08.10.01 CLIENT ADMISSIONS FORM

AcadianaCares

Please complete all sections unless they are noted "N/A" (not applicable). Choose or write only one answer unless the section says, "select all that apply." Write "N/A" for sections which do not apply to you or you don't want to answer.

Please print and complete this form and bring it with you to your appointment.
(If you are unable to print the form, you may complete it when you come for your appointment.)

Today's Date	First Name	Middle Name	Last Name

Age	Date of Birth (MM/DD/YYYY)	Social Security Number	Preferred Name

If age 17 or younger, Parent/Legal Guardian[1] First/Last Name (1: See last page for definition)	Parent/Legal Guardian Relationship	Service(s) Requested

Address	City	State	Zip Code
OK to mail information: ☐ Yes ☐ No			

Homeless	Driver's License	If "Yes", DL State and Number	Preferred Language
☐ Yes ☐ No	☐ Yes ☐ No		☐ English ☐ Other (list): ☐ Spanish

Ethnicity	Race (select all that apply)
☐ Hispanic ☐ Non-Hispanic ☐ Unknown or decline	☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian/White ☐ Decline ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Unknown

Referral Source	Referral Description/Name	Email address
☐ Agency ☐ Event ☐ Family/Friend ☐ Print Ad ☐ Social Media ☐ Website ☐ None ☐ Other		☐ N/A OK to send information: ☐ Yes ☐ No

Home Phone Number	Mobile Phone Number	Preferred Contact Method
☐ N/A OK to leave message: ☐ Yes ☐ No	☐ N/A OK to leave message: ☐ Yes ☐ No	☐ Email ☐ Phone ☐ Mail

Birth Certificate Gender	Current Gender	Relationship Status
☐ Female ☐ Male	☐ Female ☐ Male	☐ Divorced ☐ In a relationship ☐ Living with partner ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Other (describe):

Veteran	Employed	If "Yes", Employer Name	Occupation/Position
☐ Yes ☐ No ☐ Decline	☐ Yes ☐ No ☐ Decline		

Total People Living with You	Estimated Total Household Income	Education Level Completed
	☐ Monthly ☐ Annual	☐ Middle school ☐ High school ☐ Associate degree ☐ Technical/Trade ☐ Bachelor degree ☐ Other ☐ Master degree or more ☐ Unknown or Decline

Emergency Contact First/Last Name[2]	Relationship	Telephone Number
		☐ Home ☐ Mobile OK to leave message: ☐ Yes ☐ No

Emergency Contact Address	City	State	Zip Code

Primary Caregiver First/Last Name [3]	Relationship	Telephone Number
☐ N/A ☐ Same as emergency contact		☐ Home ☐ Mobile OK to leave message: ☐ Yes ☐ No

Power of Attorney First/Last Name [4]	Relationship	Telephone Number
☐ N/A ☐ Same as emergency contact		☐ Home ☐ Mobile OK to leave message: ☐ Yes ☐ No

Complete the following information for your current healthcare and insurance.

Preferred Pharmacy Name and Location	Phone Number
☐ N/A	

Primary Care Physician First and Last Name	Phone Number
☐ N/A	

Healthcare Directive(s)	Insurance
☐ None ☐ Medical power of attorney ☐ Living will ☐ Other (describe):	☐ None ☐ Medicaid ☐ Medicare ☐ Private/Company ☐ LAChip ☐ Military ☐ Student ☐ Indian Health Service Applied for within 30 days: ☐ Yes ☐ No

Insurance Policy Name (Company)	Identification Number	Group Number/Code	HMO PCP Provider

Insurance Policy Address	City	State	Zip Code

Policy Holder First/Last Name[5]	Policy Holder Date of Birth	Policy Holder Phone Number
☐ I am the policy holder (go to next section)		☐ Home ☐ Mobile

Relationship to Policy Holder	Policy Holder Social Security Number
☐ Child ☐ Spouse ☐ Other (Describe):	

Policy Holder Home Address	City	State	Zip Code
☐ Same as mine (go to next section)			

This section is intended for clients 18 years old and older. This section is optional for clients ages 14 through 17.

Sexual Orientation: The gender to which you are sexually and/or romantically attracted.			
☐ Opposite gender (straight)	☐ Same gender (gay/lesbian)	☐ Both genders (bisexual)	☐ None
☐ Unsure/Questioning	☐ Decline answer	☐ Other (describe):	

Gender Identity: The gender you feel represents you, or how you choose to express gender in clothing, behavior, and personal appearance.			
☐ Female	☐ Transgender to female	☐ Male	☐ Transgender to male
☐ Non-binary	☐ Decline answer	☐ Other (describe):	

Client Financial Responsibilities

AcadianaCares may have state, federal, or other funds available to pay for services for eligible clients, which are considered funds of last resort. **Availability of funds does not mean or guarantee services will be paid for by someone other than you.**

Each client is responsible for providing accurate, current information, including insurance and financial information, to determine eligibility regarding funds of last resort.

