MC
MEDICINE CLINIC
OF MORGAN CITY

**Natalie Dishman, M.D.  Francis Metz III, M.D.**

Patient's Name _____

We are happy to accept patients without insurance. Unfortunately, we have no way of determining how much your exact bill will be before you see the doctor. On the day of your visit, we ask that new patients pay a $147 deposit, and our existing patients pay a $90 deposit toward that day's visit. If charges exceed the amount of the deposit, you will be billed and are responsible for the difference.

These guidelines will also apply to our patients with deductible plans.

Thank you for your cooperation.

Medicine Clinic of Morgan City

_____ _____

Patient Signature  Date

## Patient Information

Name: First_____M_____Last_____

SSN_____DOB_____Drivers Lic#_____

Mailing Address:_____

City:_____State:_____Zip:_____

Physical Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email address: _____

Employer _____ Race (optional): _____ Ethnicity (optional): Hispanic / Non-Hispanic

Single_____ Married_____Widowed_____ Male_____Female_____

Primary Care Physician:_____Referring Physician:_____

## Spouse or Parent (If Minor)

Name: First_____M_____Last_____

SSN_____DOB_____

Employer _____

Work Phone:_____ Cell Phone: _____

Emergency Contact Name & Relationship:_____

Contact Phone Number :_____

### Primary

Insurance:_____Name of Insured:_____

Relation to Patient_____Policy or ID #_____Group #_____

Insured Social Security # _____ Insured DOB _____

### Secondary

Insurance:_____Name of Insured:_____

Relation to Patient_____Policy or ID #_____Group #_____

Insurance Social Security #_____ Insured DOB: _____

**I authorize Medicine Clinic of Morgan City to bill my insurance company for charges incurred during the course of my treatment and to provide any medical information necessary to process this claim. I authorize payment to be made directly to Medicine Clinic of Morgan City to inquire about my accounts and to receive any information about any and all of Medicare, Blue Shield, or other insurance assigned or non-assigned, and I understand that I am fully responsible for charges incurred with this treatment even though the doctor files my insurance for me. I understand that if I have no insurance I will be expected to pay at the time of service. I understand that delinquent accounts are subject to collection, and I acknowledge responsibility.**

Patient or Parent's Signature: _____Date:_____

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OF MORGAN CITY

## Patient Consent for Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

**I understand that as part of my health care, this office originates and maintains medical records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:**

- **A basis for planning my care and treatment**
- **A means of communication among the many health professionals who contribute to my care**
- **A source of information for applying my diagnosis and surgical information to my bill**
- **A means by which a third party payer can verify that services billed were actually provided**
- **And a new tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals**

**I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent and have been given that opportunity. I understand that the organization reserves the right to change their notices and practices and will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed but that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.**

- **I request the following restrictions to the use or disclosure of my health information:**

_____

_____

_____ _____

Signature of Patient or Legal Representative | Witness

_____ _____

Date | Notice Effective Date or Revision

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- Accept Restrictions
- Decline Restrictions

Officer: _____ Date: _____

# Medicine Clinic of Morgan City

## Confidential Communication of Protected Health Information

| **Patient Identification** |
|---|
| Name: |
| Date of Birth: |
| SSN: |

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

| | | **Type of Information** | | |
|---|---|---|---|---|
| **Name / Relationship:** | **Phone:** | *All* | *Medical* | *Billing/ Insurance* |
| _____ | _____ | ☐ | ☐ | ☐ |
| _____ | _____ | ☐ | ☐ | ☐ |
| _____ | _____ | ☐ | ☐ | ☐ |
| _____ | _____ | ☐ | ☐ | ☐ |
| _____ | _____ | ☐ | ☐ | ☐ |
| _____ | _____ | ☐ | ☐ | ☐ |

**Specific Instruction or Restrictions:**

Please be advised that we may be unable to comply with certain requests for confidential communication of your Protected Health Information. If such an event occurs, we will notify you.

_____ _____

Patient or Responsible Person's Signature Date

*(If Power of Attorney, please provide copy)*

# Medicine Clinic of Morgan City


**Natalie Dishman, M.D.  Francis Metz III, M.D.**

**1126 Marguerite St.**
**Morgan City, LA 70380**
**Phone: 985-702-8500**
**Fax: 985-702-8507**


**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

| | | | | | |
|---|---|---|---|---|---|
| Patient Name (Last, First, Middle) | | | | DOB | |
| Address | | | SSN | | |
| City | | State | | Zip | |
| **Provider Authorized to Release the PHI:** | | | **Entity Receiving the PHI:** | | |
| Name: | | | Name: **Medicine Clinic of Morgan City** | | |
| Address: | | | Address: **1126 Marguerite St.** | | |
| City: | State: | Zip: | City: **Morgan City** | State: **LA** | Zip: **70380** |
| Attention | | | Attention: | | |

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from the date signed.

**Date:** **Event:**

**Purpose of this Disclosure:**

**Protected Health Information for Use or Disclosure**

- ☐ **All PHI**
- ☐ **Progress Notes**
- ☐ **Laboratory Tests**
- ☐ **X-Ray Tests/Reports**
- ☐ **History & Physical Exam**
- ☐ **Discharge Summary**
- ☐ **Consultation Reports**
- ☐ **Itemized Billing Statement**
- ☐ **Other:_____**

**The following information will be released when included in the above information unless you indicate otherwise:**

- ☐ AIDS or HIV test results
- ☐ Psychiatric or mental care/ treatment
- ☐ Alcohol, drug or substance abuse treatment
- ☐ Other (specify):

Signature of Patient: Date:

Signature of Patient's Representative (if necessary): Date:

Personal Representative's Relationship to Patient:

MC

MEDICINE CLINIC

OF MORGAN CITY

To all of our patients,

Please take note of our updated policy for patient procedures and testing.

It is our goal to notify our patients with testing results as promptly as possible. If, however, you have not received a phone call from us within two weeks after having blood work or a hospital procedure—and you do not have a follow-up office visit scheduled with one of our providers—please contact our office so we can discuss your test results.

_____ _____

Patient Signature Date