



Orthopaedic Sports Medicine, Joint and Hand Specialists

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, Race, Ethnicity, Primary Language, Date of Birth, Age, Sex, Mailing Address, City, State, Zip, Social Security #, Phone #, Email, Marital Status, Occupation, Referring physician

IF YES, NAME OF HOME

INSURANCE INFORMATION

Primary Insurance, Policy Holder, Relationship to Policy Holder, SS#, DOB, Member ID #, Secondary Insurance

EMERGENCY CONTACT

Name, Relationship, Phone #

THIRD PARTY LIABILITY INFORMATION

Is this visit school, work, or accident related?, Name of Liable Party, Phone #, Third Party Insurance Company, Policy #, Name of Attorney, Phone #, Attorney's Address

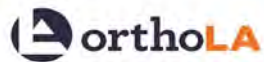
INSURANCE ASSIGNMENT AND RELEASE

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.

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



CONFIDENTIAL PATIENT MEDICAL HISTORY

FOR OFFICE USE ONLY HIGGINS ELIAS ELLENDER HILDENBRAND GREBER BORNE JOHNSON DUPLANTIS

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 L LEFT-HANDED ARE YOU CURRENTLY PREGNANT YES NO OCCUPATION \_\_\_\_\_

How did injury occur? \_\_\_\_\_ 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

Were 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 If yes, please explain:

Table with 5 columns: 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? \_\_\_\_\_

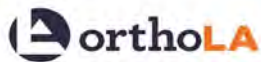
PAST MEDICAL HISTORY Check all that apply:

Table listing medical conditions: ADD, AIDS/HIV+, Anemia, Arthritis-osteo, Arthritis-rheumatoid, Asthma, Back Trouble, Bladder Infections, Bleeding Tendency, Blood Transfusions, Bronchitis, Cancer, Depression/Anxiety, Diabetes, DVT(blood clot), Epilepsy, Fibromyalgia, Glaucoma, Gout, Heart Disease, Hepatitis, High Blood Pressure, High cholesterol, Infectious Mono, Kidney Disease, Low Blood Pressure, Lupus, Migraine Headache, Mitral Valve Prolapse, Pneumonia, Polio, Restless Leg Syndrome, Rheumatic Fever, Scarlet Fever, Seizures, Sickle Cell, Sleep apnea, Stroke, Thyroid Disease, Tuberculosis, Ulcers

Other \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_



CONFIDENTIAL PATIENT MEDICAL HISTORY

CURRENT MEDICATIONS & SUPPLEMENTS

Table with 4 columns: DRUG NAME, DOSAGE, HOW OFTEN TAKEN, START DATE. Includes 5 rows of blank lines for entry.

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

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

NEUROLOGICAL

- Light headed or dizzy
Numbness or tingling
Tremors
Paralysis

RESPIRATORY

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

CARDIOVASCULAR

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

GENITOURINARY

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

ENDOCRINE

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

GASTROINTESTINAL

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

PSYCHIATRIC

- Memory loss/confusion
Nervousness
Depression
Insomnia

CONSTITUTIONAL SYMPTOMS

- Bad general health lately
Recent weight change
Fever
Fatigue
Headache

INTEGUMENTARY (SKIN,BREAST)

- Changes in skin color
Varicose veins Rash or itching

HEMATOLOGIC/LYMPHATIC

- Slow to heal after cuts
Bleeding or bruising tendency
Anemia
Enlarged glands

OTHER INFORMATION DOCTOR MAY NEED TO KNOW:

Patient verifies that questions on this form have been 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 \_\_\_\_\_

## NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

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 \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

### 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

### DISCLOSURE OF FINANCIAL INTERESTS

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 orthoLA 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, William S. Johnson III, MD, and/or Keith P. Duplantis, 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
- Episode 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

**HIPAA General Medical Release Form**

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 \_\_\_\_\_