LIFE COAST
COMMUNITY HEALTH CENTER

Date:_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name:	**Last Name**:	**MI:**
Date of Birth:	**Age:**	**SS#:**
Home Phone#:	**Cell Phone#:**	**Marital Status:**

SEX (Gender Identity)
☐Male
☐Female
☐Transgender Man/Transgender Male/Transmasculine
☐Transgender Woman/Transgender Female/Transfeminine
☐Genderqueer, neither exclusively male or female
☐Choose not to disclose
☐Other
☐Unknown

SEXUAL ORIENTATION:
☐Lesbian, gay or homosexual
☐Straight or heterosexual
☐Bisexual
☐Do Not Know
☐Choose not to disclose
☐Other

Race (circle): Black/African American White Asian American Indian/Alaska Native More than Once Race
Native Hawaiian Other Pacific Islander

Ethnicity (circle): Hispanic or Not Hispanic **Preferred Language**:

Patient Characteristics (circle): Veteran Migratory Seasonal Homeless Transitional

Mailing Address:	**City**:	**State**:	**Zip**:
Physical Address:	**City:**	**State:**	**Zip**:
Email Address:			
Income Amount: $	Weekly Monthly (circle one)	**Number of Dependents**:	
Emergency Contact Name:		**Contact Phone#:**	
Emergency Contact Relationship:			
If Minor* Guarantor Name:			
Guarantor SSN#:	**DOB:**	**Phone # (_____) _____-_____**	

INSURANCE INFORMATION

Primary Insurance:	**Policy#:**	**Group#:**
Name of Card Holder:	**SS#:**	**DOB:**
Card Holder Employer:	**Occupation**:	
Secondary Insurance:	**Policy#:**	**Group#:**
Name of Card Holder:	**SS#:**	**DOB:**
His/Her Employer:	**Occupation:**	

LIST ALL FAMILY MEMEBERS OR GUARDIANS WHO WILL HAVE AUTHORITY TO DISCUSS MEDICAL INFORMATION

Name:		
Relationship:	Phone#: (___) ___-____	Cell Phone#:
Name:		
Relationship:	Phone#: (___) ___-____	Cell Phone#: (___) ___-____

PHARMACY: **REFERRING DOCTOR:**

I voluntarily consent to all health care treatment and diagnostic procedures provided by all Life Coast providers, clinicians, and other personnel. I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations, or procedures. TREATMENT OF MINOR CHILDREN: I understand that minors must be accompanied by a parent or legal guardian.

Signature Patient/Guardian: Date:

LIFE COAST
COMMUNITY HEALTH CENTER

FINANCIAL POLICY

Thank you for choosing Life Coast Community Health Center (LCCHC). We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to, and sign prior to any treatment. All patients must complete our Patient Registration Form and Insurance Form before seeing the doctor.

Assignment of Benefits:
I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to LCCHC for any services rendered to me. I authorize any holder of my medical information to release information needed to determine these benefits to CMS (Centers for Medicare and Medicaid Services), its agents, or any insurance carrier I have. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Financial Agreement:
I agree that I am responsible for payment of services provided by providers of LCCHC. If uninsured, payment is required on the day of service per LCCHC's sliding fee scale. If insured, I understand that claims will be filed with my insurance company, and that I am responsible for any co-payments, co-insurance, non- covered, and/or deductibles as designated by my health plan. I understand that the authorized co-payment of my health plan is to be paid on the date of service. I understand that it is my responsibility to inform the providers of LCCHC of any changes in my personal information or insurance information, and that it is my responsibility to obtain appropriate referrals if required by my insurance company.

If payment is not made within 90 days from the statement issue date, your account will be considered delinquent. If my account is sent to an attorney or collection agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. There will be a $25.00 charge for all NSF checks; we will ask for all subsequent payments to be made by cash or credit card. We cannot hold checks for a later deposit date, so please make sure there are sufficient funds in your account prior to writing a check to us.

X _____
Signature, Patient or Legal Representative

_____
Print Patient's Name

_____
Date

LIFE COAST
COMMUNITY HEALTH CENTER

PRIVACY NOTICE

FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

1.) Uses and Disclosures: All providers of Life Coast Community Health Center are permitted by law to disclose the minimum necessary personal health information of each patient to carryout treatment, payment, and healthcare operations of the facility. For treatment purposes, such disclosures may be made to physicians, and other healthcare providers as necessary to effectuate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third-party payers for the purpose of obtaining payment for services provided. The facility may also use personal health information to carryout day to day operations such as scheduling, appointment, reminders, and quality review.

