FCIM
FREEDMAN CLINIC INTERNAL MEDICINE

1337 Centre Court, Alexandria, LA 71301
Phone: (318) 445-9331 Fax: (318) 619-6899

PLEASE BRING:

PICTURE ID
INSURANCE CARDS
LIST OF MEDICATIONS

PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

PATIENT information	Mr. Mrs. Miss/Ms.	First Name	Middle Name	Last Name
Patient's Date of Birth		Social Security Number		Marital Status: ☐ Married ☐ Partner ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Sex: Male ☐ Female ☐ Transgender ☐	Race: ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Native Hawaiian/ other Pacific Islander ☐ Other	Ethnicity: ☐ Hispanic ☐ Non-Hispanic		Primary Language:
E-mail address:				Does patient want to receive e-mail: yes ☐ no ☐
Home phone		Cell phone		Alternate Phone
Address	Street or P.O. Box	City	State	Zip Code
Patient's Employer	Name of Company	Address		Phone
Guardian, Spouse, information	First Name	Middle Name	Last Name	
Phone number		Spouse's Date of Birth		Spouse's Social Security Number
Address if different from above				
Guardian, Spouse, Employer	Name of Company	Address		Phone Number
Emergency Contact	Name	Relationship to patient		Phone Number (s)
Street or P.O. Box		City	State	Zip Code

IF YOU ARE LISTED AS THE DEPENDENT ON SOMEONE ELSE'S INSURANCE,
We need their name, address, date of birth and Social security number and phone number.

Policy Holders Name	Relationship to patient	Policy Holders date of birthdate	Policy Holders Social Security Number
Policy Holders Address			Policy Holders Phone number

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE.

METHODS OF PAYMENT ACCEPTED: CASH / CHECK / MONEY ORDER / CREDIT CARD

Signature _____ Date _____

Spouse or Guardian _____ Date _____

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MEDICAL BENEFITS & HIPAA PRIVACY PRACTICES

___ I, the undersigned patient of Freedman Clinic of Internal Medicine, LLP, do hereby acknowledge that I have received a copy of the Notice of Privacy Practice of this office & it is my responsibility to read its contents. I understand that a copy will always be available to me. Furthermore, I understand that any questions that I may have can be directed to the Privacy Officer and/or my physician.
___ I directly assign all Medical & Surgical Benefits provided by Freedman Clinic of Internal Medicine, LLP & understand that I am financially responsible for all charges whether or not paid by my insurance. In the event collection action becomes necessary, I agree to pay reasonable collection costs of the unpaid balance should my account be forwarded to a collection agency. I hereby authorize the provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.
___I understand that my provider may require in the course of my treatment that I have lab work, radiology, diagnostics, and/or other procedures and etc. that will be performed by offices other than FCIM and that they will send me statements from their offices and FCIM is in no way responsible for their billing practices.
___ I acknowledge that the office of FCIM has notified me of the option to access my medical records through the eClinical Works Patient Portal &/or HEALOW application and its benefits, by providing my personal email address should I choose to participate. I am aware that my health information can be transmitted by electronic transmission, fax transmittal, internet, or by email.

PLEASE CHECK ONE OF THE FOLLOWING:
___I am satisfied to read and consult the office copies of the NOTICE OF PRIVACY PRACTICIES that are always available to me.
___ I would like a personal copy to take home with me.

PRESCRIPTION HISTORY CONSENT

I agree that the clinic may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.
(PLEASE INITIAL ONLY ONE) YES _____ or NO _____

I AUTHORIZE Freedman Clinic of Internal Medicine, LLP to release my protected medical information, including prescriptions, x-rays, orders, doctors excuse, etc. and billing information as described in our Notice of Privacy Practices as well as I authorize Freedman Clinic of Internal Medicine, LLP to release my medical information to the below listed. (*THIS IS NOT A MEDICAL RECORDS RELEASE*)

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Authorization to release *APPOINTMENT INFORMATION ONLY* with a person or voicemail:

Home: _____ YES or NO

Relative: _____ Relation _____ YES or NO

Text: _____ YES or NO

Email: _____ YES or NO

- **DO NOT LEAVE MESSAGES**

Signature: _____ Date: _____