DESOTO HEALTHCARE CENTER, INC.
RURAL HEALTH CLINIC
7356 HIGHWAY 509 P.O. BOX 1384
MANSFIELD, LA 71052
PHONE: (318) 871-1633 FAX: (318) 871-1677

Identifying Information

First Name	Middle Name	Last Name	Title(Mr. Mrs. Ms, Jr. Sr. etc

Age	Marital Status	Gender/Sex	DOB	Social Security Number

Contact Information

Preferred method of communication

- ☐ Home phone
- ☐ Mobile phone
- ☐ Office
- ☐ Email
- ☐ Letter
- ☐ Other____

Email Address	Home Phone	Mobile Phone	Office Phone Ext:

Emergency Contact Person	Relationship	Telephone #	Address

Address

Address	City/State	Zip Code	Parish/County

Demographics

Ethnicity	Preferred Language
Race	Religion

Insurance Information

Payer	Priority ☐ Primary ☐ Secondary ☐ Tertiary ☐ Unknown	Type ☐ HMO ☐ PPO ☐ POS (Point of Service) ☐ Private Other____________
Plan name		

Relationship to Insured	Start Date	Insured ID #	Group #

Employer Name	Insurance Payment Type ☐ CoPay ☐ None	Payment Type ☐ Fixed Amount ☐ Payment Percentage

Address	City/State	Zip Code	Telephone #

Consent for treatment

I ____________________________________ authorize Desoto Healthcare Center, Inc. to examine and
Print Your Name

provide treatment for _______________________________________.
"self" if you are patient or name of dependent

Signature _____________________________________

Relationship ___________________________________

Date____

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Privacy/Authorization to release records

I, (print clearly) ___________________________________ understand that Desoto Healthcare Center Inc. (DHC) may be required to release information from my records, which may include personally identifying information such as name; address; date of birth; and social security number, as well as medical information such as diagnoses and treatment plans to third parties such as Medicaid, Medicare and or insurance companies in order to satisfy requirements for reimbursement to DHC for services rendered to myself, my dependents, or other beneficiaries for whom I have medical power of attorney. Such release of records is authorized by my signature below and shall not require a separate authorization. Such release of records shall remain in effect until all reimbursements for services rendered have been resolved.

DHC is not authorized and shall not release personally identifying and or medical information to any other third party, including but not limited to, other healthcare providers without a separate written authorization.

My signature below attests to the fact that I have read or have explained to me and I understand the above privacy and release authorization statements and that the Notice of Privacy Policies and Procedures have been made available to me.

Signature: ____Relationship_________________

Printed Name: ____ Date________________________

Payment Agreement

I, (print clearly) ______________________________________ authorize Medicare, Medicaid or the appropriate insurance company to reassign payments on behalf of myself, my dependents, or others for whom I have medical power of attorney, to Desoto Healthcare Center, Inc. (DHC) for services rendered by DHC to myself, my dependents, or others for whom I have medical power of attorney. I understand that and agree that any amounts denied by the insurance company/Medicare/Medicaid remain my responsibility, unless expressly prohibited by the regulations governing DHC as a participating provider in the applicable third party reimbursement program.

I further understand that if there is a balance due for services rendered, after application of third party reimbursement, that I may be billed for the balance due. I am responsible for payment of the balance due within 30 days of the billing date.

Signature _______________________________________

Relationship _____________________________________

Date____