2.) Required Authorizations: The facility will not disclose any patient's personal health information for any purpose aside from payment, treatment, and healthcare operations, without the patient's authorization to disclose such. Upon request for such authorization, the patient shall have the right to refuse and/or revoke any disclosure of patient's personal health information.

3.) Privacy Compliance: In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 ("The Privacy Regulations"), the facility has adopted privacy policies regarding usage of patients' personal health information. The facility is in compliance with the Privacy Regulations and all other laws and regulations regarding patients' right to privacy.

4.) Additional Information: For additional information regarding the facility's privacy policy or for a copy of this notice, please contact our office. The facility reserves the right to change this notice and to make the revised and changed notice effective for medical information that the facility already has about you, as well as any information the facility receives in the future.
The notice will contain the effective date.

The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.

_____
Patient Signature or Legal Representative

_____
Date

LIFE COAST
COMMUNITY HEALTH CENTER

PAYMENT AUTHORIZATION FORM

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.

3. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

4. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information at the time of service.

5. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.

6. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.

7. Would you like to keep a method of payment on file? **YES** or **NO**

   (If YES) I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH account information will be truncated and "tokenized" by the payment agent to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

_____ _____

Name as it Appears on Card/ACH Account Email Address

_____

Billing Address City State Zip Code

_____ _____

Phone Number (If YES) Authorized Amount (up to)

Authorized Signature_____ Date _____

Patient Name:
Reason for Today's Visit:
Primary Care Physician:
Preferred Pharmacy:
Drug Allergies List:

MEDICAL HISTORY

Please Check All That Apply to You

	YES	NO		YES	NO
Abdominal Pain			Heart Disease		
ADD/ADHD			Headaches		
Allergies			Heart Attack (AMI)		
Asthma			Heart Failure		
Anemia			Hemorrhoids		
Anxiety			Hepatitis B		
Arthritis			Hepatitis C		
Atrial Fibrillation (A-Fib)			High Blood Pressure		
Back Pain			High Cholesterol		
Bipolar Disorder			HIV/AIDS		
Bladder Infections			Insomnia		
Bleeding Disorder			Iron Deficiency		
Blood Clots			Irregular Heartbeat		
Bloody Stool			Peripheral Vascular Disease		
Cancer			Ischemic Vascular Disease		
What type?			Kidney Stones		
Malignant Melanoma			Muscle Pain		
Skin Cancer			Muscle Weakness		
Circulatory Problems			Neuropathy		
Cyst			Numbness		
Chronic pain			Osteoporosis		
What type?			Peptic Ulcer Disease		
Constipation			Pneumonia		
COPD			Post-Menopausal		
Depression			Rectal Bleeding		
Diarrhea			Reflux/Heartburn		
Diabetes Mellitus			Schizophrenia		
What type?			Seizures		
Do you take Insulin?			Stroke		
Difficulty Hearing			Sexually Transmitted Infection		
Difficulty Swallowing			Shortness of Breath		
Emphysema			Sleep Apnea		
Diverticulitis			Stomach Ulcer		

Medical History Continued. Check all that applies to you						
	YES	**NO**			**YES**	**NO**
Gallstones				Tuberculosis		
Gout				Vitamin D Deficiency		
Glaucoma				Vitamin B12 Deficiency		
Lump In Breast				Tingling		
Weight Gain				Thyroid Problems		
Weight Loss				Vision changes		
Suicidal Ideations				Changes in Urine		
Homicidal Ideations				Easy Bleeding		
Other:						

SURGICAL/HOSPITALIZATION/PROCEDURE HISTORY

	YES	**NO**		**YES**	**NO**
Appendix			Orthopedic Surgery:		
Caesarean Section (C-Section)			What type-**Circle** Neck Back Shoulder		
Gallbladder			Hip Knee Foot		
Hysterectomy			Breast Implants		
Tubal Ligation					
Tonsils/Adenoids					
Pacemaker/Defibrillator					
Heart Catheterization					
CABG-Coronary Bypass					
Other:					

