Elizabeth R. LaRoche, M.D.
Kathleen Rosenhagen, APN
305 Uptown Square
Murfreesboro, TN 37129

Patient Name:_____ Date of Birth:_____

Street Address: _____

City:_____ State: _____

Zip Code: ___ ____ ____ ____ _____

Home # (___)_____ Cell # (___)_____ Work # (___)_____

Primary Care Physician: _____ Location: _____

Marital Status: M S D W

Social Security Number: _____-_____-_____

Employer: _____ Employment Status: FT /PT /Retired

Emergency Contact

Contact Name:_____ Relationship: _____

Street Address: _____

Home # (___)_____Cell # (___)_____Work # (___)_____

Insurance Information

Primary Insurance: _____

Policy Holder Name: _____ Date of Birth: _____

Address (complete if different from yours) _____

Secondary Insurance: _____

Policy Holder Name: _____ Date of Birth: _____

Address(Complete if different from yours) _____

Prescription History Consent

I authorize viewing and obtaining my external prescription history via the practice's electronic medical records system. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my doctor and staff here. It may include prescriptions back in time several years. My signature certifies that I have read and understand the scope of my consent, and I authorize access.

Signature:_____ Date: _____

OTHER INFORMATION/CONSENT

Email Address: _____

Ok to leave message with details: Home: Yes/No Cell: Yes/No Work: Yes/No

Race: _____American Indian or Alaska Native _____Asian _____Black or African American

_____Native Hawaiian or other Pacific Islander _____White ____Unreported/Refused

Ethnicity: Hispanic_____ Non-Hispanic_____ Do Not Wish To Provide_____

What Language do you speak? _____English Other_____ If other, please provide_____

Name of person/persons with whom your personal medical information can be discussed

_____ Relationship_____

Pharmacy Name_____ Pharmacy Location_____

<u>Notice of Privacy Practices for Protected Health Information</u>

I acknowledge that I have reviewed the Notice of Privacy Practices with an effective date of September 2013 and that a paper coper will be provided upon my request. I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Signature_____ Date_____

Printed Name: _____

ASSIGNMENT OF BENEFITS

I hereby authorize the assignment of benefits(payments) directly to Elizabeth R. LaRoche, M.D. for all my insurance claims related to services received. I agree to pay any and all charges that exceed or are not covered by my insurance. I understand that copays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date_____

FINANCIAL POLICY

We are happy that you have chosen Elizabeth R. LaRoche, M.D. to provide your healthcare needs. We are committed to providing the best care and service available. As a part of this commitment, it is important that you have a clear understanding of our financial policies. Our staff will be glad to answer any questions you may have.

We participate in most insurance plans, but due to continuing changes within the insurance industry, we cannot guarantee that your services will be covered. However, we will work with you and your insurance company to come to an agreement if we are contracted with your carrier. As most insurance companies do not require precertification for our services, it is the patient's responsibility to check to see if predetermination is required. Our staff will furnish pertinent information upon request.

We will file all claims to the patient's insurance company(s) upon receipt of all required information and releases. You will not be sent a statement until after we have received payment or denial from the insurance accept in the case of surgeries. We will call on all surgeries and verify pre-pays in advance and require that amount before surgery is performed. All statements are due and payable upon receipt. Insurance payment authorizations are included in your paperwork. Should you refuse to sign the authorization to have your insurance benefits paid to us, you will be responsible for paying the total of your charges at the time of service.

It is the patient's responsibility to insure that Dr. LaRoche is a contracted provider for her insurance.

I understand that the contract between me and the insurance company provided that all co-payments are due and payable at the time of service and that service can be denied me if I am not prepared to pay my copay per the contract between my insurance company and the provider. (Discretionary on a case to case basis)

Unless prior arrangements have been mad, those who are uninsured are expected to pay at time of service.

We accept Visa, Mastercard, or Discover for your convenience.

I have read, understand, and agree to abide by the above policies.

_____ _____

Print Name **Date of Birth**

_____ _____

Signature **Date**

_____ _____

Witness **Date**