SureAccess MD
A DIFFERENT KIND OF DOCTOR.

# REGISTRATION FORM

| Today's date: | Patient ID# |
|---|---|

## PATIENT INFORMATION

| Patient's last name: First: Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

By what name do you prefer to be called? (i.e "Rich" instead of "Richard"):

| Street address: | Social Security no.: | Home phone #: ( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Work phone #: ( ) |
|---|---|---|

| Pharmacy: | ❑ Dr. | | ❑ Hospital |
|---|---|---|---|

| ❑ Family | ❑ Friend | ❑ Close to home/work | ❑ Yellow Pages | ❑ Other |
|---|---|---|---|---|

Other family members seen here:

Email address: Cell phone #:

Preferred method of contact: ❑ Home phone ❑ Cell Phone ❑ Work phone ❑ Mail ❑ Email

## INSURANCE INFORMATION (BRING CARD TO ALL VISITS)

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone #: ( ) |
|---|---|---|---|

Is this person a patient here? ❑ Yes ❑ No

| Occupation: | Employer: | Employer address: | Employer phone #: ( ) |
|---|---|---|---|

| Please indicate primary insurance | | | |
|---|---|---|---|

| Subscriber's name: | Subscriber's S.S. #: | Birth date: / / | Group #: | Policy #: | Co-payment: $ |
|---|---|---|---|---|---|

| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

| Name of secondary insurance (if applicable): | Subscriber's name: | Group #: | Policy #: |
|---|---|---|---|

| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone #: ( ) | Work phone #: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sure*Access* MD or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*

Rick Michael, M.D./Paul Guidry, M.D. 1534 Elizabeth Avenue, Suite 401B Shreveport, LA 71101

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_____ Date of Birth _____

Previous Name:_____ Social Security #_____

I request and authorize _____ to release healthcare information of the patient named above to:

___ **Sure*Access* MD, LLC/Rick Michael, M.D.**
**1500 Line Avenue, Suite 204**
**Shreveport, LA 71101**

**Other** _____
_____
_____
_____

**The purpose of this authorization:** ___further medical care ___personal ___legal investigation or action

___changing physicians ___research related treatment ___creating health information for disclosure to a third party

___other (specify)

**This request and authorization applies to:**

___Healthcare information relating to the following treatment, condition or dates:_____

___All healthcare information

___Other:_____

**Definition:** Sexually Transmitted Disease (STD), as defined by law (RCW 70.24 et. Seq.), includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

___YES ___NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

___YES ____NO I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 1 year of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Policy for instructions on how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once information is disclosed per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996.

Patient Signature_____Date Signed_____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

SureAccess MD
A DIFFERENT KIND OF DOCTOR.

1534 Elizabeth Avenue, Suite 401B
Shreveport, LA 71101

**AGREEMENT AND CONSENT TO PARTICIPATE IN SURE*ACCESS* MD, LLC PROGRAM**

The purpose of this Agreement is to explain the terms and conditions under which you, the Patient, will participate in the program provided by Sure*Access* MD, LLC for the providing of primary care services by Dr. Richard (Rick) Michael, or Dr. Paul Guidry in a unique practice setting. Membership in this practice will be limited to the Patients who agree to pay the membership fee set forth in exhibit "A" to this Membership Agreement and who are accepted into the practice as indicated by Dr. Michael's, or Dr. Guidry's signature on this Agreement.

**1. Patient/Member**

"Patient"/"Member" refers to the individual whose name is listed on the signature page of this Membership Agreement. If a spouse, a family member, (parent or children), or a guardian signs for an individual, the Patient/Member shall refer to the member receiving the healthcare provided. Signing this agreement does not vary applicable state, federal and local laws regarding healthcare, confidentiality of medical information, or contractual reimbursement.

**2. Doctor**

Dr. Richard (Rick) Michael, or Dr. Paul Guidry, as well as any physician subsequently employed or contracted by Sure*Access* MD, LLC, will be the primary care physician for purposes of this Membership Agreement. During the times that the Doctor is on vacation, a qualified physician/provider will be available to provide as the services listed in this Agreement (as close to a normal routine as is possible while the doctor is out). The Doctor will be available to see Patients/Members in an office setting during regular business hours, but available to the Patient/Member twenty-four hours a day via phone and email services.

