



Patient Registration Form

DATE: _____

First Name:

Last Name:

MI:

Date of Birth:

Age:

SS#:

Home Phone#:

Cell Phone#:

Marital Status:

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:

NOTE: As a Federally Qualified Health Center, Federal Law requires Life Coast Community Health Center (LCCHC) to collect the following information for statistical purposes only. This information is reported annually on a total patient basis. Individual patient information is NOT reported or disclosed. The collection of this information also assists LCCHC in applying for additional grant funds to support and expand its services. **Thank you for your cooperation.**

How many people live your home?

Approximate *monthly* household income? Check off below

☐ Under \$1,000 ☐ \$1,000-\$1,500 ☐ \$1,500-\$2,000 ☐ \$2,000-\$2,500 ☐ \$2,500-\$3,000
☐ \$3,000-\$3,500 ☐ \$3,500-\$4,000 ☐ \$4,000-\$4,500 ☐ \$4,500-\$5,000 ☐ \$5,000-\$5,500 ☐ Over \$5,500

Other Sources of Income? (Mark all that apply):

☐ SSI ☐ Veterans Assistance ☐ AFD/TANF ☐ Food Stamps
☐ Social Security ☐ Retirement Benefits ☐ Section 8 Housing ☐ Child Support

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 MEMBERS OR GUARDIANS WHO WILL HAVE AUTHORITY TO DISCUSS MEDICAL INFORMATION

Name:

Relationship:

Phone#: (____) ____-_____

Cell Phone#:

Name:

Relationship:

Phone#: (____) ____-_____

Cell Phone#: (____) ____-_____

PHARMACY:

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:



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. I understand and agree that if my account is delinquent LCCHC will make every effort to collect on the debt by offering payment options in the form of payment plans.

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



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 carry out 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 carry out 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



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. In the case of a patient balance that is not satisfied at the time of service by payment or payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date.

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.

Authorized Signature _____

Date _____

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

MEDICAL HISTORY

Please Check All That Apply to You

	YES	NO			YES	NO
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		
Cancer				Ischemic Vascular Disease		
What type?			Kidney Stones			
Circulatory Problems				Neuropathy		
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			
Difficulty Hearing				Sexually Transmitted Infection		
Diverticulitis				Sleep Apnea		
Easy Bleeding				Stomach Ulcer		
Emphysema				Stroke		
Gallstones				Tuberculosis		
Gout				Vitamin D Deficiency		
Glaucoma				Vitamin B12 Deficiency		

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							
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	

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	

SOCIAL HISTORY

Do you drink alcohol? Circle	YES	NO
Do you smoke? Circle	YES	NO
Present or history of drug use? Circle	YES	NO

FAMILY HISTORY

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?

ARE YOU TAKING ANY OF THE FOLLOWING: (circle)			Have you been treated with any of the following oral or IV bisphosphonate medications:		
Aspirin	YES	NO	Fosamax (alendronic)	YES	NO
Anticoagulants	YES	NO	Aredia (pamidronate)	YES	NO
Antibiotics or Sulfa	YES	NO	Zometa (Zoledronic Acid)	YES	NO
High Blood Pressure Medicine	YES	NO	Reclast (Zoledronic Acid)	YES	NO
Antidepressants or tranquilizers	YES	NO	Xgeva (Denosumab)	YES	NO
Insulin, Orinase or other diabetic medication	YES	NO	Prolea (Denosumab)	YES	NO
Nitroglycerine	YES	NO	Actonel (risedronate Sodium)	YES	NO
Cortisone or other steroids	YES	NO	Boniva (Ibandronate Sodium)	YES	NO
Osteoporosis (bone density)	YES	NO			



LIFE COAST

COMMUNITY HEALTH CENTER

504 North Acadia Rd., Thibodaux, LA. 70301

Phone 985-492-6170

Fax 985-492-6177

AUTHORIZATION RELEASE OF PROTECTED 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:																	
<table><tr><td>_____ Discharge Summary</td><td>_____ X-Ray Reports</td></tr><tr><td>_____ History and Physical Exam</td><td>_____ X-Ray Films/Images</td></tr><tr><td>_____ Consultation Reports</td><td>_____ Billing Reports</td></tr><tr><td>_____ Operative Reports</td><td>_____ Itemized Bill</td></tr><tr><td>_____ Pathology Reports</td><td>_____ Complete Health Record</td></tr><tr><td>_____ Laboratory Test Results</td><td>_____ ER Report</td></tr><tr><td colspan="2">_____ Other: _____</td></tr></table>				_____ Discharge Summary	_____ X-Ray Reports	_____ History and Physical Exam	_____ X-Ray Films/Images	_____ Consultation Reports	_____ Billing Reports	_____ Operative Reports	_____ Itemized Bill	_____ Pathology Reports	_____ Complete Health Record	_____ Laboratory Test Results	_____ ER Report	_____ Other: _____	
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_____ Pathology Reports	_____ Complete Health Record																
_____ Laboratory Test Results	_____ ER Report																
_____ Other: _____																	
I understand, and hereby 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															



Date: _____

Patient Name: _____

Thank you for choosing Life Coast Community Health Center. We are continuously striving to provide the best medical care for our patients. At Life Coast Community Health Center, you will find caring providers and staff members who take the time to build relationships with you and your family.

It is our policy to maintain a trust-based, cooperative relationship with our patients. Life Coast Community Health Center does not currently offer chronic pain management to its patients. Life Coast Community Health Center does not have a chronic pain management clinic as defined by the Louisiana State Board of Medical Examiners. **While we will continue to manage your other medical needs,** we are providing you with a list of chronic pain management providers. Within this area, who may be able to better serve your chronic pain management needs.

- Haydel Spine and Pain Wellness 985-223-3132
Houma, Louisiana
- Headache and Pain Center 985-580-1200
Gray, Louisiana
- Ochsner Specialty Health Care 985-537-2666
Raceland, Louisiana
- Pain Center at Thibodaux Regional 985-493-4080
Thibodaux, Louisiana
- Louisiana Pain Specialist 504-302-0359
Kenner, Louisiana

Our Goal is to provide the highest quality care for all our patients in a timely and respectful manner. Please do not hesitate to contact your physician if you have questions or concerns. We can be reached online through your E Clinical Works account or by Calling 985-492-6170.

Patient Acknowledgement- Please Sign: _____



Thibodaux 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) 492-6170. 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.



504 North Acadia Rd.
Thibodaux, LA 70301
Ph # 985-492-6170

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, Pediatrics, OB/GYN, Endocrinology, Dermatology, 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 985-492-6170.