Thibodaux Regional Physician Network

LOC: CV EN FAM IM NL NS OR PM PU RA TWC

Acct #: _____ ❑ Request for Confidential Communications Attached Completed Date: _____

P-INS Code: _____ S-INS Code: _____

PATIENT INFORMATION

Prefix:
Mr./Mrs./Other: _____ Patient*⇳: _____
Last First Middle

Suffix: Jr./Sr./Other: _____ Previous Name: _____

Mailing Address: _____ _____ _____ _____
If PO Box, complete Street Address Below City State Zip

Street
Address: _____ _____ _____ _____
City State Zip

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Circle the preferred phone #/email contact. Leave message at what phone number? ☐ Home ☐Work ☐ Cell ☐ None

Email: _____

Marital Status*: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Social Security#: _____

Employer: _____ Occupation: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired _____ ☐ Military Active ☐ Unknown
MMDDYY

Student Status: ☐ Full Time ☐ Part Time ☐ N/A Patient & Responsible Party are the same*? ☐ Yes ☐ No (complete below)

Race*: ☐ African American ☐ Caucasian/White ☐ Other: _____

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Preferred Language*: ☐ English ☐ Spanish ☐ Other: _____

☐ Provide copy of insurance card(s) to be scanned⇳ Do you have wellcare/preventative coverage for annual exams: ☐ Yes ☐ No
(if not, complete below)

Primary Insurance: _____ Secondary Insurance: _____

Primary Ins Policy #: _____ Secondary Ins Policy #: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

RESPONSIBLE PARTY INFORMATION

ONLY COMPLETE IF OTHER THAN PATIENT (NOT SELF), THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION

Prefix: Mr./Mrs./Other: _____ Responsible Party: _____
(Employer Info if work related) Last First Middle

Suffix: Jr./Sr./Other: _____ Relationship to Patient: _____ Social Security #: _____

Mailing Address: _____ _____ _____ _____
If PO Box, complete Street Address Below City State Zip

Street Address: _____ _____ _____ _____
City State Zip

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Date of Birth*: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Email: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Employer: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Disabled ☐ Retired ☐ Military Active ☐ Not Employed

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How were you referred to our practice: ☐ Friend/Relative ☐ Newspaper ☐ Radio ☐ Healthsource ☐ Other: _____

☐ Referred Physician: _____ Phone #: _____

Primary Care Provider (PCP): _____ Address: _____ Phone: _____

Preferred Pharmacy: _____ Address: _____ Phone: _____

Do you have an Advanced Directive (living will, durable power of attorney)? ☐ Yes ☐ No → If 'Yes', provide copy:

Rec'd by: _____ Date: _____

By signing this form, I verify all above information is true and accurate as of the below indicated date.

TRND & TRMC Covered Entities:

Anesthesia, Heart & Vascular Center of Thibodaux Regional, EKG, Endocrinology Clinic, Family Medical Center – Paincourtville, Family Medical Center – Pierre Part, Geri-Psychology, Hospitalists, Internal Medicine Clinic, Maternal Fetal Women's Center of Thibodaux Regional, Neurology Clinic, Brain and Spine Clinic of Thibodaux Regional, Cancer Center of Thibodaux Regional, Orthopaedic & Sports Medicine Clinic of Thibodaux Regional, Pediatric Cardiology, Pain Center of Thibodaux Regional, Pulmonology & Critical Care Specialists, Radiology/Radiology Wellness, Rheumatology Clinic, Thibodaux Women's Center.

When receiving services at any of the above covered entities, you may receive a separate bill and/or statement from each provider and a separate bill and/or statement from the facility.

_____ (Initial) I hereby acknowledge Thibodaux Regional Network Development Corporation (TRND) has an organized healthcare arrangement (OHCA) with several different covered entities (CE), i.e., practices representing different specialties/clinics, which are legally separate but are clinically/operationally integrated and participate in joint activities to share protected health information (PHI) about their patients in order to manage and benefit their joint operations. TRND has the right to use and disclose PHI between these CE's for treatment, payment and health care operations, and that I have received the HIPAA Notice of Privacy Practices for Protected Health Information (NOPP). I understand I have the right to restrict how my PHI is used or disclosed, and that TRND is not required to agree to any restriction, but if an agreement is reached, TRND is bound by the agreement.

_____ (Initial) I hereby acknowledge that all TRND and Thibodaux Regional Medical Center (TRMC) covered entities (CE) may transfer funds due to an overpayment/credit from any specialty office/clinic/hospital account to another specialty office/clinic/hospital account. I understand this is done in an effort to reduce collection costs and prevent accounts with outstanding balances being transferred to outside collection agencies.

_____ (Initial) I hereby authorize Thibodaux Regional Network Development Corporation (TRND) Practitioners to evaluate and recommend any testing and/or additional treatment and send my lab work to TRMC or other referenced lab; who will in turn bill me for their services. I understand I have the right to refuse any such recommendations/treatment.