**3. Sure*Access* MD, LLC**

Sure*Access* MD, LLC is a Louisiana Limited Liability Company. Sure*Access* MD, LLC is owned by Drs. Richard (Rick) Michael, and Dr. Paul Guidry and will administer certain non-medical aspects of the practice. As long as the Patient/Member participates in the Sure*Access* MD, LLC program, Dr. Michael, or Dr. Guidry will have the authority and responsibility for the providing of medical services to the Patient/Member.

The membership fee that the Patient/Member pays under this Agreement to participate in this medical practice will be collected by Sure*Access* MD, LLC and paid to Sure*Access* MD, LLC as

payment for services outlined in the Membership Agreement and provided by Dr. Richard (Rick) Michael, or Dr. Paul Guidry.

4. **Doctor's Services**

Dr. Richard (Rick) Michael, or Dr. Paul Guidry (or a replacement when they are out of the office on vacation) will provide primary medical care services to the Patient/Member and a level of professionalism and expertise that is consistent with the care generally provided by primary care physicians who are practicing in the Shreveport area. In addition, the Doctor agrees to setup his practice in order to afford the Patient/Member the care and attention described in this Membership Agreement. Generally, the Doctor agrees to limit his practice to no more than five hundred (500) Patients/Members during the term of this Membership Agreement.

The Doctor will supply the Patient/Member with his/her personal cell phone number or an after-hour phone number that will directly connect to his/her cell phone, as well as an e-mail address. He/She, or his covering physician/provider, will make every effort to be personally available to the Patient/Member at all times whether in the office or during non-office hours (evenings and weekends).

The Doctor, to the extent reasonably possible, will make his best efforts to see the Patient/Member in the office on the same or the next business day after a request for appointment is made for routine or urgent care.

In addition, to the extent reasonably possible, the Doctor will see the Patient/Member in the office at the time of the scheduled appointment with the goal to keep the waiting time to the absolute minimum.

***No service that is currently, or will in the future, be considered allowable by Medicare or reimbursed by a private insurance company can be included in the annual fee.***

5. **Additional Delineation of Services Provided By Membership Fee**

The services or amenities provided by the Annual or Monthly Membership fee includes, but is not limited to, the following:

**A.** As above, the Doctor will maintain a small practice population (small relative to a traditional practice in the Shreveport-Bossier City area) that allows the Patient/Member same day or next day access to the Doctor, after-hour access to the Doctor, and longer appointment times with the Doctor that will be focused on a comfortable pace and interaction, as well as an attempt to provide very detailed and thorough primary care.

**B.** The Doctor will be available to see the Patient/Member in an out of office setting (home, nursing home, skilled nursing facility, etc.) when clinically appropriate and agreed upon between the Doctor and Patient/Member.

**C.** The Doctor will be available to accompany the Patient/Member to an appointment with a Specialist when clinically appropriate and agreed upon between the Doctor and Patient/Member.

**D.** The Doctor will review the Patient's/Member's electronic health record prior to each Patient/Member visit in order to create a list of objectives for the visit that will make the visit as productive and efficient as possible.

**E.** The Doctor will provide the Patient/Member with an executive level Annual Exam ("Physical") once every one to two years (with an attempt to do it once a year when feasible). This Annual Exam will include a screening EKG (heart scan of electrical activity) and screening spirometry testing (lung function evaluation through measuring lung volumes), meaning that there is no clinical reason to perform these tests and that these tests are not billed to the Patient's/Member's insurance company.

**F.** The Doctor will attempt to communicate lab results, radiologic results, and other Patient/Member results to the Patient/Member in writing (snail mail), email, or via phone conversation within five days of acquiring such data.

**G.** The Doctor will enroll the Patient/Member, when appropriate, in the Practice's Vascular Screening Program as arranged with the Highland Clinic Vascular Lab. This is a program that screens for asymptomatic vascular disease (blockages, aneurysms, etc.) in the carotid arteries, abdominal aorta, and lower extremity arteries. This Vascular Screening Program is paid for by the Doctor out of Membership Fees received from the Patient/Member. This Vascular Screening Program is not usually done for general routine health maintenance in asymptomatic patients and is not paid for by insurance programs for asymptomatic patients.

