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PATIENT REGISTRATION FORM

Please PRINT & Complete all information
Mark N/A for Not Applicable & P/D for Patient Declined

Patient Name: _____ Today's Date: _____
Last Name First Name MI

If Minor, Accompanying Parent/Guardian _____ Race: _____

Ethnicity: _____

Date of Birth: _____ Age: _____ Sex: Male Female Languages Spoken: _____

Mailing Address: _____ Birth Order: 1 2 3 4 5 6 7 8 _____

City: _____State: _____ Zip: _____

Marital Status: Single Married Separated Divorced or Widow (er)

Social Security Number: _____ **Preferred Method of Contact**: Cell Phone / Home Phone

Cell Phone: _____ **Patient/Guarantor's Employer**: _____

Home/Other: _____ Patient Occupation: _____

Email: _____ Work Phone: _____

(Necessary to access e health records)

Primary Care Physician: _____ Does Patient Live in a Nursing Home? YES NO

Referring Physician: _____ Name of Nursing Home: _____

INSURANCE INFORMATION- REQUIRED COMPLETION

Primary Insurance: _____ Name of Policy Holder: _____

Relationship to Policy Holder: Self/Spouse/Child/Other Policy Holder's Employer: _____

Member ID#: _____ Policy Holder's DOB: _____ Policy's Holder's SSN: _____

Secondary Insurance: _____Name of Policy Holder: _____

Relationship to Policy Holder: Self/Spouse/Child/Other Policy Holder's Employer: _____

Member ID#: _____ Policy Holder's DOB: _____ Policy's Holder's SSN: _____

THIRD PARTY LIABILITY INFORMATION – REQUIRED COMPLETION

Is this visit school, work, or accident related? **YES NO** **Type of Accident:** _____

Name of Liability Party: _____ Phone: _____

Third Party Insurance Co: _____ Third Party Policy #: _____

Name of Attorney representing patient related to this service: _____

Attorney Phone: _____ Attorney's Address_____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Insurance Assignment and Release

I certify the information above is complete and accurate and I will be responsible for any errors or omissions. I assign directly to Orthopaedic Sports Specialist, d/b/a Ortho LA, all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor/medical group may use my health care information and may disclose my personal information for purposes of coordinating care, obtaining payment for services and determining insurance benefits for related services. This consent will continue until revoked by patient or guardian.

Medicare/Medigap Authorization

I request payment of authorized Medicare and/or Medigap benefits, be made either to me or on my behalf to Orthopaedic Sports Specialist, d/b/a Ortho LA for services rendered by provider group. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and/or their agents' information needed to determine these benefits or benefits for related services.

_____ _____ _____

Patient/Guardian Printed Name Patient/Guardian Signature Date

Form Updated 07/27/2017

Confidential Patient Medical History

Updated ***07/27/2017***

FOR OFFICE USE ONLY: BORNE ELIAS ELLENDER GREBER HIGGINS HILDENBRAND MORVANT

Height: ____’__” **Weight: _____lbs.** **Age: _____** **BP ____ / _____** **Pulse _____** **Temp_____**

Patient Name: _____ DOB: _____ SSN: _____

Reason for present visit? _____ Affected Side: Left Right Bilateral

Date of Injury: _____ Are you: Right-Handed ? / Left-Handed?

Occupation: _____ Are you currently pregnant? Yes / No

Is this visit related to: Work injury? Yes No Verification of Work Injury Required from employer.
Student athlete injury? Yes No Student Athletic Injury Form Required from school.
Auto injury? Yes No Name of liable party: _____

Pain & Discomfort:

Location: _____ **Type:** _____
Where is the pain/problem? Does it travel to other areas? Is the pain dull, throbbing, sharp? If lump, is it warm, tender, red?

Severity: _____ **Duration:** _____
How severe is the pain on a scale from 1-10 with 10 being the most severe? How long have you had this pain/problem? When did it start?

Timing: _____ **Context:** _____
Does the pain/problem occur at a specific time? Is it rare, intermittent, or constant? What were you doing at the onset of this pain/problem?