_____ (Initial) I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility and that TRND is an Out of Network provider for Ochsner Plans and all services will be the patient's responsibility.

_____ (Initial) I hereby authorize all of my insurance companies to pay directly to Thibodaux Regional Network Development Corporation (TRND) benefits due on my behalf, if any, as provided in the above provided unexpired policy.

_____ (Initial) I understand that any payment(s) made by me to TRND in the form of a check will be processed as an electronic check transaction; therefore, the funds will be debited immediately from my checking account.

_____ (Initial) I agree that TRND may contact me via any means that I have provided including but not limited to land lines, cell phones (text and mobile applications), and email, etc.

_____ _____

Signature ☐ Patient ☐ Responsible Party Date

OFFICE USE ONLY

TRND Staff: Scan to patient demographics 'eCW/INS' folder

** = Required for eCW ⇳ = Interfaces to MEDPM*

Provide ABN for all potentially non covered services.

Thibodaux Regional Physician Network

LOC: CV EN FAM IM NL NS OR PM PU RA TWC

Acct #: _____ ❑ Request for Confidential Communications Attached Completed Date: _____

Patient Name: _____ Date of Birth: _____

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

*Note: If request initiated, assign Account Status: R - HIPAA Restricted (in **MED**PM); send copy to MEDDATA.*

Please list any person(s) other than yourself, and their relationship to you, that we may discuss your medical information with:

Person:	Relation:	Phone #:
1)		
2)		
3)		
4)		
5)		

EMERGENCY CONTACT: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Email: _____

Any special instructions: _____

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? ☐ Yes ☐ No

If 'Yes', office staff to assist in completing a Hospice/HHA/NH/SNF Facility Information Form.

❑ Hospice/HHA/NH/SNF Facility Info Form

Signature: _____ Date: _____

Thibodaux Regional Physician Network

Acct # _____ Completed Date: _____

HOSPICE/HHA/NH/SNF FACILITY INFORMATION FORM

PATIENT INFORMATION

Prefix: Mr./Mrs./Other: _____ Patient: _____ Suffix: Jr./Sr./Other: _____
Last First Middle

If Hospice/HHA/NH/SNF patient and answered 'Y'es on Demographics Intake Form, TRND staff to assist patient in completing the below data and ask about an ABN Form.

FACILITY INFORMATION

Type: ☐ Hospice ☐ Home Health (HHA) ☐ Nursing Home (NH) ☐ Skilled Nursing Facility (SNF) ☐ Other: _____

Facility Name: _____ Contact Name _____
Last First Middle

Mailing Address: _____ _____ _____ _____
City State Zip

Phone: _____

Completed By: _____ Date: _____

OFFICE USE ONLY

Provide ABN form for all services.

If currently a Home Health patient, all charges must be paid for prior to receiving services by the facility or the patient must be redirected to the HHA facility for care.

Refer to **User Guide: SNF/Home Health/Hospice Billing Medicare & LA Medicaid**

Confirmation of Above Facility Information: *(must be confirmed prior to each visit)*

Date:	Confirmed by:	Updates/Additions:

Thibodaux Regional Physician Network

Acct # _____ Completed Date: _____

ACCIDENT/INJURY INFORMATION FORM

PATIENT INFORMATION

Patient: _____ Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____
Last First Middle

If patient has had an accident or injury and answered 'Y'es *to same* on Demographics Intake Form, complete below data. Please ask if you have any questions.

ACCIDENT/INJURY INFORMATION

Type: ☐ Accident ☐ Injury

Date of: _____ Date symptoms began: _____

Motor Vehicular Accident (MVA): ☐ Yes ☐ No If 'Yes', State Code: _____

Give details of accident/injury (Description/Reason): _____

Slip & Fall: _____

Prior Physicians Seen (Treated by, date and Treatment Place): *(List)* _____

❑ Release Form Needed *(Provide Physician Address)* _____

Prior Tests with approximate date: *(List)* _____

❑ Patient is Providing Results OR ❑ Release Form Needed *(Provide Facility and Address)* _____

Prior Surgery (Treated by, date and and Treatment Place): *(List)* _____

WORKERS' COMP INFORMATION

Resp Employer: _____ Work Ph.: _____

Mailing Address: _____ _____ _____ _____
City State Zip

Workers' Comp Ins Co.: _____ Phone: _____

Mailing Address: _____ _____ _____ _____
City State Zip

Adjuster: _____ Approved: _____

Phone: _____ Spoke with: _____

Claim #: _____ Any testing: _____

Patient's Attorney: _____ Phone: _____

Mailing Address: _____ _____ _____ _____
City State Zip

Completed By: _____ Date: _____

OFFICE USE ONLY

Refer to **User Guide: Workers' Compensation Accounts and Claims.**