**H.** The Doctor will refer the Patient/Member, when it is clinically appropriate, for low cost screening tests such as coronary artery screening for blockages (CT Coronary Artery Calcium Scoring), for genetic testing to evaluate disease risk and metabolism of certain medications, and for other innovative testing/technologies that are not generally done in a traditional primary care practice.

**I.** The Doctor will make arrangements for members admitted as inpatients to all local hospitals to be admitted to and cared for by the designated hospitalist services at each specific hospital. The Doctor will maintain, as best he/she can, access to the computer systems for each local hospital in order to stay aware of care of the member while in the hospital. The Doctor will make every effort to expediate care and maintain continuity of care once the member is discharged home and requires needed follow-up.

**J.** The Doctor will evaluate patients with cognitive complaints with a commercial platform designed for cognitive assessment called BrainCheck when clinically appropriate.

**K.** The Doctor will promise to always strive to evaluate his practice style and practice offerings in order to evolve his concierge practice to provide his Patients/Members with high yield and cutting-edge technologies that promote better individual health and/or better understanding of one's health status.

6. **Term**

The term of the Agreement shall be one (1) year from the effective date of this Agreement to be automatically renewed for an additional one (1) year upon payment of the membership fee, unless otherwise terminated as provided in the termination section 8 of this Agreement.

7. **Hospital Care**

As stated above, the Doctor will make arrangements for members admitted as inpatients to all local hospitals to be admitted to and cared for by the designated hospitalist services at each specific hospital. The Doctor will make social calls and periodically follow the Patient/Member where appropriate, but the Doctor will not be the admitting Doctor for the Patient /Member at this facility. The Doctor will continue to be the Patient's/Member's primary care Doctor after hospital admission to either facility for the purpose of providing primary care and post hospital care.

**8. Patient Responsibility**

The Patient/Members agrees to pay Sure*Access* MD, LLC the membership fee described on exhibit "A" attached to this Agreement. This membership fee is due at the time of signing (three months' nonrefundable initial payment before starting monthly payments). Sure*Access* MD, LLC may change the membership fee at any time by sending the Patient/Member a new schedule of membership fees. Any revised membership fee will be applicable at the designated time as outlined in the new fee schedule. Notwithstanding any other provisions of this agreement, the first three months of the program fee is not refundable in whole or in part.

The Patient/Member does acknowledge that membership in Sure*Access* MD is not in any way a substitute for health insurance. It is the Patient's/Member's responsibility to maintain health insurance. Sure*Access* MD, LLC and the Doctor will bill the Patient's/Member's insurance for applicable medical services provided by the Practice and the Doctor (office visit professional fees, hospital visit professional fees, vaccinations and other injectable medications administered). The Patient/Member will be financially responsible for all co-pays, co-insurance payments, and deductibles as defined by their insurance plan. While membership in Sure*Access* MD does carry with it benefits and rewards, basic medical care must still be paid for either by the Patient/Member, Patient's/Member's insurance, or the applicable government program.

It shall be the responsibility of the Patient/Member to either assist or affect the proper filing of insurance or payment of fees for services rendered which are not covered by the annual membership charge. Billing and collecting for Sure*Access* MD, LLC (both membership fees and insurance charges/co-pays/deductibles) will be handled by the Business Manager for Sure*Access* MD, LLC.

**9. Termination**

The Patient/Member may terminate this Agreement at any time by notifying Sure*Access* MD, LLC, or the Doctor, of termination in writing, effective on the date of receipt. A prorated refund may be due to the Patient/Member. If the Patient/Member elects to terminate participation in Sure*Access* MD, LLC, the Patient/Member agrees that a new primary care physician will have been selected before the effective termination date by the Patient/Member or accepts the responsibility for finding their own primary care physician in the future. Once the Patient/Member notifies Sure*Access* MD, LLC of the name of the Patient's/Member's new primary care physician, and written authorization is provided by the Patient/Member, Sure*Access* MD, LLC will transfer a copy of the Patient's/Member's medical records maintained by Sure*Access* MD, LLC to the new primary care physician. However, at all times, the original medical records of the Patient/Member are and will remain the property of Sure*Access* MD, LLC and the Doctor.

