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Orthopaedic Sports Medicine, Joint and Hand Specialists

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PATIENT REGISTRATION

Please print and complete all information and mark N/A for Not Applicable and P/D for Patient Declined

Patient Name _____ Today's Date _____
Last First MI

If minor, parent/guardian _____ Race _____

Date of Birth _____ Age _____ Sex: ◯Male ◯Female Ethnicity _____

Mailing Address_____ Primary Language _____

City, State, Zip_____ Patient's Social Security #_____

Primary Phone #_____ Secondary _____ Email _____

Preferred Method of Contact: ◯Phone ◯Email Patient's Marital Status: ◯Single ◯Married ◯Separated ◯Divorced ◯Widowed

Patient/Guarantor's Employer_____ Employer's Phone # _____

Patient's occupation _____ Patient's Primary Care Doctor _____

Is patient in a nursing home? Y◯ N◯ _____ Referring physician _____
IF YES, NAME OF HOME

INSURANCE INFORMATION

Primary Insurance _____ Policy Holder _____

Relationship to Policy Holder: ◯Self ◯Spouse ◯Child ◯Other Policy Holder's SS# _____ Policy Holder's DOB _____

Policy Holder's Employer _____ Member ID # _____

Secondary Insurance _____ Policy Holder _____

Relationship to Policy Holder: ◯Self ◯Spouse ◯Child ◯Other Policy Holder's SS# _____ Policy Holder's DOB _____

Policy Holder's Employer _____ Member ID # _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone # _____

THIRD PARTY LIABLITY INFORMATION

Is this visit school, work, or accident related? ◯YES ◯ NO If so, type of accident _____

Name of Liable Party _____ Phone # _____

Third Party Insurance Company _____ Policy # _____

Name of Attorney representing patient related to this incident _____ Phone # _____

Attorney's Address, City, State, Zip _____

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 orthoLA, 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 any 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 orthoLA for services rendered by provider group. I authorize any holder of medical and or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap Insurer, and/or their agent's information needed to determine these benefits or benefits for related services.

_____ _____ _____
Patient/Guardian Name (Printed) **Patient/Guardian Signature** **Date**

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CONFIDENTIAL PATIENT MEDICAL HISTORY

FOR OFFICE USE ONLY HIGGINS ELIAS ELLENDER HILDENBRAND GREBER BORNE JOHNSON

HEIGHT _____' _____' **WEIGHT _____lbs** **AGE _____** **BP_____/_____** **PULSE _____ TEMP_____**

PATIENT NAME_____ DOB _____ SS# _____

REASON FOR PRESENT VISIT _____ AFFECTED SIDE: ◯ LEFT ◯ RIGHT ◯ BILATERAL

DATE OF INJURY _____ ARE YOU: ◯ RIGHT-HANDED ◯ LEFT-HANDED ARE YOU CURRENTLY PREGNANT: ◯ YES ◯ NO

OCCUPATION _____ How & where did injury occur?_____

Is this visit related to: Work Injury? ◯ **YES** ◯ **NO** **VERIFICATION OF WORK INJURY REQUIRED FROM EMPLOYER**
Student Athlete Injury? ◯ **YES** ◯ **NO** **STUDENT ATHLETE 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 places? Tender? Red? **Is the pain dull, throbbing, sharp? If it is a lump, is it warm?**

SEVERITY/DURATION _____
How severe is the pain on a scale from 1-10 with 10 being most severe? How long have you had pain? Start date?

TIMING/CONTEXT _____
Does the pain/problem occur at a specific time? Rare, intermittent or constant? What were you doing at onset of pain/problem?

MODIFYING FACTORS _____
What makes this problem worse or better? (activities)

PAST HISTORY OF PRESENT ILLNESS

Where you referred by another doctor or therapist for condition? ◯ YES ◯ NO If yes, referral name _____

Have you seen any other doctors regarding this condition prior to coming to our office? ◯ YES ◯ NO

TREATMENT	DOCTOR	DATE	TESTS	RESULTS

Have you ever experienced any injury or symptoms related to this body part before? ◯ YES ◯ NO If yes, provide details:

_____

Hobbies/Activities you enjoy _____

Are any of the above affected by your pain/problem? _____

PAST MEDICAL HISTORY *Check all that apply*:

☐ ADD	☐ Bladder Infections	☐ DVT(blood clot)	☐ High Blood Pressure	☐ Mitral Valve Prolapse	☐ Sickle Cell
☐ AIDS/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	☐ Scarlett Fever	☐ Ulcers
☐ Back Trouble	☐ Diabetes	☐ Hepatitis	☐ Migraine Headache	☐ Seizures	

Other _____

PAST SURGICAL/HOSPITALIZATION HISTORY (Please include: Date, Surgery/Illness, Doctor, Facility)

