Psychological Healthcare of South Louisiana

126 Rue Colette
Thibodaux, LA 70301
985-625-0023 Telephone
985-625-0022 Facsimile

PATIENT INFORMATION FORM

****EVERY SECTION MUST BE COMPLETED****

Name:		Birthdate:		Age:		Gender: ☐ M ☐ F
Ethnicity or Race:	☐ Caucasian ☐ Hispanic/Latino ☐ African American ☐ Native American ☐ Asian ☐ Other: ______________					
Address:		City:		State:		Zip:
Cell phone:	( )	Home phone:	( )	Work phone:	( )	
Prefer:	☐ Cell ☐ Home ☐ Work	Email:				
Do you want appointment reminder text messages?	☐ Yes ☐ No					

Care Team

Referred by (full name):					
Primary Care Doctor (full name):					
Pharmacy name:		Located at:			
Who is completing this form (full name)?		Relationship to patient?			
Address:		City:		State:	Zip:

Primary Insurance

Carrier:		ID Member Number:		Group Number:			
Policy holder information							
Name:		Birthdate:		SSN:			
Address:		City:		State:		Zip:	
Phone:	( )	Relationship to patient:					

Secondary Insurance, if applicable

Carrier:		ID Member Number:		Group Number:			
Policy holder information							
Name:		Birthdate:		SSN:			
Address:		City:		State:		Zip:	
Phone:	( )	Relationship to patient:					

CURRENT MEDICATION LIST		
Patient name:		**Date:**
Medication	**Dosage Level**	**Times Per Day**

Medication History: What has the patient tried in the past for the symptoms being treated today? This is important for treatment and getting new medication prior authorization from insurance.

Medication	When tried?	What was the outcome?

Patient Payment Guarantee

In consideration for treatment as a patient, the undersigned hereby accepts the financial responsibility for all charges and services (including but not limited to, conference calls, record review and correspondence). As a courtesy to our patients, the office will call to verify insurance benefits and to possibly obtain pre-certification for services when we are in-network. However, this is no guarantee of payment by the insurance. Therefore, the patient should be involved in the pre-certification process to ensure the accuracy of the information that is received. <u>The undersigned ultimately, unconditionally guarantees payment and understands that the undersigned remains responsible for all charges incurred, notwithstanding any insurance or other third party coverage that may provide benefits for these services.</u> It is understood that assigning any benefits due under any insurance policies does not relieve the undersigned of financial responsibility for payment of services rendered.

The undersigned agrees to pay 25% attorney's fee if referred for collection. The undersigned agrees to pay 18% per annum on any balance owed for 90 days or more.

ASSIGNMENT OF BENEFITS:
I assign all benefits and rights to which I am entitled and which are otherwise payable to me under any and all insurance contracts, self-insured programs or from any third party payer and authorize and direct that payment of such be made directly to the provider for services rendered including any and all statutory penalties, which may also be claimed and collected.

CANCELLATION POLICY:
All cancelled appointments require **24 hour notice of cancellation**. If an appointment is not canceled with 24 hour notice and the patient does not show for the scheduled appointment, the patient will be billed for the visit and will not be rescheduled until the fee is paid. This fee is 100% the patient's responsibility and is not reimbursable by third parties. Furthermore, a provider reserves the right to discharge a patient who incurs excessive cancellations and/or no shows, meaning the patient will be notified by letter that they will have continued care for 30 days to allow them time to find a new provider.

Late cancellation rates are as follows:

Dr. Chris Rachal, ABN, PhD, MP	($80.00)
Dr. Alyse Blanchard, PhD	($80.00)
Mary Esteve, LSSP	($80.00)
Jason Talbot, LSSP	($80.00)
Ryan Kelley, PMHNP-BC	($80.00)
Dawn Toups, LPC	($75.00)
Windy Rachal, LPC	($75.00)
Mike DiSalvo, LPC	($75.00)
Kelli Daigle, LPC	($75.00)
Cecilia Daigle, LMFT	($75.00)
Mark Dufrene, PLPC	($50.00)
Jill Talbot, LPC	($50.00)
All testing appointments	($150.00)

I have read the above and I understand and agree to the terms contained herein.

____ ________________
Patient name **Date of Birth**

____
Guardian name, if minor

____ ________________
Signature of patient or guardian **Today's Date**