If the Patient/Member becomes dissatisfied with any of the non-clinical or medical services provided by Sure*Access* MD or the Doctor, the right to terminate this Agreement will be the Patient's/Member's only remedy.

Sure*Access* MD, LLC and/or the Doctor may terminate the Patient's/Member's membership at anytime, for any reason (such as failure to pay amounts due hereunder or inability of the Patient/Member-Doctor relationship to flourish) with thirty (30) days written notice and without any further obligation other than a prorated refund of the membership fee as indicated below.

If the Doctor dies or becomes unable to carry on his practice because of disability or death, termination would be effective immediately. Since all payments are now monthly, no refund will be due to any member from the Doctor or SureAccess MD, LLC.

**10. Assignment**

This Agreement may not be assigned by either party to this Agreement without the prior written consent of the other.

**11. Notice**

Any notice required or given under the Agreement shall be deemed given if in writing and sent via certified mail, return receipt requested or hand delivered to the address listed below for Sure*Access* MD, LLC or to the Member's last known address.

This Agreement contains the entire understanding of the parties. It may not be changed orally, but only by an Agreement in writing signed by both parties.

**SIGNATURE PAGE OF SURE*ACCESS* MD, LLC**
**Membership Agreement**

List names of Patient(s)/Member(s) and relationship (family):

_____

_____

_____

_____

_____

Signature of Person Responsible for Billing:

_____

_____
(Print name)

_____
Date

The effective date of this Patient Membership Agreement shall be the

_____ day of _____, 20_____.

Accepted:

By: _____ Date: _____

Richard Michael, M.D.
Paul Guidry, M.D.
Sure*Access*, MD, LLC
1534 Elizabeth Avenue, Suite 401B
Shreveport, LA 71101

# Exhibit "A"

Program Fee Schedule:

| Fee Schedule | Type of Member |
|---|---|
| $175/month | Individual with Monthly Payment (Nonrefundable Three (3) Month Payment Due at Initiation of Membership) |

******Addendum 3/8/2021******
The decision was made to move all Patient/Member payments to a monthly fee schedule on 5/1/2017. This membership fee will be due either by ACH drafting from the Patient's/Member's designated bank account or by charging the Patient's/Member's designated credit card or debit card. Such transactions would be initiated and administered by the Business Manager of Sure*Access* MD, LLC.

Patient/Member Initials _____

Revised 8.15.2022

**Richard Michael, M.D.**
**Paul Guidry, M.D.**

**1534 Elizabeth Avenue, Suite 401B**
**Shreveport, LA 71101**

# Patient Contact Policy

In caring for you, our patients, it will become necessary or desirable to contact you at some time. When you are not available to speak with us directly, we would like to leave you a message, send an email, or send a fax to a personal fax machine.

In order to protect your privacy, we have developed a policy for contacting you:

1. We will not leave messages (other than we tried to contact you) with anyone except you, the patient.
2. We will not leave information (other than we tried to contact you) on an answering machine.
3. We will not leave messages on a voice mail system.

***Unless*** we have your written permission to leave messages for you or to contact you by phone, email, or fax. Please read the information below and indicate by what method(s) you would like us to contact you.

I, _____, give Sure*Access* MD, LLC my permission to contact me regarding my medical care in the following ways as of ___/ ____/ 20___:

Email (address) _____ (initial) _____
***(Please realize that email is NOT secure – others may have access to your information once it leaves our office on the internet)***

Home phone (number)_____ (initial) _____

Office phone (number)_____ (initial) _____

Cell phone (number)_____ (initial) _____

***Thank You!***

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# PATIENT INTAKE QUESTIONNAIRE

