BAYOU REGIONAL
WOMEN'S CLINIC, LLC

Patient Demographic & Insurance Information

Basic Patient Information

Name _____
First Middle Last

What would you like us to call you? _____

Date of Birth ____/____/____ **Social Security Number** _____

Address _____

City, State & Zip _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Please indicate which phone number you would like for us to contact you on.

Email Address _____

Marital Status □Single □Married □Divorced □Separated □Widowed

Insurance Information
Please present insurance card/cards to the front desk receptionist

Primary Insurance _____

Policy Holder Name _____
First Middle Last

Date of Birth ____/____/____ **Social Security Number** _____

Relationship □Self □Spouse □Child □Other _____

Secondary Insurance _____

Policy Holder Name _____
First Middle Last

Date of Birth ____/____/____ **Social Security Number** _____

Relationship □Self □Spouse □Child □Other _____

Emergency Contact Information

Name _____
First Middle Last

Address _____

City, State Zip _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Patient Signature

_____ _____

Patient or Legal Guardian's Signature **Date**

BAYOU REGIONAL
WOMEN'S CLINIC, LLC

PATIENT AUTHORIZATION FORM

To request Health Information

Patient Name: _____

DOB: _____ SSN: _____

By signing this form I authorize _____ to disclose, to:

Bayou Regional Women's Clinic
6550 Main St Ste 2000
Zachary, LA 70791
Phone: 225-658-1303 Fax: 225-658-1304

The following protected health information:

_____

_____

The purpose of this disclosure is:

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this authorization. Bayou Regional Women's Clinic will not condition my treatment or payment for my treatment on whether I provide authorization for the requested use or disclosure unless health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or State law.

This authorization will expire one year after the date listed below.

_____ _____

Patient or Legal Guardian's Signature Date

BAYOU REGIONAL
WOMEN'S CLINIC, LLC

6550 Main Street, Suite 2000
Zachary, LA 70791

Dear patient,

Welcome to Bayou Regional Women's Clinic. We are pleased that you have selected our office for you OB/GYN services. Please take the time to thoroughly read the following policies.

Cancellation/Missed Appointments
We request that if you are unable to make your scheduled appointment time that you extend the courtesy of notifying our office no later than 24 hours prior to your appointment. Our Doctors have reserved that time to provide you personalized quality care. If you cancel an appointment within 24 hours or do not show for your scheduled appointment, you may incur a fee of $50. Please note, this fee is not covered by your insurance carrier and will be your responsibility. If you miss more than two appointments without calling our office, our policy is to discharge you from care with Bayou Regional.

Appointments
We will make our best effort to honor your scheduled appointment time. However, there may be unforeseen delays due to surgeries, deliveries, and emergencies at the hospital. We hope that you understand that this may occur and we will notify you so that you can make the decision to wait or to reschedule if you are unable to wait.

Insurance Filing
As a courtesy, we will file your insurance claims to your carrier. We accept most major medical plans. Please check with the billing department if you have any questions. Please be aware that it is your responsibility to know your benefit coverage. Your insurance may not pay for all the services provided at BRWC and you will be responsible for the services not paid by your carrier.

Payments
Copayments and coinsurance payments are expected at the time of service. This is the amount of the charges that your insurance carrier has determined to be your responsibility for your visit. BRWC accepts cash, check, Mastercard, and Visa payments. We do not accept post-dated checks for payment. If you do not have insurance, payment in full is expected at the time of service, also note that you will receive a separate bill from the lab company if any tests are performed.

Prescription Refill Requests
If you need a prescription refill, please have your pharmacy fax our office a request at 225-658-1304. Refill requests will be accepted Monday through Thursday 8:00 to 4:00. We do not call in any medication after hours as the physician does not have access to your medical records during this time.

Patient Inquiries
If you have a non emergent issue during regular business hours, you can leave a message for one of the Doctors with the appointment desk. Your call will be returned at the end of the business day.

After Hours and Emergency Problems
In the event of a true emergency, please dial 911 or go to the nearest Emergency Room. If there is a serious concern or issue that cannot wait until regular business hours, you may call 225-658-4545 and the OB/GYN on call will be notified. We ask that you only utilize these services when there is a true urgent or emergent situation.

Please sign below to acknowledge that you have read and agree to the above policies.

_____ _____

Patient/Responsible Party Signature Date

BAYOU REGIONAL
WOMEN'S CLINIC, LLC

6550 Main Street, Suite 2000
Zachary, LA 70791

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my medical information:

_____

_____

If you wish for another person(s) to have access to your health information, please list them here:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

_____ _____

Patient/Responsible Party Signature Date

BAYOU REGIONAL
WOMEN'S CLINIC, LLC

Bayou Regional Women's Clinic
Medical History

Name _____

Menstrual cycles

The first day of my last menstrual period was _____.
I have a menstrual cycle every _____ days.
My menstrual cycle lasts _____ days.
I would characterize my menstrual flow as (circle one) light, normal, or heavy.

Pregnancies

Please list all pregnancies, including miscarriages, abortions, and tubal pregnancies.

Date	Sex	Weight	Length	Type of Delivery	Hospital	Complications

Allergies

Are you allergic to anything? □ Yes □ No
If yes, please list what you're allergic to and your reaction.

Allergy	Reaction

Personal History

Do you have a personal history of any of the following diseases/problems? If yes, please list date of diagnosis next to the condition.

□ Abnormal pap smear
□ Alcohol/Drug abuse
□ Anemia
□ Anxiety/Depression
□ Asthma/Lung disease
□ Bladder/Kidney infections
□ Breast problems
□ Chron's/UC/IBS
□ Diabetes
□ GERD
□ Seizure disorder
□ Gall bladder problems
□ Heart disease/Murmur/Arrhythmia
□ Hypertension
□ High cholesterol
□ Kidney disease
□ Liver disease
□ Migraine headaches
□ Multiple sclerosis
□ Blood clot/Stroke
□ Thyroid problems
□ Other _____

Medications

Are you taking any medications? □ Yes □ No

If yes, please list the medication, dosage, and how long you have taken this medicine.

Medication	Dosage	How long you have taken it

Surgeries

Please list all surgeries, date, hospital, Doctor, and complications.

Surgery	Date	Hospital	Doctor	Complications

Family History

Do any of the following diseases run in your family (1ST or 2nd degree relatives only)? If yes, please list relative affected by the disease next to the condition.

□ Breast cancer
□ Ovarian cancer
□ Endometrial cancer
□ Colon cancer
□ Other _____

□ Blood clot/Stroke
□ Hypertension
□ Diabetes
□ Heart disease

Social History

Do you smoke cigarettes? □ Yes □ No

If yes, how many packs per day? _____

How long have you smoked? _____

Do you drink alcohol? □ Yes □ No

If yes, do you drink beer, wine, or mixed drinks (circle all that apply)?

How many drinks do you have per week or per day? _____

Do you use any other drugs? □ Yes □ No

Are you sexually active? □ Yes □ No

If yes, how long have you been with your current partner? _____

_____ _____

Patient or Legal Guardian's Signature **Date**