Modifying factors: _____
What makes this problem worse or better? (activities)

Past History of *Present* Illness:

Were you referred here by another doctor or therapist for this condition? Yes / No Referred By_____

Have you seen any other physicians regarding ***this*** condition prior to coming to our office? Yes / No

Doctor	**When**	**Tests**	**Results**	**Treatment**

Have you ever experienced any injury or symptoms regarding this body part before? Yes / No *If yes, provide details:*

_____

List hobbies/activities you enjoy: _____

Which of the above activities are you unable to perform due to your pain? _____

Past Medical History: Have ***you*** *ever* had any of the following? *Circle all that apply.*

ADD	Bladder Infections	DVT (blood clot)	High Blood Pressure	Mitral Valve Prolapse	Sickle Cell
AIDS or HIV+	Bleeding Tendency	Epilepsy	High Cholesterol	Pneumonia	Sleep Apnea
Anemia	Blood Transfusions	Fibromyalgia	Infectious Mono	Polio	Stroke
Arthritis - Osteo	Bronchitis	Glaucoma	Kidney Disease	Restless Leg Syndrome	Thyroid Disease
Arthritis - Rheumatoid	Cancer	Gout	Low Blood Pressure	Rheumatic Fever	Tuberculosis
Asthma	Depression/Anxiety	Heart Disease	Lupus	Scarlet Fever	Ulcers
Back Trouble	Diabetes	Hepatitis	Migraine Headaches	Seizures	

Other: _____

Past Surgical/Hospitalization History

Date	Surgery/Illness	Doctor	Facility

Current Medications & Supplements:

Drug name:	Dosage (mg):	How often do you take?	Date Began Taking:

Preferred Pharmacy: _____ ***Location:*** _____ ***Phone:*** _____

Allergies:

Medication Allergies:_____ Describe Reaction: _____

Food Allergies: _____ Environmental Allergies: _____

Surgical Tape Allergy? Yes / No Latex Allergy? Yes / No

Patient Social History:

Tobacco Use: Never Former Occasional Use Daily Use _____ (amount)

Alcohol Use: None Past Year 1 per day 2-3 per day 4-5 per day 6+ per day

Use of Recreational Drugs: Never Previous Current _____(list)

Living Situation: With Family With Friends Live Alone Nursing Home Other _____

Family Medical History:

	Known Conditions or Diseases of Immediate Family:	If Deceased, Cause of Death:
Father:	_____	_____
Mother:	_____	_____
Siblings:	_____	_____

Review of Systems: Please indicate if ***you*** have any of the following– circle all that apply.

Musculoskeletal
Joint Pain
Joint stiffness or swelling
Weakness of muscles or joints
Muscle pain or cramps
Back pain
Cold extremities
Difficulty in walking

Cardiovascular
Hearth trouble
Chest pain or angina pectoris
Palpitation
Shortness of breath while walking
Swelling of feet, ankles or hands

Constitutional Symptoms
Bad general health lately
Recent weight change
Fever
Fatigue
Headaches

Ears/Nose/Mouth/Throat
Hearing loss or ringing
Earaches or drainage
Chronic sinus problems
Nose bleeds
Bleeding gums
Sore throat or voice change
Swollen glands in neck

Genitourinary
Frequent urination
Burning or painful urination
Blood in urine
Incontinence or dribbling

Integumentary (skin, breast)
Rash or itching
Changes in skin color
Varicose veins

Neurological
Light headed or dizzy
Numbness or tingling sensations
Tremors
Paralysis

Endocrine
Excessive thirst or urination
Heat or cold intolerance
Skin becoming dryer

Hematologic/Lymphatic
Slow to heal after cuts
Bleeding or bruising tendency
Anemia
Enlarged glands

Psychiatric
Memory loss or confusion
Nervousness
Depression
Insomnia

Respiratory
Chronic or frequent coughs
Spitting up blood
Shortness of breath
Wheezing

Gastrointestinal
Loss of appetite
Nausea or vomiting
Frequent diarrhea
Constipation
Rectal bleeding, blood in stool
Abdominal pain

Other: Information your doctor might need: _____
_____
_____
_____

Patient verifies that questions on this form have been answered accurately. Patient understands that incorrect information or omissions may be dangerous to his health. It is patient responsibility to inform the doctor of ***any*** changes in my medical status, prescriptions & insurance information with ***each and every*** visit. Patient authorizes the health care staff to perform medical testing & treatment.

Signature of Patient or Legal Guardian: _____ Date: _____

Reviewing Physician Signature: _____ Date: _____

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DISCLOSURE OF FINANCIAL INTERESTS

(Updated July 27, 2017)

Louisiana law and various federal regulations (Stark Law; Patient Protection, and Affordable Care Act) require physicians and other health care providers to make certain disclosures to a patient when they refer a patient to those entities for certain designated health care services. (R.S. 37;1744 and LAC 46; XLV, 4211-4215).