1. I understand AcadianaCares uses a sliding or reduced fee scale for services provided. AcadianaCares collects and uses financial information to determine eligibility and keeps this information confidential. Clients with Medicaid are exempt from (or do not participate in) applying for a sliding fee scale. I may be asked to complete other forms describing my income or stating I have no income to determine service billing and funding.

   Initials:_____

2. I understand my insurance, including Medicaid and/or Medicare, will be billed for services delivered by AcadianaCares. Billing time varies and may be delayed based on credentialing with insurance companies. Withholding insurance information or misrepresenting my financial status may make me ineligible for services and/or result in me being billed for the cost of services delivered.

   Initials:_____

3. I understand I am responsible for the cost of services delivered but not covered (paid for) by my insurance, Medicaid, or Medicare. This includes any insurance co-pay required at each appointment.

   Initials:_____

4. AcadianaCares is authorized to provide my medical information to my insurance, Medicaid, and/or Medicare to process claims for payment.

   ☐ Yes ☐ No Initials:_____

5. I have had an opportunity to ask questions and have them answered in a language I understand.

   ☐ Yes ☐ No Initials:_____

Consent for Services

In order to provide any service, AcadianaCares requires consent to collect additional information and/or medical specimens to determine eligibility. Information is maintained according to confidentiality requirement defined by law. Except when required by law and as described in this section, identifying information will not be released to persons outside of AcadianaCares without your consent.

You have the right to revoke (take back) your consent to collect information at any time by providing AcadianaCares written notice. Please note: Consent given for actions and/or services already provided cannot be revoked.

1. I understand AcadianaCares does not provide emergency medical services or non-emergency medical services after posted hours of operation. I understand I am able to leave a message for an AcadianaCares physician using the answering service (337-704-0787).

   Initials:_____

2. I understand arriving more than 15 minutes late for a scheduled appointment may result in rescheduling or waiting for the next available appointment time.

   Initials:_____

3. I understand AcadianaCares reports to the Louisiana Department of Health and Human Services (DHH) names and addresses of persons testing positive for HIV, Tuberculosis, Chlamydia, Gonorrhea, and Syphilis. This reporting is a Louisiana requirement and may include follow-up from a DHH employee to make sure treatment is followed and other persons exposed through sex or needle-sharing are notified.

   Initials:_____

4. I understand I cannot hold AcadianaCares employees, volunteers, contractors, partners, or board members responsible for personal damages, losses, expenses, or legal actions related to my receipt of services.

   Initials:_____

5. AcadianaCares has my permission to obtain medical history information from other healthcare organizations, including but not limited to pharmacies.

   ☐ Yes ☐ No Initials:_____

6. AcadianaCares has my permission to perform medical tests upon my request and provide appropriate, related medical and therapeutic treatment.

   ☐ Yes ☐ No Initials:_____

7. AcadianaCares has permission to submit my prescriptions electronically using digital prescription software.

   ☐ Yes ☐ No Initials:_____

I agree to the terms described on this and previous pages of this document. My consent is given freely.

The information provided on this form is true and correct to the best of my knowledge and belief. I understand providing false information can result in disqualification from services and responsibility to fully pay for services provided based on false information.

I have been given the opportunity to review AcadianaCares documents 1) Notice of Private Practices, 3) Client Rights and Responsibilities, and 2) Client Grievance Procedure.

I agree this consent remains in effect until I revoke my consent in writing. I understand I am free to revoke my consent at any time.

Client/Representative Signature:_____ **Date:**_____

Thank you! Please return completed form to the AcadianaCares Admissions Navigator.

Definitions

1. **Legal Guardian:** The primary person appointed by a court to make healthcare/legal decisions in place of a client.
2. **Emergency Contact:** The person to contact if an emergency situation occurs while the client is receiving services.
3. **Primary Caregiver:** The person responsible for providing day-to-day care for a client.
4. **Power of Attorney:** (or Healthcare Proxy) A person appointed by a client to make healthcare/legal decisions in their place.
5. **Policy Holder:** The individual responsible for maintaining health insurance/Medicaid/Medicare.

FOR OFFICE USE ONLY

This section is to be completed by the AcadianaCares Admissions Navigator.

Client Photo Identification Type Reviewed		Client Identification Number Assigned

Seasons of Serenity Program Only: (From the medical assessment)

Primary Diagnosis:_____

☐ 303.90/F10.20 ☐ 304.10/F13.20 ☐ 304.30/F12.20 ☐ 304.50/F16.20 ☐ 304.80/F19.20
☐ 304.00/F11.20 ☐ 304.20/F14.20 ☐ 304.40/F15.20 ☐ 304.60/F18.20

Employee Name (print):_____

Employee Signature:_____ **Date:**_____