WELLNESS SCREENINGS

	Date Performed
Breast Cancer Screening /Mammogram	
Colorectal Cancer Screening	
Cervical Cancer Screening (Pap Smear)	
HIV Screening	
Bone Density	
Eye Exam	

VACCINES

	Date Given
Influenza	
Pneumococcal	
Shingles	
Covid	
Other:	

FEMALES ONLY		
Are you currently pregnant? **Circle**	YES	NO
Number of Pregnancies		
Number of Children		
Last Menstrual Period	Date	
Every Had Hormone Replacement Therapy?	Yes	No

SOCIAL HISTORY		
Do you drink alcohol? **Circle**	YES	NO
Do you smoke? **Circle**	YES	NO
Present or history of drug use? **Circle**	YES	NO
History of Smoking?	Yes	NO

FAMILY HISTORY	
Skin Cancer?	**Relationship to patient:**
Malignant Melanoma?	**Relationship to patient:**
Breast Cancer?	**Relationship to patient:**
Ovarian Cancer?	**Relationship to patient:**
Please list any immediate family members who have or had a history of illness and their relationship to the patient.	

MEDICATIONS

Include over the counter

MEDICATION	STRENGTH	HOW OFTEN IS IT TAKEN?

LIFE COAST
COMMUNITY HEALTH CENTER

605 Enterprise Drive Ste C. Houma, LA 70360
Phone 985-360-3755
Fax 985-879-4580

AUTHORIZATION RELEASE OF PROTECED HEALTH INFORMATION

Patient's Name		DOB	SS#
Patient's Address	City		State: Zip:
Requestor's Name		Requester Telephone# ( )	
Requestor's Address	City		State: Zip:
Date of Service			

Description of Information to be Released:

_____Discharge Summary
_____History and Physical Exam
_____Consultation Reports
_____Operative Reports
_____Pathology Reports
_____Laboratory Test Results
_____Other: _____

____X-Ray Reports
____X-Ray Films/Images
____Billing Reports
____Itemized Bill
____Complete Health Record
____ER Report

I understand, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information, sexually transmitted disease, Hepatitis B and C testing, Sickle Cell Anemia, and/or other sensitive information. I agree to release any of the above.

_____(Initials) If not applicable, check here_____

I understand that:

1. I may refuse to sign this authorization, and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I can inspect or copy the protected health information to be used or disclosed.
4. I may revoke this authorization at any time, in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
5. I give Life Coast Community Health Center permission to download my electronic prescription history from an online pharmacy clearing house.
6. If the requester or receiver is not a health plan or health plan provider, the release of this information may no longer be protected by federal privacy regulations and may be re-disclosed.
7. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee, if I ask for it.
8. I get a copy of this form after I sign it.
9. I acknowledge that I have been provided with a copy of the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices.

I have read the above and authorized the disclosure of the protected health information as stated.

_____ _____
Patient Signature Date

_____ _____
Authorized Representative & Relationship Date

_____ _____
Witness Date

LIFE COAST
COMMUNITY HEALTH CENTER

Clinic
After Hours Care

Thank you so much for choosing Life Coast Community Health Center for your health care needs. We know how difficult things can get when you are not feeling well and want you to know that you can call us with any of your health care needs.

If it is after our regular office hours (after 5:00 p.m. Monday-Thursday or after 12:00 pm Friday), and you need to speak to one of our health care providers about your health, please call (985) 360-3755. Someone from the answering service or the office staff will take your information and communicate it to a provider. If it is an emergency, please do not wait to talk to a Life Coast Provider, have a loved one take you to the nearest Emergency Department.

To ensure we provide you with the best possible care, we are asking that you let us know if you have a planned or unplanned admission to the hospital. Upon discharge, please give our clinic a call, so that we can make sure you have everything you need when you get home.

LIFE COAST
COMMUNITY HEALTH CENTER

605 Enterprise Drive, Ste C
Houma, La. 70360
Ph # 985-360-3755

Sliding Fee Discount Program

Life Coast Community Health Center makes the Sliding Fee Discount Program (SFDP) available to all patients. We offer the SFDP services and procedures based on family size and income to ensure that all patients of all ages have access to our services (Primary Care, OB/GYN, Behavioral Health and Dental), regardless of their ability to pay.

Please ask one of our team members if you would like more information or call 985-360-3755.