Please be advised that Orthopaedic Sports Specialists of Louisiana d/b/a Ortho LA and/or one or more of its staff physicians (David W. Elias, M.D., Patrick R. Ellender, M.D., Jason A. Higgins, M.D., John C. Hildenbrand, M.D.; and/or Richard A. Morvant, Jr., M.D.) may have an economic interest in one or more of the following entities:

- Bayou Regions Surgical Center
- Cypress Clinical Labs of Louisiana, L.L.C
- Health Scripts of America Central Louisiana LLC
- Thibodaux Physician Investors, L.L.C.
- Thibodaux Surgery Center, L.L.C.
- Venture Medical L.L.C.

PATIENT ACKNOWLEDGEMENT

Subject to insurance limitations and coverages, patients have the right to choose their health care providers. By signing below, you or your legal representative, acknowledge that you have received, read, and understand this disclosure of financial interests in advance of referral to any of the entities listed above.

Patient Name: _____ Date of Birth: _____
(Please Print)

_____ _____
Signature of Patient or Patient Representative Date

Copy of this signed document shall be scanned to the patient medical record under the patient demographics tab.

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NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

Updated and Effective October 9, 2017

Our office provides services in good faith that it will be appropriately compensated, at time of service. It is your responsibility to understand your individual health policy. Ortho LA will file with your primary and secondary health insurance; but requires timely payment from both insurance and the patient.

Patients are responsible for letting us know of any changes in insurance coverage or other pertinent demographic information prior to services being rendered. You must provide our office with your current insurance card(s) as well as a current state issued photo ID or driver's license with each and every visit. Non U.S. Citizens must provide copy of their passport. If you do not provide us with the correct insurance information and benefits are reduced or denied as a result, you will be responsible for charges incurred.

Deductible, copayments & coinsurance are due at time of service. As part of our insurance contracts and government regulation, we are not allowed to write off patient coinsurance and deductibles.

Outstanding patient balances must be paid prior to new appointments being made. We reserve the right to charge an Administrative Fee of $25.00 for regenerating patient statements on non-payment and/or partial payments of accounts. Late/partial payment fees are not covered by insurance and are the responsibility of the patient/guarantor. *Subject to CMS rules & restrictions for Medicare patients*.

All outstanding patient balances, deductibles, coinsurance & estimated deposits must be paid in full at least 3 business days prior to an elective surgery.

We will coordinate with your employer for work related injuries. It is the patient's responsibility to let us know if a visit is work related and to provide all necessary details *prior to services being rendered* so we may follow appropriate regulations.

We ***do not*** coordinate with third party liability *(example: MVA)*. If we are contracted with your health insurance company, we will submit a claim to your health insurance. You will still be responsible for deductible, copayments, and coinsurance at time of service. If you do not have health insurance or your health insurance denies coverage due to a third party liability, then you will be held responsible for all non-covered charges. We will not suspend patient collections based on the outcome of a third party liability claim. You are obligated to provide us with accident detail information and contact information on legal representation. Unpaid claims will be forwarded to our attorney for lien placement and collections.

Interest, penalty, & collection costs including but not limited to attorney's fees incurred in order to obtain patient payment are the responsibility of the patient/guarantor.

Patients are expected to honor their scheduled appointment times. Missed appointments are subject to a fee.

I have received, read, and understand Orthopaedic Sports Specialists of Louisiana, d/b/a Ortho LA Notice of Patient Financial Responsibility Policy. I understand my right and responsibilities and also agree to abide by this policy.

Patient/Legal Guardian Signature _____ Date _____

Patient Name_____ Patients Date of Birth_____
(Please Print)

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NOTICE OF PRIVACY PRACTICES

Updated 07/20/2017

A. OUR LEGAL DUTY:

Law requires us to: (1) Keep your medical information private; (2) give you notice describing our duties, privacy practices and your rights regarding your medical information; (3) follow the terms of the current Notice of Privacy Practices.

We have the right to: Change our privacy practices & the terms of this notice at any time as law allows including all medical information that we keep, including information previously created or received before such changes.

Notice of Change to Privacy Practices: When we make an important change to our privacy practices, we will change this notice and make it available upon written request.

B. USE AND DISCLOSURE OF MEDICAL INFORMATION:

Below is a non-inclusive list of ways we are permitted to use and disclose medical information. Other disclosures require your written permission, unless required by law. Any authorization you provide may be revoked at any time by written notification.

1. **Treatment** – for purpose of medical treatment or services including disclosure to/from other doctors, nurses, technicians, medical students and other people taking care of you.
2. **Payment** – for payment purposes including insurance companies, medical auditing, third-party payers, claims processing entities, legal counsel and collection agencies.
3. **Health Care Operations** – for purpose of measuring and improving quality, evaluating employee performance, training, accreditation, certification, licenses and credentialing.

