



Kenner
708 W. Esplanade Ave
Kenner, LA 70065
504-451-9660

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: ___ DOB: ___/___/___
SSN: _____ - _____ - _____ Gender: M /F Home phone : (____) _____ - _____
Street: _____ Apt _____ Cell phone:(____) _____ - _____
City: _____ State: ___ Zip: _____ Email: _____ @ _____
Primary Physician: _____ Race: Amer. Indian / Asian / African Amer. / Native Hawaiian / White
Ethnicity: Hispanic or Latino / Not Hispanic or Latino Pref. Language _____
Employer: _____ Status: FT / PT / Retired /Unemployed Phone number:(____) _____ - _____
Best Form of Contact: H / C / Other:(____) _____ - _____ Best Time: _____ Notes: _____
Confidential Contact Information: H / C / Other (____) _____ - _____ Email: _____ @ _____
Emergency Contact Name: _____ Phone :(____) _____ - _____ Relationship: _____

INSURANCE

Ins. Company: _____ Member#: _____ Group#: _____
Address: _____ Effective Date: ___/___/___

Policy Holder Information/Responsible Party

Relationship to Insured: _____ Name: _____ M / F
DOB: ___/___/___ SSN: _____ - _____ - _____ Phone number :(____) _____ - _____
Address (if different from above): _____

Additional Insurance Information (Secondary Insurance):

Ins. Company: _____ Member#: _____ Group#: _____
Address: _____ Effective Date: ___/___/___
Relationship to Insured: _____ Name: _____ M /F
DOB: ___/___/___ SSN: _____ - _____ - _____ Phone number :(____) _____ - _____
Address(if different from above): _____

I consent to treatment for myself or above minor child. I understand that the examination and/or medical treatment I will receive is NOT intended to replace complete medical care by my personal primary care physician. I am aware that I will be responsible for co-payment, deductible, co-insurance or full payment at the time of service. Any pre-certification requirements that my insurance company requires is my responsibility to make. Furthermore, I allow East Jefferson After Hours (EJAH) to accept assigned payments made by my insurance company on my behalf. I understand that by my lack of payment in full or if my insurance denies payment, I am responsible for payment in full for services rendered. My failure to pay may result in collection proceedings and/or late fees. In addition, I authorize EJAH to release to my primary care physician or specialty referral, any and all information related to my treatment at this clinic.

Patient Signature (Parent if a minor) _____ Date ___/___/___



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Reason for Visit and Medical History

Patient Name: _____ Date of Birth: _____
 Reason for visit: _____ Work Related Injury? Y/N Date of Accident: _____
 Auto Accident? Y/N Date of Accident: _____ Which state? _____ Other Accident? _____

Please read the information below and circle any problems you are having TODAY

CONSTITUTIONAL	CARDIO	GU	HEMA/LYMPH
Chills	Chest pain	Pain with urination	Anemia
Decreased Appetite	Chest pressure	Blood in urine	Bleeding
Fatigue/weakness	Leg swelling	Pregnant (currently)	Easy bruising
Fever	Palpitations	Frequent urination	Painful lymph nodes
Sweating	RESPIRATORY	Vaginal bleeding	Swollen lymph nodes
Weight Loss	Asthma	Vaginal discharge	ALLERGY/IMMUN
EYES	Cough	Vaginal itching/irritation	Hives
Blurred Vision	Pain with cough/breathing	MUSC/SKEL	Seasonal allergies
Eye discharge	Shortness of breath	Back pain	Itchy eyes
Eye pain/pressure	Sputum	Edema	Watery eyes
Eye redness	(color: _____)	Joint pain	Sneezing
Eyelid swelling	Wheezing	Muscle spasm	NEURO
Glasses or contacts	GI	Muscle weakness	Dizziness
ENT/MOUTH	Abdominal Pain	Neck pain	Fainting
Ear drainage	Constipation	Joint swelling/Redness	Headache
Ear pain/pressure	Cramping	SKIN/BREAST	Loss of consciousness
Hearing loss	Bloating	Abrasion	Numbness
Hoarseness	Diarrhea	Abscess/Boil	Tingling
Post- nasal drip	Hemorrhoids	Discharge/drainage	Seizures
Sinus drainage	Nausea	Redness of skin	PSYCH
Sinus pressure	Rectal bleeding	Itch	Anxiety
Sore throat	Ulcers	Lesions	Depression
Toothache	Vomiting	Rashes	Insomnia

