Acadiana Medicine Clinic, APMC
Drs. Bordelon, Nix and Santiago
1200 Hospital Drive, Suite 4
Opelousas, LA 70570
Phone (337)948-7090; Fax (337)942-8108

Patient Name_____
(print)
Date of Birth_____

Parent/Agent Name_____
(print)

CONSENT FOR EXAMINATION & TREATMENT: I hereby authorize the healthcare providers of Acadiana Medicine Clinic to treat me/my child and consent to blood testing and diagnostic testing upon order of physician*(*includes nurse practitioner/physician assistant). **Initial Here:_____**

RELEASE OF INFORMATION: I authorize Acadiana Medicine Clinic and its employees or agents to use and disclose my protected health information for the purpose of treatment, payment and operations as described in the Notice of Privacy Practices. **Initial Here:_____**

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that I have received a copy of the Notice of Privacy Practices that describes how my protected health information may be used and shared. I understand this office may change this notice at any time. I may obtain a copy of the Notice by contacting the Clinic's Privacy Officer. **Initial Here:_____**

AUTHORIZATION TO OBTAIN MEDICATION HISTORY: I hereby authorize Acadiana Medicine Clinic's staff to obtain Medication History related to the patient above, from community pharmacies, pharmacy benefit managers, or other external sources for the purpose of continued treatment. **Initial Here:_____**

MEDICARE ASSIGNMENT: The undersigned certifies that the information given by him/her in applying for payment under Title XVII of the Social Security Act is correct. The undersigned authorizes any holder of medical or other information about him/her to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. The undersigned requests that payment of authorized benefits be made on his/her behalf and assigns the benefits payable for healthcare services to the physician*/organization furnishing the services or authorize each physician*/organization to submit a claim to Medicare for payment. **Initial Here:_____**

ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned is entitled to physician* benefits of any type whatsoever arising out of any policy of insurance patient or any other party liable to patient, said benefits are hereby assigned to each physician* for application to patient's bill, and it is agreed that this office may receive for any such payment and such payment shall discharge the said insurance company of any and all obligations under the policy to the extent for such payment, the undersigned and/or patient being responsible for charges not covered by this assignment. **Initial Here:_____**

FINANCIAL AGREEMENT: The undersigned agrees, whether signing as an agent or as a patient, that in consideration of the services to be rendered to the patient, that he/she individually obliges himself/herself to pay the account to the physician*/organization in accordance with the regular rates and terms including, but not limited to, collection agency costs. **Initial Here:_____**

The undersigned certifies that he/she has read the foregoing, and is the patient or agent authorized to execute the above and accepts its terms.

_____ _____ _____
Patient signature Parent or Agent Signature Date