Rachelle Meaux, M.D.
Board Certified Gynecology

PATIENT INFORMATION

Date: ______________ Patient Name: ____
(First) (MI). (Last)

Preferred Name (Nickname): ____

Date of Birth: ______________________ SS#: _____________________ Race: ______________

Husband's / Significant Other's Name: ______________________________ Marital Status: _______

Home Phone Number: ____________________________________

Cell Phone Number: _____________________________________

Address: ____

City: ___________________________________ State: _____ Zip Code: ___________________

Employer: ______________________________ Occupation: ____________________________

Work Phone Number: _____________________________________

Email Address: ____

(Results are sent via patient portal – Email address is required. If you do not have an email address, please notify receptionist.)

Referred By: ____

Emergency Contact: ____________________________________ Relationship: ________________

Emergency Contact Phone Number: ____

Preferred Pharmacy/Location: ____

Preferred Pharmacy Phone Number: ____

200 BEAULLIEU DRIVE BUILDING # 4 LAFAYETTE, LA 70508
Phone: 337.216.0000 Fax: 337.216.0009
WWW.DRRACHELLEMEAUX.COM

Patient name: ______________________________

Insurance Information

Primary Insurance

Insurance Name: ______________________________

Policy / Member #: ____________________ Group #: ____________________

*If you are the Subscriber, you may skip next section

Subscriber: ______________________________ Relationship: ____________________

Subscriber Employer:______________________________ Employer's Phone:____________________

Subscriber Date of Birth: ____________________ Subscriber SS#: ____________________

Subscriber Address: ______________________________

City: ______________________________ State: ________ Zip Code: ____________

Subscriber Phone Number: ______________________________

Secondary Insurance

Insurance Name: ______________________________

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

Signature of Responsible Party:

______________________________**Date:**____________________

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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 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 time of service.**
- All forms of payment are accepted for services. Credit card transactions will incur a charge up to what is allowed by current laws.
- NSF Checks: Any non-sufficient funds check will incur an **NSF 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 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 monthly. 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 may be referred to an outside collection agency. In such 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 care, however the balance is my responsibility, whether my insurance company pays or not. My insurance policy is contract between my insurance company and me. My physician is not a party to this contract.

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

To ensure claims are processed accurately and efficiently, you must provide all active insurance policies and correct data (i.e. address, name, date of birth, and social security number). Failure to provide accurate information regarding billing / insurance may result in termination from the practice.

USUAL AND CUSTOMARY RATES

Usual and customary rates for this area are 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 FINACIAL AGREEMENT. BY SIGNING THIS CONTRACT I AM AGREEING TO THE TERMS STATED WITHIN.

Print Name: ______________________________

Signature of Patient / Guardian: ______________________________

Date: ____________________

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RESTRICTIONS ON USES AND DISCLOURES OF PHI

In general, the HIPPA privacy rule gives individuals 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 communication 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.

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

1. ______________________________ Relationship ______________________________

2. ______________________________ Relationship ______________________________

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

___ Current Home/ Cellular Phone
___ OK to leave message with detailed information
___ Leave message with call back number only

___ Current Work Telephone
___ OK to leave message with detailed information
___ Leave message with call back number only

___ Written Communication
___ OK to mail to home address
___ OK to fax to this number ______________

____
Date of Birth

____
Date

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. Their 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 / Parent Signature

____
Print Name

I have received the Notice of Privacy Practices

I have been provided an opportunity to review it

Signature: ______________________

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