**NAME:** _____ **DOB:** _____ **DATE:** _____

**Primary Care Physician:** _____

**Other Physicians you are currently seeing:** _____

_____

## ACTIVE MEDICAL PROBLEMS (List primary reason for visit, then list all current medical problems):

**1**. _____

**2**. _____

**3.** _____

**4**. _____

**5**. _____

**6**. _____

**7.**_____

**8.**_____

OTHER PAST MEDICAL HISTORY: _____

_____

_____

**CURRENT PRESCRIPTION MEDICINES (include dosage of medicine and frequency of taking):**

Example: Lisinopril 20mg once a day for blood pressure _____

_____

_____

_____

_____

_____

_____

_____

## List all OVER-THE-COUNTER MEDICINES, vitamins, and supplements that you take:

_____

_____

_____

## ALLERGIES: (medication and resulting allergy):_____

_____

**Sure*Access* MD, LLC**
1534 Elizabeth Avenue Suite 401B Shreveport LA 71101
318.300.4926 (phone) 318.383.3951 (fax) www.SureAccessMD.com

**SURGERIES (include year, surgeon, hospital):** _____

_____

_____

_____

_____

_____

_____

_____

_____

**HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital):** _____

_____

_____

_____

_____

_____

_____

## WOMEN

Date of onset of last period _____ No. of pregnancies _____ No. of live births _____

Birth control method _____ Any history of hormone replacement? _____

Date of last pap _____ Any abnormal paps? _____ When? _____

Date of last mammogram _____ Have you ever had an abnormal mammogram or biopsy?_____

Date of last Bone Density (DEXA) and result _____

**Is there any possibility you could be pregnant? _____**

## VACCINATION HISTORY

Date of last Tetanus/Diphtheria/Pertussis (TDaP) vaccine _____

Date of last Influenza vaccine _____

Date of last Pneumovax or Prevnar (pneumonia shot) _____

Date of Shingles (Zostavax) vaccine _____

Have you received any other vaccines (Hep B, Hep A, MMR in adulthood, Menactra, vaccines for travel)? _____

_____

## HABITS (please check all that apply)

(  ) Tobacco: How long have (or did) you use it? _____How many per day_____ Quit? _____ When? _____

(  ) Alcohol: _____ monthly or less _____weekly _____several days per week.  How many per day? _____

(  ) Other drugs? What_____

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318.300.4926 (phone)  318.383.3951 (fax)  www.SureAccessMD.com

## SOCIAL HISTORY

Marital Status: ( ) single ( ) married ( ) widowed ( ) divorced ( ) domestic partner

Are you sexually active? ( ) with spouse ( ) never ( ) with males ( ) with females ( ) both

Whom do you live with? _____

Do you have children? ( ) yes ( ) no

Occupation: _____

## FAMILY HISTORY (list any known health issues)

Father_____

Mother_____

Brothers_____

Sisters_____

Grandparents_____

Others_____

□Alcohol or Drug Addiction (list family member and addiction) _____

_____

## HEALTH MAINTENANCE EXAMS NOT OTHERWISE COVERED

Date of last colonoscopy and result _____

Date of last stress test and result_____

Date and findings of last Ophthalmologic/Optometric/Eye exam and by whom

_____

_____

Date of last PSA, results, and by which MD_____

Any other significant test results _____

_____

## REVIEW OF SYSTEMS (Mark any of the below problems you are experiencing):

**Gen:** Fever □ ; Chills □ ; Sweats □ ; Fatigue/Weakness □ ; Weight Loss □ ; Weight Gain □

**Sleep Hygiene:** Change in sleep habits □; Loud snoring □; Waking self from sleep due to snoring; Insomnia □

**Head & Eyes:** Head injury □ ; Headaches □ ; Visual Loss/Blurriness □ ; Double vision □ ; Light sensitivity □ ;
Eye redness/discharge □

**Ears, Nose, & Throat:** Hearing loss □ ; Ears ringing □ ; Ear pain □ ; Nasal Drainage □ ; Nose bleeds □ ; Sore throat □ ; Lip ulcers □

**Neck:** Pain □ ; Stiffness □ ; Lumps or masses □

**Respiratory:** Cough □ ; Sputum production □ ; Coughing up blood □ ; Shortness of breath @ rest □ ; Shortness of breath with exertion (more than anticipated) □ ; Chest pain with inspiration □ ; Wheezing □

**Cardiovascular:** Chest pain/pressure □ ; Palpitations (heart racing) □ ; Shortness of breath when lying flat at night (need to prop head on pillows)□ ; Awakening short of breath at night □ ; Lower extremity edema □ ; Syncope (Passing/Blacking out) □ ; Pain in legs with walking that is relieved by rest (Claudication) □