Please check all that apply to you (conditions you have been diagnosed with and/or being treated for):

- | | | | |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Other _____ |

Drink Alcohol (amout/freq) _____ / _____ Smoke(amount/freq) _____ / _____

Current medications: _____

Date of last Tetanus shot: _____ Any previous surgeries? Y/N _____

Medication allergies? Y/N _____

Other Medical History: _____

Females Only: Date of last menstrual cycle: _____ Taking birth control? Y / N Are / Could you be pregnant? Y / N



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Thank you for selecting East Jefferson After Hours (EJAH)

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

From time to time East Jefferson After Hours uses and discloses confidential personal health information about patients. We know this information is private. We call this information “protected health information “(PHI). We are required to protect the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. This notice describes how we may use and disclose your PHI and certain rights you have with respect to your PHI.

Uses and Disclosure for Treatment, Payment, and Health Care Operations

HIPAA privacy rules permits us to use or disclose your PHI for the purpose of treatment, payment, and health care operations, described in more detail below, without obtaining specific written permission from you, known as “authorization”. We may use or disclose PHI:

For treatment: To coordinate your healthcare. We may consult with other healthcare providers who are involved in your healthcare.

For payment: To get payment for health care services you receive. For example, we may provide PHI to bill your health plan for services provided to you.

For health care operations: In performing business activities in order to allow us to improve the quality of care we provide.

Appointments and other health information: We may send you reminder for medical services or information about health services that may be of interest to you.

Other uses and disclosures for which authorization is not required

In addition to using and disclosing PHI for treatment, payment and health care options, the HIPAA Privacy Rule permits (or requires) us to use and disclose PHI without your written authorization under the circumstances described below:

As required by law and for law enforcement: When required or permitted be federal or state law or by a court order. If federal or state law creates higher standards of privacy, we will follow the high standard.

For abuse reports and investigations: If we reasonable believe a patient has been a victim of abuse or neglect, we may disclose PHI as required by law.

For government programs: For public health benefits under other government programs. For example, for the determination of Supplemental Security Income (SSI) benefits.

To avoid harm: To law enforcement agencies in order to avoid a serious threat to the health, welfare, and safety of a person or the public.

For research: For studies and to develop reports.

Family, Friends, and others: To family or other persons involved in the patient’s medical care. You have the right to object to sharing your PHI.

Please list names of the persons to who we may disclose PHI and state how the individual is related to the patient:

Name: _____ Relationship _____

Name: _____ Relationship _____ Initial _____

Other uses and disclosures requiring your written authorization

For other situations, we will ask for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. We cannot take back any uses or disclosures already made with your authorization.

Your Privacy Rights:

Right to inspect and copy medical records: In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

Right to request restrictions: You have the right to ask us to limit how your information is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom you want the limits to apply. We are not required to agree to the limits. You can request in writing that the limit be terminated.

Right to amend: You may ask us to change or add missing information to your records if you think there is a mistake. You must make the request in writing and provide a reason for your request.

Right to receive certain disclosures: You have the right to ask for a list of disclosures. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment or health care operations. This list will not include information provided directly to you or your family or information sent with your authorization.

Right to obtain a paper copy: You have the right to ask for a paper copy of this notice at any time.

Right to file a complaint: You have the right to file a complaint with us at the address listed below and with the Secretary of the United States Department of Health and Human Services if you do not agree about how we have used or disclosed information about you.

Right to revoke permission: If you are asked to sign authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

Right to choose how we communicate with you: You have the right to ask that we share information with you in a certain way or in a certain place. You must make this request in writing.

Right to receive notice of change: You have a right to receive notice of changes in our privacy statement that affect you on or after the effective date of change.

If you have any questions about this notice, you may contact:

Millennium Healthcare Management, Inc.
3510 N. Causeway Blvd, Ste. 300
Metairie, LA 70002
(504)831-3112

I hereby acknowledge that I have received a copy of this practice’s Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this Notice should it be amended, modified, or changed in any way.

