Ref. ID

1124 Burnside Ave.
Gonzales, LA 70737
Ph.225 644 5503
www.CoastalUC.com

Coastal URGENT CARE
Baton Rouge, Gonzales, Houma, Thibodaux

STOP **Please NOTIFY STAFF if you have an emergency such as: CHEST PAIN, a HEAD INJURY, SHORTNESS OF BREATH, SEVERE ABDOMINAL PAIN, or the WORST HEADACHE OF LIFE before continuing.** STOP

Is this visit the result of an accident? Yes No Did this accident occur at work? Yes No

Patient Last Name_____ First Name_____ M. Name + Suffix _____

Sex_____ Date of Birth:_____ SSN_____

Home Phone_____ Cell Phone_____

Street Address / P.O. Box_____ Apt. / Lot # _____

City_____ State_____ Zip _____

Marital Status S M D WD

Email_____ No Email

Language _____ Race _____ Ethnicity _____

GUARANTOR (Person Responsible for bill) same as patient above

Relationship to patient Spouse Child Other_____

Last Name_____ First Name_____ M. Name + Suffix _____

Street Address/P.O.Box_____

City_____ State_____ Zip _____

Date of Birth_____ SS #_____ Phone _____

PRIMARY INSURANCE Name of Ins. _____

Patient's Relationship to Policy Holder Self Spouse Child Other_____

Last Name_____ First Name_____ M.Name + Suffix _____

Policy #_____ Date of Birth_____ SS #_____

SECONDARY INSURANCE Name of Ins. _____

Patient's Relationship to Policy Holder Self Spouse Child Other_____

Last Name_____ First Name_____ M. Name + Suffix _____

Policy #_____ Date of Birth_____ SS #_____

I consent to treatment for myself or above minor child. I understand that the examination and/or medical treatment I will receive is NOT intended to replace complete medical care by my personal primary care physician. Coastal Urgent Care is contracted with many of the local and national managed care plans. However, there are some plans that we do not currently have contracts with, including Medicaid. If you belong to a plan that we are not contracted with, our insurance/billing office will be glad to file a claim for you with the understanding that full payment is due at the time of service.
It is important for you to understand that the patient is ultimately responsible for knowing their individual benefits/coverage and is responsible for any fees that are not covered by their insurance provider, including durable medical equipment (splints, crutches, ace wraps, etc). If you have any questions concerning the coverage your plan has with Coastal Urgent Care, please contact your insurance provider.
I have reviewed and agree with the above information. I certify that the information I have provided is true and correct to the best of my knowledge.

_____ _____

Patient Signature (if minor, signature of parent/guardian) Date

POS® Reorder # 1313634

HIPAA / Financial Policy

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Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Coastal Urgent Care, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name, relationship and a personal identification method of persons you wish to allow access – for example:

Name:	**Relationship:**	**Personal Identification:**
John Doe	**Father**	**Date of Birth, Address or last 4 of SS #**

Restriction Request: _____

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Coastal Urgent Care and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ Date _____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

Date of Birth of Personal Representative _____ Last 4 of SS# _____

If not signed by the patient, please indicate relationship and describe authority to act:

Name of Patient: _____ parent or guardian of minor patient
guardian or conservator of an incompetent patient

Coastal URGENT CARE

Room #:_____

Patient's Name: _____ Age: ____ DOB: _____

Phone: _____ Email: _____

Ht: _____ Wt: _____ LBS KG

Vital Signs: BP-_____ Pulse-____ Resp.-_____ **LMP: _____**

Temp.-___ Pulse Ox-_____

Complaint:_____

_____

_____

Onset: _____days/weeks/months

Allergies: _____

Medications: _____

_____

Past Med/Surg History: _____

_____

Family History: Mother_____

Father_____

Smoke/Drink/Drug Use

☐ Drink ☐ Drug Use _____ Years Smoked _____ Years Smokless Tobacco

☐ Passive Smoke Exposure

Occupation: _____

Immunizations: Up to Date: Y N

Last Tetanus Date: _____

Celestone ___mg

Strep _____

FLU _____

Decadron ___mg

Toradol ___mg