**Breast:** Lumps/masses □ ; Pain □ ; Swelling □ ; Nipple crusting/discharge □

**Gastrointestinal:** Appetite change □ ; Craving unusual foods □ ; Difficulty swallowing □ ; Pain swallowing □ ; Nausea □ ; Vomiting □ ; Vomiting blood □ ; Yellowing of skin/eyes □; Excessive belching □ ; Abdominal swelling/bloating □ ; Change in stool caliber □ ; Dark/tarry stools or bright red blood in stools □

**General Genitourinary:** Burning with urination □ ; Frequent daytime urination □ ; Frequent nighttime urination □ ; Blood in urine □; Urine incontinence □

**Male Genitourinary:** Penile discharge/lesions □ ; ED □ ; Loss of libido □ ; Testicular pain □

**Female Genitourinary:** Vaginal discharge/bleeding □ ; Pain with menstrual flow/menses □ ; Loss of libido □

**Endocrine:** Excessive appetite □ ; Excessive thirst □ ; Frequent urination □ ; Heat intolerance □ Cold intolerance □; Unusual hair loss on scalp □ ; Unusual hair growth on face/arms/torso/genitalia □

**Hematologic/Lymphatic:** Easy bruising □ ; Excessive bleeding (especially after surgery or childbirth) □ ; Gum bleeding □ ; Lymph node or glands swelling □

**Musculoskeletal:** Bone/joint pain □ ; Joint stiffness/swelling □ ; Muscular tenderness/atrophy □ ; Muscular weakness □ ; Back pain □

**Neurologic:** Dizziness □ ; Tremor □ ; Poor balance □ ; Tingling/Numbness over arms/legs □ ; Seizures □ ; Memory Loss □

**Psychiatric:** Depression □ ; Anxiety □ ; Any desire to hurt yourself or others □ ; Obsessions □ ; Emotional lability □ ; Hallucinations □; Delusions (False beliefs) □

**Skin/Integument:** Rashes □ ; Skin pigmentation changes □ ; Worrisome moles/skin lesions □ ; Itching □ ; Hair loss □ ; Nail changes □

**Allergy/Immunology:** Sinus pain □ ; Sinus Congestion □ ; Watery/itchy eyes/nose □ ; Hives □; Swelling of lip or tongue □

**PLEASE SIGN** _____ **DATE** _____

FOR MD USE ONLY====>

**Cardiac Risk Factors:** Age ____ HTN ____ Increased Chol ____ Tobacco use ____ FH ____ Prev. CAD ____ Obesity ____

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**Richard Michael, M.D.**
**Paul Guidry, M.D.**

**1534 Elizabeth Avenue, Suite 401B**
**Shreveport, LA 71101**

# Medical Information Release Form

## *(HIPAA Release Form)*

**Name:** _____ **Date of Birth:** _____/____/_____

***Release of Information***

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.
This ***Release of Information*** will remain in effect until terminated by me in writing.

***Messages***

Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me: [ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____
The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____
Witness:_____ Date: ___/____/_____

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**Effective Date: _____Membership Rate: _____**

## PAYMENT METHOD

### CREDIT CARD

**Name on Credit Card:**

**Type of Credit Card: _____VISA _____MASTERCARD _____AMERICAN EXPRESS _____DISCOVER**

**Credit Card Number:**

**Expiration Date:** **Credit Card Security #:**

**Patient Name:** **Zip Code:**

**Authorized Signature for Credit Card:** **Date:**

**Authorization to Charge Credit Card for Deductibles/Co-Pays/Co-Insurance (Receipt will be Mailed)**

**_____YES _____NO Authorized Signature: _____**

### AUTOMATED BANK DRAFT

**Name on Bank Account:**

**Bank Routing Number (Lower Left Hand Corner of Check):**

**Patient Name:**

**Bank Account Number:**

**Authorized Signature for Bank Account:** **Date:**

**Authorization to Process Bank Draft for Deductibles/Co-Pays/Co-Insurance (Receipt will be Mailed)**

**_____YES _____NO Authorized Signature: _____**