Preferred Pediatrics

Dr. Anne T. Boudreaux, M.D. Catherine S. Fangue, FNP-C Hayley M. Chatagnier, FNP-C

Patient Information

Date: _____

Minor/Child:

Last Name:_____First Name: _____ Middle:_____

Patient Primary Phone:_____ Sex:_____ Date of Birth:_____

Mailing Address:_____

City:_____State_____Zip:_____

Race:_____ **Ethnicity** (Check one): Hispanic or Latino: yes __ no__

Siblings:_____

Responsible Parties:

Father/Guardian's Name:_____Date of Birth:_____

Mailing Address:_____Home Phone:_____

City:_____State:_____Zip:_____Cell Phone:_____

SSN:_____Employer:_____Work Phone:_____

Mother/Guardian's Name:_____Date of Birth:_____

Mailing Address:_____Home Phone:_____

City:_____State:_____Zip:_____Cell Phone:_____

SSN:_____Employer:_____Work Phone:_____

Insurance Information

Name of Primary Policy Holder:_____Date of Birth:_____

Mailing Address:_____Home Phone:_____

City:_____State:_____Zip:_____Cell Phone:_____

SSN:_____Employer:_____Work Phone:_____

Insurance Company:_____Group & Policy #:_____

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST

Emergency Contact (other than parent/guardian):_____

Relationship:_____Daytime Phone:_____Cell Phone:_____

How did you hear about our practice:_____

142 Rue Marguerite
Thibodaux, LA 70301
Phone: 985-449-7529
FAX: 985-449-7518

Date:_____

Designation of Individual Involved in My Care

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), you have the right to authorize the release of your protected health information, including medical and billing records, to an individual(s) you designate. Please complete this form in its entirety designating the individual(s) with whom you would like **PREFERRED PEDICATRICS, L.L.C.** to share your information.

Patient Name: _____ Date of Birth:_____

Designation of Individual(s) Involved in My Care:

At my request, I hereby identify the following individual(s):

_____

(List NAME(S) AND PHONE NUMBER(S) of designated individual(s))

_____

(collectively, the "Designated Individual") as individual(s) involved my care and I hereby authorize **PREFERRED PEDIATRICS, L.L.C.** (the "Clinic") to release any and all protected health information about me, including billing and medical records, to the Designated Individual. This authorization permits both the disclosure of paper records and verbal communications. Additionally, to the extent my medical or billing records contain information related to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, HIV/AIDS, and /or other sensitive information, I hereby agree to its release.

Termination/Revocation of Designation:

Unless terminated sooner in writing by me, this authorization will terminate three (3) years after my last date of treatment by the Clinic. I understand that I may revoke this authorization and cancel this designation by sending a written Revocation of Designation Form to the Clinic at 142 Rue Marguerite, Thibodaux, Louisiana 70301. I understand and acknowledge that the revocation or cancellation of this designation shall not apply to information that has already been released prior to the revocation/cancellation date.

Re-Disclosure

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPPA.

No Obligation to Sign:

I understand that I do not have to sign this authorization and treatment of me will not be denied if I do not sign this form. I hereby release and discharge the Clinic, its employees, agents and owners of any liability and will hold them harmless for complying with this authorization.

_____ _____

Signature of Patient **Date**