_____

_____

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CONFIDENTIAL PATIENT MEDICAL HISTORY

CURRENT MEDICATIONS & SUPPLEMENTS

DRUG NAME:	DOSAGE:	HOW OFTEN TAKEN:	START DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Preferred Pharmacy _____ **Location** _____ **Phone #** _____

Medication Allergies:_____ **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/day ◯ 2-3 per day ◯ 4-5 per day ◯ 6+per day

RECREATIONAL DRUG USE: ◯ Never ◯ Previous ◯ Current _____

LIVING SITUATION: ◯ With Family ◯ With Friends ◯ 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 ***Check all that apply to YOU:***

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

CARDIOVASCULAR
- ☐ Heart 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
- ☐ Headache

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)
- ☐ Changes in skin color
- ☐ Varicose veins Rash or itching

NEUROLOGICAL
- ☐ Light headed or dizzy
- ☐ Numbness or tingling
- ☐ Tremors
- ☐ Paralysis

ENDOCRINE
- ☐ Excessive thirst/urination
- ☐ Heat/cold intolerance
- ☐ Skin becoming dryer

PSYCHIATRIC
- ☐ Memory loss/confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomia

HEMATOLOGIC/LYMPHATIC
- ☐ Slow to heal after cuts
- ☐ Bleeding or bruising tendency
- ☐ Anemia
- ☐ Enlarged glands

RESPIRATORY
- ☐ Chronic/frequent cough
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Nausea/Vomiting
- ☐ Frequent diarrhea
- ☐ Constipation
- ☐ Rectal bleeding/bloody stool
- ☐ Bloody Stool

OTHER INFORMATION DOCTOR MAY NEED TO KNOW: _____

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

Signature of patient/legal guardian _____ Date _____

Reviewing physician signature _____ Date _____

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NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

Updated and Effective May 1, 2020

In good faith, our office provides services with the expectation that it will be appropriately compensated at the time of service. It is your responsibility to understand your individual health policy. OrthoLA will file with your primary and secondary health insurance, but requires timely payment from insurance companies and the patient.

Patients are responsible for letting orthoLA 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 at each 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 appropriate regulations are followed.

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 orthoLA's 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 (printed) _____ Patient's Date of Birth _____

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NOTICE OF PRIVACY PRACTICES

Updated January 1, 2020

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. 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.
2. 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.
3. 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.
4. Request that we change certain parts of your medical information if it is inaccurate. If we disagree, we will provide written explanation.
5. 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.

OrthoLA
ATTN: PRIVACY OFFICER
Post Office Box 28
Thibodaux, LA 70302

Phone: (985) 625-2200
Fax: (985) 625-2206

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DISCLOSURE OF FINANCIAL INTERESTS
(Updated January 1, 2020)

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 (Jason A. Higgins, MD, David W. Elias, MD, Patrick R. Ellender, MD, John C. Hildenbrand IV, MD, Eric M. Greber, MD, Allen T. Borne, MD, and/or William S. Johnson III, MD) may have an economic interest in one or more of the following entities:

- Bayou Regions Surgical Center
- Southlake Surgery Center
- Health Scripts of America Central Louisiana LLC
- Thibodaux Physician Investors, L.L.C.
- Thibodaux Surgery Center, L.L.C.
- Venture Medical L.L.C.
- Zimmer Biomet
- Epidose Solutions

PATIENT ACKNOWLEDGEMENT OF FINANCIAL INTERESTS

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's Name (printed) _____ **Date of Birth** _____

Signature of Patient or Patient Representative_____ **Date** _____

ACKNOWLEDEMENT OF RECEIPT & UNDERSTANDING OF NOTICE OF PRIVACY PRACTICES

I have received, read, and understand the Notices of Privacy Practices provided to me by orthoLA. I understand my rights and responsibilities and agree to abide by this policy.

Patient's Name (printed) _____ **Date of Birth** _____

Signature of Patient or Patient Representative_____ **Date** _____

Opting Out of Appointment Reminders

By initialing below, I am opting out of orthoLA's reminder service and understand I will not receive any reminders of my upcoming appointments with orthoLA.

_____Patient/Legal Guardian Initials

Jason A. Higgins, MD
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HIPAA General Medical Release Form
(Updated January 1, 2020)

I hereby authorize the disclosure of my medical information by orthoLA to the following persons (print):

Name/Relationship _____ **Date of Birth** _____

Name/Relationship _____ **Date of Birth** _____

Name/Relationship _____ **Date of Birth** _____

Name/Relationship _____ **Date of Birth** _____

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:

Patient Name _____

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

Street Address _____

City, State, Zip _____

Patient's DOB _____ **Contact Phone Number**_____

Patient's Signature _____ **Date** _____

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