HEALTHremède
FAMILY WALK-IN CLINIC
OCCUPATONAL MED
WELLNESS

3235 Perkins Road
Baton Rouge, LA 70808
Office: (225) 387-3030
Fax: (225) 387-4521

8742 Goodwood Blvd
Baton Rouge, LA 70806
Office: (225) 231-7070
Fax: (225) 231-7069

13466 Vera McGowan Road
Walker, LA
Office: (225) 380-1720
Fax: (225) 380-1719

PATIENT REGISTRATION FORM

Patient Name *(Last, First, M.I.):* ☐ M ☐ F		**SSN#:**
Address:		
City:	**State:**	**Zip:**
Home Telephone: ( )	**Cell: ( )**	
Age:	**DOB:**	
Driver's License #:		
Place of Employment:	**Work Phone: ( )**	
Date:		

How did you find out about HEALTHremède?

Emergency Contact/Spouse/Responsible Party		
Name:		
Address:		
City:	**State:**	**Zip:**
Relationship to you:	**Work Phone: ( )**	
Home Phone: ( )	**Cell: ( )**	
If Patient is a minor, we need both parent's & employer's phone numbers:		
(parent/employer phone con't):		

Payment is expected at the time of service

You are expected to show a picture ID when requested. METHOD OF PAYMENT_____CASH_____CREDIT CARD

* HEALTHremède does not accept checks as a form of payment, sorry for any inconvenience.

INSURANCE		
☐ American Life Care	☐ Blue Cross/ PPO	☐ First Health
☐ CIGNA/ PPO	☐ Group Benefits/ PPO	☐ MEDICARE
☐ United Health Care	☐ Aetna	☐ Other:

***Please check the appropriate insurance program above if you are a member and inform the receptionist. Please have your ID card present and wait until your insurance is verified.**

HEALTHremède physicians are not primary care providers for any patient because HEALTHremède is a walk-in clinic open M-F, 8:00 – 5:00.

I the undersigned hereby irrevocably assign and transfer benefits to this provider but not limited to penalties and attorney or collection fees per LRS 22: 657 and I authorize the release of any medical or other information necessary to process this claim. I also accept responsibility for the balance of my account, if my insurance fails to pay for the services. I also authorize this provider to charge my credit care in case of non-payment of NSF

checks.

I do not authorize HEALTHremède to release my protected health information to any entity/person without my written consent with the exception of third party payers or other medical providers involved in my present care or my place of employment as only in case of drug screens, physicals or injuries acquired at work-site. However, in case I am referred to another doctor or facility by HEALTHremède providers, I will make it sure that HEALTHremède providers receive the results from these referrals.

PATIENT'S or AUTHORIZED PERSON'S SIGNATURE