIC

5236 Veterans Blvd.
Metairie, LA 70006
Ph: 504.885.8700
Fax: 504.885.8701

1000 Clearview Pkwy
Metairie, LA 70001
Ph: 504.455.4433
Fax: 504.455.4490

101 W. Robert E. Lee Blvd. Ste. 100
New Orleans, LA 70124
Ph: 504.288.3456
Fax: 504.288.3556

545 Oaklawn Drive
Metairie, LA 70005
Ph: 504-500-7350
Fax: 504-603-2774

2515 Manhattan Blvd.
Harvey, LA 70058
Ph: 504-336-2515
Fax: 504-322-2336

Have You been tested for **COVID-19**? ☐YES ☐NO Date of Test:_____

MEDICAL HISTORY:

PATIENT NAME:_____ **REASON FOR VISIT:**_____

ALLERGIES:_____

Is this visit related to: Motor Vehicle Accident: ___Y___N
Work Injury: ___Y___N Date of Injury _____

LAST MENSTRUAL PERIOD DATE: _____ **PREGNANT:** □ Y □ N **BREASTFEEDING:** □ Y □ N

PLEASE CHECK ANY OF THESE CONDITIONS YOU HAVE HAD IN THE PAST:

□ HEART DISEASE	□ LIVER DISEASE	□ LUMBAR SPINE DISORDER	□ HIGH BLOOD PRESSURE	□ BOWEL DISEASE
□ SEVERE HEADACHES	□ HIGH CHOLESTEROL	□ CANCER (PAST OR PRESENT)	□ TUBERCULOSIS/TB	□ LUNG DISEASE/ASTHMA
□ MUSCLE DISEASE	□ DIABETES	□ BLOOD CLOTS	□ SLEEP APNEA	□ STOMACH DISEASE
□ SEIZURES	□ LOW BLOOD SUGAR	□ BLEEDING TENDENCY	□ DEPRESSION	
□ THYROID DISEASE	□ STROKE	□ CHRONIC SKIN DISEASE	□ MENTAL HEALTH PROBLEMS	
□ JOINT REPLACEMENT	□ NERVE IMPAIRMENT	□ CERVICAL SPINE DISORDER	□ ANEMIA (OR OTHER BLOOD DISEASE)	
□ KIDNEY, BLADDER OR PROSTATE REPLACEMENT		□ OTHER:_____		

CURRENT MEDICATIONS (INCLUDES NON-PRESCRIPTION AND PRESCRIPTION PRODUCTS) PLEASE INCLUDE DOSAGE

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

PERSONAL HABITS

Do you drink caffeinated beverages (coffee, tea, soda)? Y_____N_____ Daily Intake?_____

Do you drink alcoholic beverages? Y_____N_____ If yes_____ drinks/□day, □ week, □ month

Do you smoke or chew tobacco? Y_____N_____ If yes_____/day,_____ years of use. If no, any prior nicotine use? _____years

ORTHOPEDIC OR OTHER MAJOR SURGERIES

Approximate Date:_____ Surgery_____

Approximate Date:_____ Surgery_____

Approximate Date:_____ Surgery_____

Approximate Date:_____ Surgery_____

FAMILY HISTORY (PLEASE CHECK ANY CONDITIONS THAT RUN IN YOUR FAMILY) **LIST FATHER, MOTHER, SISTER, BROTHER, MATERNAL OR PATERNAL GM/GF**

□ HEART DISEASE_____	□ STROKE_____	□ DIABETES_____
□ HIGH BLOOD PRESSURE_____	□ ANEURYSMS_____	□ THYROID DISEASE_____
□ HIGH CHOLESTEROL_____	□ MENTAL DISORDERS_____	□ CANCER: TYPE_____
□ DISEASE, OTHER_____	□ OTHER_____	

OFFICE USE ONLY:

DOB: _____ **PT ID:** _____ **DATE:** _____

INSURANCE: _____

BP:_____/_____ **P:**_____ **Res:**_____ **Temp:**_____ **Wt:**_____ **LBS. O2:**_____%

CHIEF COMPLAINT: **PAIN SCORE: 1 2 3 4 5 6 7 8 9 10 /10**

LABS:	SHOTS:	X-RAYS	PROCEDURES:	MISC:

PLAN:_____ MD SIG:

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PATIENT INFORMATION

Name (First, Middle, Last)

Address

City State Zip

Sex ☐ M ☐ F

Date of Birth Age

Home Phone

Cell Number Email

Social Security Number

Responsible Party or Parents Name (if minor) Guar. BOD

Patient's employer or parent occupation

Work Phone

Spouse's Name

Employer (Spouse's)

Work Phone (Spouse's)

Cell Number Email

In case of emergency who should we contact?

Name

Relationship

Address

City State Zip

Telephone

Primary Care Physician

Information concerning your care provided by Doctors After Hours will be forwarded to your referring doctor/source unless otherwise specified

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance Carrier

Insurance Company Name Insurance Phone

Address

City State Zip

Policy Number Group Number

Insured Name **Insured SSN & DOB**

Patient's relationship to insured:
☐ Self ☐ Spouse ☐ Dependant ☐ Other

Secondary Insurance Carrier

Insurance Company Name Insurance Phone

Address

City State Zip

Policy Number Group Number

Insured Name **Insured SSN & DOB**

Patient's relationship to insured:
☐ Self ☐ Spouse ☐ Dependant ☐ Other

Please remember insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL COST OF BILLING, WE REQUEST CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to Doctors After Hours. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature Date

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Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A **"designated record set"** contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction or your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation for you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at this time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Complaints

You may complain to us or to the Office of Civil Rights if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may obtain the address of the OCR Regional Manager, Denver, CO, from our privacy officer.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 504-885-8700.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____