Dr. Louis P Coates

Patient Registration Information

Date_____

Patient Name: Last_____ First_____ Middle _____

Address: _____City_____ St_____ Zip_____

Home #: _____ Work#: _____ Mobile#_____

Date of Birth: _____Social Security #: _____ - _____ - _____

Marital Status: _____ Male _____ Female_____

Employer: _____Address:_____City_____St____Zip____

Occupation: _____ Phone #: _____

Person responsible to pay bill if patient is under 18 years old

Name: _____ Relationship: _____Date of Birth: _____

Address: _____ Social Security #: _____ - _____ - _____

Employer: _____ Address: _____

Occupation: _____ Work #: _____ Home #: _____

Insurance Information

Name of Insured: _____ Insured's Birthdate:_____

Insured's SSN:_____Carrier name:_____

ID#:_____Group#:_____Insurance company's Phone#:_____

I give my permission for Louis P Coates LLC to treat the above named patient and I am legally able to give such permission if he/she is a minor. I understand that I am legally responsible for payment of all bills for care given by Louis P Coates LLC to myself or any of my dependents, regardless of insurance reimbursement.

Patient or responsible party signature_____Print name_____

Emergency Notification

Name: _____ Address:_____

Phone_____ Relationship _____

Dr. Louis P Coates

Acknowledgment of Receipt of Privacy Notice

By signing this form, you acknowledge that Louis P Coates, LLC has notified you of its Privacy Notice, which explains how your health information will be handled in various situations. Due to HIPPA laws we must try to have you sign this form on your first date of service with us after April 14, 2003. The Privacy Notice is posted on the wall in the lobby, available online at www.firewheelfp.com or available to take home upon request.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ] I have received Louis P Coates' Privacy Notice.

[ ] Louis P Coates LLC has given me the chance to discuss my concerns and questions about the privacy of my health information.

Patient's Signature_____ **Date:**_____

.....

Staff must complete the following if Acknowledgment Form is not signed:
Does patient have a copy of the Privacy Notice?
[ ] Yes [ ] No

Please explain why the patient was unable to sign an acknowledgment form and Louis P Coates' LLC efforts in trying to obtain the patient's signature:

_____

Release of Medical Information

I hereby give permission to release any information to:

1._____ Relationship to patient_____

2._____ Relationship to patient_____

3._____ Relationship to patient_____

I wish to be contacted in following manner:

Home_____ Okay to leave a detailed message? Please initial _____

Cell _____ Okay to leave a detailed message? Please initial _____

Signature of Patient:_____ Date_____

We must take several steps to verify the identity if callers. We may ask one of more of the following questions:

"What is the patient's date of birth, last four digits of their SS#, health insurance carrier, treating physician and/or mailing address.

AUTHORIZATION TO RELEASE VERBAL HEALTH CARE INFORMATION DURING THIS ADMISSION

I understand there are times when the law allows *Louis P Coates LLC* to release information regardless of whether or not I give my consent as outlined in the notice of privacy practices. For example, *Louis P Coates LLC* may release information to doctors, nurses and other who provide me with health care or are prospective health care providers; to government agencies as authorized by law to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues a subpoena or court order. I understand this information may be released either orally or in document form.

☐ **STANDARD DISCLOSURE** – I authorize *Louis P Coates LLC* and staff members to discuss my medical history, diagnosis, treatment and prognosis as provided in the notice of privacy practices. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse. I have the right to add anyone or organization that I do not wish to have my medical information by requesting in writing at any time.

☐ **NO INFORMATION** – I do not authorized release of any information regarding my admission or treatment; I choose to be a "No Information" patient. My medical information will only be given to me directly and not anyone else including family members. (Please Note: *Louis P Coates LLC* staff will not be able to acknowledge nor deny my absence or presence to anyone calling including family members.)

This authorization will expire at the end of my clinic service at Louis P Coates LLC, unless I revoke the consent prior to that time.

Signature of Patients or Legally Authorized Representative	**Relationship to Patient**	**Reason Patient Unable to Sign**

CONSENT FOR TREATMENT

I understand that my health condition may require inpatient or outpatient admission, I consent to and authorize testing, treatment and/or hospital care as ordered by my doctor and his/her consultants, associates and assistants. I authorized *Louis P Coates LLC's* nurses, employees and others as necessary to carry out the instructions of my doctor(s) with respect to the procedures and treatment they have ordered. I understand that it may be necessary for representatives of outside health care companies to assist in my care. I also understand student nurses and others in professional training programs may be among the individuals who provide care to me. I understand any tissue or body parts removed from my body may be retained or disposed of by *Louis P Coates LLC* at its sole discretion.