Signature of Patient/Guardian Date

Patient/ Guardian unable or refused to sign due to _____ Date _____ Witness _____

EAST JEFFERSON AFTER HOURS - KENNER

708 W ESPLANADE, KENNER, LA 70065 PHONE(504)451-9660 FAX(504)461-8450

Our physicians are contracted with many of the local and national insurance plans. However, there are some plans that we do not currently contract with as participating providers. If you belong to such a plan, our billing office will be glad to file a claim for you with the understanding that full payment is due at the time of service. Your claim will probably be applied to an out-of-network deductible or denied. It is important for you to understand that the patient is ultimately responsible for the fees that are not covered by the plan in this case. If you have any questions concerning the benefits/coverage your plan provides , please call the member relations department of your plan.

INSURANCE PATIENTS

It is your responsibility to keep us updated with your correct insurance information. It is your responsibility to understand your benefit plan with regard to, covered services and participating providers, including laboratories. For example, not all plans cover annual physicals, sports physicals, or hearing and vision screenings. If these services are not covered, you will be responsible for payment. It is your responsibility to know if a written referral or authorization is required to see a specialist, whether preauthorization is required prior to a procedure, and what services are covered.

NON COVERED SERVICES

Your insurance company will only pay for services that it determines to be a covered benefit. If your insurance company determines that a particular service is not a covered benefit, your insurance company will deny payment for that service. The responsible party will be responsible for any durable medical equipment (splints, crutches, ace wraps, and etc.) and medications not covered by the insurance plan or any services applied towards the deductible. If my insurance company denies payment, I agree to be personally and fully responsible for payment to East Jefferson After Hours (**EJAH**).

INSURANCE PAYMENTS

If applicable, due to your insurance plan, we will collect a deposit today. We anticipate a discount for our contractual allowance, so this payment today reflects only a portion of your total charges.

Our billing office will file a medical claim for your visit today. If you have a balance due after your claim is processed, you will receive a bill from our office. However, if you are due a refund because of a possible overpayment, you may request to receive a refund. If you have any questions regarding your bill, please contact our billing office, Millennium Healthcare Management, Inc. A representative from the billing office can be reached Monday-Friday, 8:30am to 4:30pm at (504)831-3112.

ASSIGNMENT OF BENEFITS

I hereby assign to **EJAH** any insurance or other third-party benefits available for health care services provided to me. I understand that **EJAH** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **EJAH**, I agree to forward to **EJAH** all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

TRICARE REFERRAL REQUIREMENT

Urgent Care Services are covered when required for illness or injury that would not result in further disability or death if not immediately treated, but does require professional attention and has the potential to develop into such a threat if treatment is delayed longer than 24 hours. Urgent Care Services for TRICARE Prime, TRICARE Prime Remote (TPR), and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) beneficiaries should be provided by their assigned primary care manager (PCM), unless the beneficiary has obtained a referral prior to the Urgent Care visit.

I have read and understand the East Jefferson After Hours- Kenner insurance information/billing policies.

Patient Signature _____

Patient/ Guardian unable or refused to sign due to _____ Date _____ Witness _____

WAIVER OF RIGHTS UNDER LOUISIANA’S UNIFORM UNCLAIMED PROPERTY ACT OF 1997

In the event that I overpay for any reason for services rendered, I understand that any balance of \$100 or less otherwise due to me will be held as a credit for my account. If this credit goes unclaimed for a period of THREE(3) YEARS, I further understand that the credit shall be presumed abandoned and will become the property of Millennium Healthcare Management, Inc.

By signing this waiver, I acknowledge that I am intentionally relinquishing my known legal rights with respect to any unclaimed credit for my account. Upon the expiration of THREE(3) YEARS from the time of the overpayment, I hereby waive, relinquish, and forfeit any and all legal rights to the resulting credit and acknowledge that any overpaid funds, which may have been held for my account, are the property of Millennium Healthcare Management, Inc..

Printed Patient’s Name

Signature of Patient/Guardian

DOB

Today’s Date