08.10.01 CLIENT ADMISSIONS FORM

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

Today's Date	First Name	Middle Name	Last Name

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

Preferred Name	Preferred Pronouns (optional)	Birth Certificate Gender	Age	Date of Birth (MM/DD/YYYY)
		☐ Female ☐ Male		

If age 17 or younger, Parent/Legal Guardian[1] First/Last Name 1: See page 5 for definition	Parent/Legal Guardian Relationship	Service(s) Requested

Social Security Number	Cellular Phone Number	Other Phone Number
	☐ None OK to leave message: ☐ Yes ☐ No	☐ None OK to leave message: ☐ Yes ☐ No

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

Relationship Status	Preferred Language
☐ Divorced ☐ In a relationship ☐ Living w/ partner ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Other:	☐ English ☐ Other (list): ☐ Spanish

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

Agricultural Worker

☐ Yes ☐ No If yes: ☐ Employed Year-Round ☐ Migrant ☐ Retired Farmworker ☐ Seasonal

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

Gender Identity: The gender you feel represents you, or how you choose to express gender in clothing, behavior, and personal appearance.

☐ Female ☐ Transgender female ☐ Male ☐ Transgender male
☐ Non-binary ☐ Decline answer ☐ Other (describe):

Sexual Orientation [2]:

☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Pansexual ☐ Asexual/None
☐ Unsure/Questioning ☐ Decline answer ☐ Other (describe):

Emergency Contact First/Last Name [3]	Relationship	Telephone Number
		☐ Home ☐ Cellular OK to leave message: ☐ Yes ☐ No

Emergency Contact Address	City	State	Zip Code

Complete the following information for your current healthcare and insurance.

Preferred Pharmacy Name and Location	Phone Number
☐ None	

Primary Care Physician First and Last Name	Phone Number
☐ None	

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

Insurance Policy Address	City	State	Zip Code

Policy Holder First/Last Name [4]	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)			

Healthcare Directive(s)
☐ None ☐ Medical Power of Attorney ☐ Living Will ☐ Other (describe):

Primary Caregiver First/Last Name [5]	Relationship	Telephone Number
☐ None ☐ Same as emergency contact		☐ Home ☐ Cellular OK to leave message: ☐ Yes ☐ No

Power of Attorney First/Last Name [6]	Relationship	Telephone Number
☐ None ☐ Same as emergency contact		☐ Home ☐ Cellular OK to leave message: ☐ Yes ☐ No

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

Total People Living in the Household	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 ☐ Decline

Would you like to apply for reduced fees? (If yes, please ask the receptionist for an application)

☐ Yes ☐ No ☐ Tell me more

Would you like to receive support services (such as HIV case management, substance use treatment, or housing assistance) from AcadianaCares? (If yes, please ask to complete an initial needs assessment with a Navigator)

☐ Yes ☐ No ☐ Tell me more

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.

For each of the following statements, please write your initials if you are in agreement:

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.

   Initials:_____

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

   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.

For each of the following statements, please write your initials if you are in agreement:

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.

   Initials:_____

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

   Initials:_____

7. AcadianaCares has permission to submit my prescriptions electronically using digital prescription software. Telehealth services may be scheduled upon mutual agreement between patient and provider.

   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, 2) Client Rights and Responsibilities, and 3) 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. **Sexual Orientation:** The gender to which you are sexually and/or romantically attracted.
3. **Emergency Contact:** The person to contact if an emergency situation occurs while the client is receiving services.
4. **Policy Holder:** The individual responsible for maintaining health insurance/Medicaid/Medicare.
5. **Primary Caregiver:** The person responsible for providing day-to-day care for a client.
6. **Power of Attorney:** (or Healthcare Proxy) A person appointed by a client to make healthcare/legal decisions in their place.

FOR OFFICE USE ONLY

Employee Name (print):_____

Employee Signature:_____ **Date:**_____