I also understand and acknowledge that Texas law provides if any health care worker is exposed to my blood or other bodily fluid, *Louis P Coates LLC* may perform tests, with or without my consents, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, HIV/AIDS and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of *Louis P Coates LLC.* I understand that the results of tests taken under these circumstances are confidential and do not become a part of my medical record.

NO GUARANTEE: I acknowledge that no guarantees or warranties have been made to me with respect to treatment to be provided at *Louis P Coates LLC.*

I HAVE READ AND UNDERSTAND THIS INFORMATION.

Signature of Patients or Legally Authorized Representative	**Relationship to Patient**	**Reason Patient Unable to Sign**
Witness	**Title**	**Date of Signature**

LOUIS P COATES LLC
5915 Murphy Road – Garland, Texas 75044
Phone (972) 496-6937 Fax (972) 496-6979

FINANCIAL AGREEMENT

The office of *Louis P Coates LLC* files insurance claims for all services with primary insurances. Patients are billed for the remaining balance after payment has been received from the insurance company. Any non-covered services are the financial responsibility of the patient. In the event that the insurance carrier denies payment for a service performed, it is the **patient's** responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the patient and the insurance company. If a patient has no insurance coverage they are financially responsible for all charges incurred. **Co-payments, co-insurance, non-covered services and or deductibles are the responsibility of the patient and are payable at the time of service.**

BY SIGNING THIS, I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICE. IF MY PHYSICIAN IS A PARTICIPANT IN MY HEALTH PLAN, I MUST PRESENT A VALID INSURANCE CARD AT EACH TIME OF SERVICE AND PAY MY COPAYMENT AND NON-COVERED SERVICE AMOUNT PRIOR TO CHECKING OUT OF THE OFFICE. I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY HEALTH PLAN WITHOUT LIMITATION OF DEDUCTIBLE, COPAYMENT OR CO-INSURANCE AMOUNT.

Date: _____ **Signature**_____

Nurse Practitioner / Physician Assistant Consent for Treatment

Dr. Coates has on staff Nurse Practitioners and Physician Assistants to assist in the delivery of primary medical care.

A Nurse Practitioner is not a doctor. A Nurse Practitioner (NP) is a registered nurse who has completed specific advanced nursing education (generally a master's degree or doctoral degree) and training and can diagnose, treat, and monitor common acute and chronic diseases, as well as provide health maintenance care. In addition, the NP may treat minor lacerations and other minor injuries.

A Physician Assistant is not a doctor. A Physician Assistant (PA) is a healthcare professional trained and licensed to practice medicine with limited supervision of a physician. A physician assistant is concerned with preventing, maintaining, and treating human illness and injury by providing a broad range of health care services that are traditionally performed by a physician. Physician assistants conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, and write prescriptions. In addition, the PA may treat minor lacerations and other minor injuries, as well as perform surgical procedures.

I have read the above, and hereby consent to the services of Nurse Practitioner or Physician Assistant for my health care needs.

I understand that at any time I can refuse to see the Nurse Practitioner or Physician Assistant and request to see a physician.

Patient Name	Date of Birth
Patient / Guardian Signature	Date

Patient History Questionnaire

Name_____ DOB_____

Are you allergic to any medication?

Medication	Reaction

Are you currently taking any medications?

Medication	Dosage	How Often

Do you suffer from any of the following medical conditions? Check Yes or No

	YES	NO
High Blood Pressure		
Heart Attack		
Stroke		
Diabetes		
Asthma		
Cancer		
Seizures		
Do you smoke?		
Do you drink alcohol?		

Does any member of your immediate family suffer from the any of the following medical conditions? (ex. Mother, Father, Brother,or Sister)

	Mother	Father	Brother	Sister
High Blood Pressure				
Heart Attack				
Stroke				
Diabetes				
Asthma				
Cancer				
Seizures				

Have you ever had surgery? Please include dates and as much information as possible _____

_____

_____

_____

Female Patients only, date of last menstrual period _____