Dr. Louis P Coates
Patient Registration Information Date________________________

Name: Last__________________________________ First_____________________________ Middle________________

Address ____ City_________________________________ Zip___________

Cell#_______________________________ Work# ____________________________ Home#________________________

Date of Birth_____________________________ Social Security# _________ - _________ - _________

Marital Status_____________ Male_____ Female _____ Occupation____

Email address ____

Person Responsible for payment if patient is under 18 years old

Name____Relationship_________________________DOB______________

Address____ Social Security# _________ - _________ - ________

Employer____ Address____

Occupation_________________________________ Work# _______________________ Home ______________________

Insurance Information

Name of Insured ____ Insured's DOB __________________________

Insured's SSN# _________ - _________ -_________ Carrier name____

ID# ____Group# ____

I give permission for Louis P Coates LLC to treat the above named patient and I am legally able to give permission if he/she is a minor. I understand that I am legally responsible for payment of all bills for care given by Louis P Coates LLC to myself and any of my dependents, regardless of insurance reimbursement.

Patient or responsible party

Signature ____ Printed____

Emergency Contact ______________________________________ Relationship________________________________

Cell# _____________________________ Home# ___________________________ Other#__________________________

Acknowledgment of Receipt of Privacy Notice

By signing this form you acknowledge that Louis P Coates LLC has notified you of its Privacy Notice, which explains how your health information will be handled in various situation. Due to HIPPA laws we must try to have sign this form on your first date of service with us after April 14, 2003. The privacy Notice is available in the office and online at www.drcoates.net.

Check all that are true:

_______I have received Louis P Coates' Privacy Notice

_______ Louis P Coates LLC has given me the chance to discuss my concerns and questions about the privacy of my health information

Patient Signature____ Date _____________________

If the patient is unable to sign this acknowledgement please explain why

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Release of Medical Information

I hereby give permission to release any information to:

1____ Relationship____

2____ Relationship____

3 ____ Relationship____

Preferred Method of Contact

Cell# ____ Home# ____

Okay to leave detailed message on cell? Please Initial ___________________

Okay to leave detailed message on home? Please Initial ____________________

We must take several steps to verify the identity of callers. We may ask one or more of the following questions and/or not limited to: Date of Birth, last four digits of SSN#, mailing address, health insurance carrier.

Authorization to Release Verbal Health Care Information During This Admission

I understand there are times when the law allows Louis P Coates LLC to release information regardless of whether or not I give my consent as outlined in the notice of privacy practice. For example: Louis P Coates LLC may release information to doctors, nurses, and other who provide me with healthcare or are prospective healthcare providers, to government agencies as authorized by law to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues subpoenas or court orders. I understand this information may be released either orally or in document form

☐ **STANDARD DISCLOSURE** – I authorize Louis P Coates and staff members to disclose my medical history, diagnosis, treatment and prognosis as provided in the notice of privacy practices. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health, and drug, alcohol or chemical abuse. I have the right to add anyone or organization that I do not wish to have any medical information by requesting in writing at any time.

☐ **NO INFORMATION** – I do not authorize release of any information regarding my admission or treatment. My medical information will only be given to me directly and not to anyone else including my family members. (Please note: Louis P Coates LLC will not be able to acknowledge nor deny my absence or presence to anyone calling including family members)

This authorization will expire at the end of my clinic service at Louis P Coates LLC, unless I revoke the consent prior to that time.

__________________________	__________________________	__________________________
Patient Signature or Authorized Legal Representative	Relationship to Patient	Reason Patient Unable to Sign

Consent for Treatment

I understand that my health condition may require inpatient or outpatient admission, I consent to and authorize testing, treatment and/or hospital care as ordered by my doctor and his/her consultants, associates and assistants. I authorize Louis P Coates LLC's nurses, employees and others necessary to carry out the instructions of my doctor with respect to the procedures and treatment they have ordered. I understand that it may be necessary for representatives of outside healthcare companies to assist in my care. I also understand student nurses and others in professional training programs may be among the individuals who provide care to me. I understand any tissue or body parts removed from my body may be retained or disposed of Louis P Coates LLC at its sole discretion.

I also understand and acknowledge that Texas law states if any healthcare worker is exposed to my blood or other bodily fluid, Louis P Coates LLC may perform tests, with or without my consent, on my blood or other bodily fluids to determine the presence of any communicable disease, including but not limited to, Hepatitis, HIV/AIDS and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of Louis P Coates LLC. I understand that Louis P Coates LLC is required by law to report the presence of any of these diseases to the local health department.

NO GUARANTEE: I acknowledge that no guarantee or warranties have been made to me with respect to treatment to be provided at Louis P Coates LLC.

I HAVE READ AND UNDERSTAND THIS INFORMATION

__________________________	__________________________	__________________________
Patient Signature or Authorized Legal Representative	Relationship to Patient	Reason Patient Unable to Sign
__________________________	__________________________	__________________________
Witness	Title	Date of Signature

Louis P Coates LLC
5915 Murphy Rd. Garland, Texas 75048
Phone (972) 496-6937 Fax (972) 496-6979

FINANCIAL AGREEMENT

The office of Louis P Coates LLC files insurance claims for all services with primary insurances. Patients are billed for the remaining balance after payment has been received from the insurance company. Any non-covered services are the financial responsibility of the patient. In the event that the insurance carrier denies payment for a service performed, it is the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the patient and insurance company. If a patient has no insurance coverage they are financially responsible for all charges incurred. Co-payments, co-insurance, non-covered services and or deductibles are the responsibility of the patient and are payable at the time of service.

By signing this, I understand that payment is expected at the time of service. If my physician is a participant in my health plan, I MUST present a valid insurance card at each time of service and pay my co-payment and non-covered service amount prior to checking out of the office. I understand that I may be responsible for any amount not covered by me health plan without limitation of deductible, co-payment or co-insurance amount.

Signature____ Date___________________________

5915 Murphy Rd.   Garland, Texas 75048
Phone (972) 496-6937   Fax (972) 496-6979

Physician Assistant Consent for Treatment

Dr. Louis P Coates has on staff Physician Assistants to assist in the delivery of primary care.

A Physician Assistant is not a doctor. A physician assistant (PA) is a healthcare professional trained and licensed to practice medicine with limited supervision of a physician. A physician assistant is concerned with preventing, maintaining, and treating human illness and injury by providing a broad range of healthcare services that are traditionally performed by a physician. Physician assistants conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive healthcare, and write prescriptions. In addition, the PA may treat minor lacerations and other minor injuries, as well as perform surgical procedures.

I have read the above, and hereby consent to the services of Physician Assistant for my healthcare needs.

I understand that at any time I can refuse to see the Physician Assistant and request to see a physician.

__________________________________   _________________________
Patient/Guardian name   Date of Birth

__________________________________   _________________________
Patient/Guardian Signature   Date

Patient History Questionnaire

Name ______________________________ Date of Birth ____________________

Are you allergic to any medication?

Medication	Reaction

Are you currently taking any medication?

Medication	Dosage	How Often

Do you suffer from any of the following medical conditions? Check Yes or No

	Yes	No
High Blood Pressure		
Heart Attack / Stroke		
Diabetes		
Asthma		
Cancer		
Seizures		
Do you smoke?		
Do you use alcohol?		

Does any member of your immediate family suffer from any of the following medical condition? (ex: Mother, Father, Brother, Sister)

	Mother	Father	Brother	Sister
High Blood Pressure				
Heart Attack/Stroke				
Diabetes				
Asthma				
Cancer				
Seizures				

Have you ever had surgery? Please include type and date______________________________

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