WOMAN 2 WOMAN
RACHELLE MEAUX, M.D., APMC
OBSTETRICS & GYNECOLOGY

200 Beaullieu Dr. Building # 4
Lafayette, La 70508
(337) 216-0000

PATIENT INFORMATION

Account#____________________ **Date:**____________________

Patient Name:____

Date of Birth:____________ **Sex:**______ **Marital Status:**____________

Husband's / Significant Other's Name:________________________

Patient's Social Security Number:____________ **Home Phone:**____________

Address:____

City:________________ **State:**______ **Zip:**________________

Employer:____________________ **Occupation:**______________

Work Phone:________________ **Cell Phone:**________________

Preferred Pharmacy:________________ **Pharmacy Phone:**____________

Referred by:____

Emergency Contact:____________________________________

Emergency Contact Phone:________________________________

Best place/time to contact you with results:________________________

RESTRICTIONS ON USES AND DISCLOSURES OF PHI

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PH: (337) 216-0000
FAX: (337) 216-0009

In general, the HIPPA privacy rule gives individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

__ Home Telephone ____________________
  __ O.K. to leave message with detailed information
  __ Leave message with call-back number only

__ Work Telephone ____________________
  __ O.K. to leave message with detailed information
  __ Leave message with call-back number only

__ Cell Phone ____________________
  __ O.K. to leave message with detailed information
  __ Leave message with call-back number only

__ Written Communication
  __ O.K. to mail to my home address
  __ O.K. to mail to my work/office address
  __ O.K. to fax to this number ____________

__ MedVoice
  __ O.K. to leave message on MedVoice system

__ Other ____________________

I have received the Notice of privacy Practices And I have been provided and opportunity to review It.

Name: ____________________

DOB: ____________________

Signature: ____________________

Date: ____________________

Please understand we are unable to speak to anyone about your care unless you list them here.

1. ____________________

2. ____________________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. There provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

____________________ Patient Signature

____________________ Date

____________________ Print Name

____________________ Birthday

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LAFAYETTE, LA 70508
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FINANCIAL POLICY

Thanks for choosing us as your healthcare provider. This office is committed to providing you with quality medical care. Understand that payment for services is essential to the wellbeing of this practice. Please read the following and sign prior to treatment:

PAYMENT:

- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**
- **CASH, CHECKS, VISA, AND MASTERCARD** are accepted forms of payment. Post-dated checks may be accepted as an alternative form of payment
- **NSF checks:** Any Non-sufficient funds check will incur a **$30 charge** over the amount of the check for services. If I fail to make a payment in full within 10 days of notification, I understand that you reserve the right to exercise your legal rights to recover these fees, including court costs and attorney fees.
- **Overdue payments:** If complete payment is not received, I will be notified of my balance due. Any amount that remains **31 days** after the balance is due will be subject to **finance charges.** After **60 days** of notification if I fail to pay my balance, or I make no effort to show good faith by negotiating a payment plan, I understand **my account will be referred to a collection agency.** In such a case, I will also be liable for all collection fees charged by the agency.
- **Appointment cancellations/No shows:** I will give **24 hour notice** if I cannot keep an appointment. If I do not give this notice, or fail to show for an appointment, I will be charged a **"NO SHOW" fee.** Consideration will be given for illnesses and emergencies.

REGARDING INSURANCE

Assignment of insurance benefits may be accepted on hospital care, however the balance is my responsibility, whether my insurance company pays or not. My insurance policy is a contract between my insurance company and me. My physician is not a party to this contract. Therefore, I will make arrangements with the business office for payment of the uninsured amount.

If my physician is a participating provider of my plan, I will pay all deductibles and co-pays at the time of service. I understand that most lab fees are not included in co-pay amounts, and I will be required to pay those as well. If my insurance plan changes to one in which my physician is not a provider, I will pay the balance in full.

USUAL AND CUSTOMARY RATES

Usual and customary rates for this area charged for services. I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I HAVE READ AND FULLY UNDERSTAND THIS FINANCIAL AGREEMENT. BY SIGNING THIS CONTRACT, I'M AGREEING TO ITS TERMS

X______________________________ ________________

Signature of Patient/Guardian **Date**

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Insurance Information

Acct # : ______________________ Date: ________________________

Patient Name: ____

Primary Insurance

Name of Insurance Co.: ________________________________
Name on card (insured) : ______________________________
ID# / SS# : __________________________ Policy / Group# : ____________
Insured's relationship to patient : self spouse other : ____________
Insured's place of employment : __________________________
Employment Phone: __________________________

Secondary Insurance

Name of Insurance Co.: ________________________________
Name on card (insured) : ______________________________
ID# / SS# : __________________________ Policy / Group# : ____________
Insured's relationship to patient : self spouse other : ____________
Insured's place of employment : __________________________
Employment Phone: __________________________

I hereby authorize this physician to release any information acquired in the course of my examination or treatment and permit payment directly to the physician. I understand that I am financially responsible for all charges whether or not paid by my insurance. I also understand that I will be responsible for all charges, fees and billings, incurred in collections and said due accounts.

_______________________________________ ______________________

Signature of Responsible Party **Date**