C. ADDITIONAL USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION:

1. **Notification** – to help notify family members; your personal representative or other persons responsible for your care. We will share information about your location, general condition, or death. In an emergency, we will share health information directly necessary for your health care according to our professional judgment and make decisions about allowing someone to pick up your medicine, medical supplies, x-rays or medical information.
2. **Disaster Relief** – to assist in disaster relief efforts, we may share medical information with entities or people legally authorized to do so.
3. **Research in Limited Circumstances** – Where research has been approved by a review board and protocols exist to ensure privacy of medical information.
4. **Funeral Director, Coroner, Medical Examiner, Organ Procurement Agency** – to help carry out their duties; we may share medical information of a person who has died.
5. **Specialized Government Functions** – for purposes of military, national security, intelligence activities and medical suitability determinations for the Department of State, correctional institutions and other custodial law enforcement situations.

6. **Court Orders, Judicial and Administrative Proceedings and Law Enforcement** – In response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstance or to protect public safety.
7. **Public Health Activities** – for purpose of preventing or controlling diseases, injury or disability, including child abuse or neglect, adverse events, product safety or exposure to communicable diseases. We may also notify individuals who may be at risk of contracting or spreading communicable diseases or conditions.
8. **Victims of Abuse, Neglect, or Domestic Violence** – to appropriate authorities if we believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
9. **Workers' Compensation & Work-Related Programs** – to comply with laws relating to work-related injury programs.
10. **Health Oversight Activities** – to comply with audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure, or disciplinary actions or other authorized activities.
11. **Appointment Reminders** – for purposes of sending you appointment reminders via mail, telephone, voice mail, email, text messages or fax transmission. If you wish to opt out of our reminder service, please initial in the space provided on the Acknowledgment of Receipt & Understanding.
12. **Alternative and Additional Medical Services** – to furnish information about health-related benefits and services that may be of interest to you.

D. YOUR INDIVIDUAL RIGHTS:

1. Get copies of certain parts of your medical information, upon written request, subject to applicable duplication fees. Certain parts of your medical information can also be accessed online at **https://ossl.etransmedia.com**. There is no cost to access summary information through this secure patient portal.
2. Receive a list of disclosures of your medical information for purposes other than treatment, payment, and health care operations or compliance with legal & regulatory compliance.
3. Request in writing that we place additional restrictions on disclosure of your medical information. We are not required to agree to these restrictions; but if we do agree we will abide by the request.
4. Request that we communicate with you about your medical information by other means or to other locations. If we deny your request, we will provide written explanation.
5. Request that we change certain parts of your medical information if it is inaccurate. If we disagree, we will provide written explanation.
6. Obtain paper copy of this notice by contacting our office in writing.

E. QUESTIONS, COMPLAINTS & REQUESTS

If you have questions, complaints or requests regarding your privacy rights, please contact us as indicated below.

ATTN: PRIVACY OFFICER
ORTHOPAEDIC SPORTS SPECIALISTS OF LOUISIANA
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Thibodaux, LA 70301
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ACKNOWLEDGEMENT OF RECEIPT & UNDERSTANDING
of Notice of Privacy Practices

(Updated July 20, 2017)

I have received, read, and understand the Notices of Privacy Practices provided to me by Orthopaedic Sports Specialists of Louisiana d/b/a Ortho-La. I understand my rights and responsibilities and agree to abide by this policy.

Patient/Legal Guardian Signature _____ Date _____

Patient Name_____ Patients DOB _____
(Please Print)

Opting Out of Appointment Reminders
By initialing below, I am opting out of Ortho-LA's reminder service and understand I will not receive any reminders of my upcoming appointments with Ortho-LA.

_____ Patient/Legal Guardian Initials

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HIPAA General Medical Release Form

(Updated July 20, 2017)

I hereby authorize the disclosure of my medical information by Ortho-LA to the following persons: (Please Print)

Name/Relationship _____ DOB: _____

Name/Relationship _____ DOB: _____

Name/Relationship _____ DOB: _____

Name/Relationship _____ DOB: _____

This authorization applies to the following:
(Please Initial)

All Records _____ Labs _____ Imaging/Diagnostic Testing Reports _____

Billing/Insurance _____ Appointment Dates & Times _____

Name of Person authorizing release of information:
(Please Print)

Patient's Name _____

Guarantor's Name _____
(if patient is a minor)

Street Address _____

City _____ State _____ Zip Code _____

Patient's DOB_____ Contact Phone Number _____

Patient's Signature _____ Date _____

Guarantor's Signature _____ Date _____
(if patient is a minor)