LOUISIANA CENTER FOR ADVANCED MEDICINE

NEW PATIENT REGISTRATION

Patient Name: First: ____________________ Middle: ____________________ Last: ________________________

Preferred Name: ________________________ Birth Date: _________________ SSN: _____________________

Gender: ___________ Ethnicity/Race: ___________ Preferred Language: _______________________

Marital Status: __________________________________ U.S. Military/Veteran? ___________

Mailing Address: ____

street *city* *state* *zip*

Phone Number(s): ____

home *mobile* *work*

Email Address: ____

Emergency Contact: __________________________ Phone: ____________________ Relation to Patient: _____

Is the patient employed? ________________ Is the patient a student? ___________

Employer: _______________________________________ School: _____________________________________

Person Completing form if not patient: ___________________________________ Relation to patient: _________

Were you referred to LCAM? ________________

Referring Provider: ____ Location: _________________________

Primary Care Provider :____ Location: _________________________

MINORS ONLY

GUARANTOR INFORMATION

*Guarantor is a parent or guardian responsible for minor and anything insurance does not cover

Mother/Guardian's Name: ______________________ Father/Guardian's Name: ___________________________

Person responsible for Bill (guarantor, NOT insurance): _____________________________________

SSN: ______________________ Relation to patient: ________________________ DOB: __________

Address: ____ Employer: __________________________

myChart

Online patient portal – send your healthcare team messages, see test results, make/confirm appt, see medications, see your bill and more!

Since patient is a minor, they will have to have an adult as a "proxy" to set up and have access to this account.

Who should have access to myChart? : ______________________ Relation to Patient: ___________________

Proxy's DOB: ___________ SSN: _________________ Phone #: ____________________________________

Email Address: ____

PLEASE TURN OVER TO COMPLETE →

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INSURANCE

Primary Insurance

Insurance Company: ______________________________

Name of Subscriber: ______________________________

Relation to Patient: _________ SSN: ___________________

Subscriber Address: _______________________________

City/State/Zip: ___________________________________

Policy #: _______________________ Group #: _________

Place of Employment: ______________________________

Subscriber Gender: ________ Date of Birth: __________

Secondary Insurance

Insurance Company: ______________________________

Name of Subscriber: ______________________________

Relation to Patient: _________ SSN: ___________________

Subscriber Address: _______________________________

City/State/Zip: ___________________________________

Policy #: _______________________ Group #: _________

Place of Employment: ______________________________

Subscriber Gender: ________ Date of Birth: __________

AUTHORIZATIONS & ACKNOWLEDGEMENTS

Acknowledgement of Notice of Privacy Practices

Initial here ______ I, the patient or authorized representative of the patient, acknowledge that a copy of the Notice of Privacy Practices was provided to me.

General Consent to Treatment and Test

Initial here ______ I, the patient or authorized representative of the patient, am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse or other health care professionals in this clinic. I also consent to any medical procedures, x-ray, laboratory tests, or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

Release of Information

Initial here ______ I, the patient or authorized representative of the patient, authorize the Louisiana Center for Advanced Medicine to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial here ______ I, the patient or authorized representative of the patient, authorize payment directly to the Louisiana Center for Advanced Medicine for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible.

Communications Regarding My Account

Initial here ______ I, the patient or authorized representative of the patient, agree that the facility or any other collection or servicing agency or agencies retained by the facility to collect any money that I owe to the facility may contact me by telephone, text message, email, or letter.

I authorize release of my personal information including medical treatment, scheduling and billing information to the individuals listed below.

Name	Relationship

____ ______________________

Signature of patient/parent/guardian/person authorized to represent the patient — Date