Orthopedic Center of LA, L.L.C. Patient Registration

(PLEASE PRINT)

PATIENT INFORMATION

Name (Last, First, M.I.) :		SSN :	
Address :	City :	State :	Zip :
Physical (911) Address :	City :	State :	Zip :
Home Phone:	Work Phone :	Cell Phone:	
Patient Employed by :	Occupation :		
Birth date : Age :	Sex ☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	
Notify in case of emergency :	Relationship :	Phone :	
Notify in case of emergency :	Relationship :	Phone :	

IF PATIENT IS A MINOR – COMPLETE

Father's Name: (Last, First, M.I.) :		Social Security # :	Birth date :
Address (if different from patient's) :			Phone :
City :	State :	Zip :	Employer :
Employer's Address :			Employer Phone :
Marital Status ☐ Single	☐ Married	☐ Widowed	☐ Divorced
Mother's Name: (Last, First, M.I.) :		Social Security # :	Birth date :
Address (if different from patient's) :			Phone :
City :	State :	Zip :	Employer :
Employer's Address :			Employer Phone :
Marital Status ☐ Single	☐ Married	☐ Widowed	☐ Divorced

IF PATIENT IS MARRIED – COMPLETE

Spouse's Name (Last, First, M.I.) :	
Social Security # :	Birth date :
Employer :	Employer Phone :
Employer's Address :	

OTHER MEMBERS IN HOUSEHOLD

Name (Last, First, M.I.) :	Birth date :
Name (Last, First, M.I.) :	Birth date :
Name (Last, First, M.I.) :	Birth date :

Use back for additional listings

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with _____

Name of Insurance Company(ies)

And assign directly to **Orthopedic Center of LA** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges** whether or not paid by insurance. I hereby authorize **Orthopedic Center of LA** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature	Relationship	Date

Orthopedic Center of Louisiana, LLC

Medical History Form

Appointment Date:_____ Appointment Time:_____

Patient Name:_____ with Doctor:_____

Age:_____ Sex: F___M___ Dominant Hand: R___L___ Did you bring x-rays? Y___N___ Latex Allergy: Y___N___

Primary Physician: _____ Date of injury: _____

Reason for visit? Pain___Numbness___Weakness___Swelling___Stiffness___Other_____

Body part? Shoulder R__L__ Elbow R__L__ Wrist R__L__ Hand R__L__ Finger T 2 3 4 5 Knee R__L__ Ankle R__L__ Foot R__L__
Hip R__L__ Pelvis R__L__ Neck ___ Back ___ Low back___

Other: _____

How long ago did it start? Days___ Weeks___ Months___ Years___ Have you had a problem like this before? Y___N___

■ **NO INJURY** (onset was gradual____ or sudden____

■ **INJURY due to**: Accident ___ Sport___ Work___ **Date of injury**:_____ How_____

■ **INJURY AT WORK** Yes _____ No____describe_____ Date _____

Work status: regular___ light duty___ disabled___ not working due to this problem___ Date last worked _____

Currently receiving or applied for: disability___ worker's compensation___ unemployment___

■ **AUTO ACCIDENT** describe _____ Date _____

■ **Is there an attorney involved with this injury?**

How severe is the pain10 being worst? (circle) 0 1 2 3 4 5 6 7 8 9 10 Sharp___Dull___Stabbing___Throbbing___Aching___Burning___

Does the pain wake you from sleep? Y___N___ constant___ comes and goes___ getting better ___getting worse ___unchanged__.

What makes the symptoms worse? _____

better? _____

Prior problem with this condition _____

Had any of the following? Injection___ brace___ physical therapy ___ cane/crutch___ x-rays___ MRI___ CT scan___ bone scan___

REVIEW OF SYSTEMS:

Are you diabetic? Y___N___

Constitutional: normal__weight loss___ loss of appetite___ fever___ cancer___
Eye: normal__glasses___ contacts___ double vision___ cataracts___
ENT: normal__hearing loss___ hoarseness___ ringing in ears___
Cardiovascular: normal__high blood pressure___ heart attack___ blood clots___
Respiratory: normal__asthma/cough___ pneumonia___ shortness of breath___ tuberculosis___
GI: normal__stomach ulcer___ hepatitis___ blood in stool___
GU: normal__pain with urination___ blood in urine___ kidney disease ___
Skin: normal__skin ulcers___ rash___ lumps___
Neurologic: normal__seizures___ stroke___ balance problem___ headaches___
Psychiatric: normal__depression___ nervousness___ sleep disorder___
Hematologic: normal__easy bleeding___ easy bruising___ anemia___

None of the above_____

Other_____

Orthopedic Center of Louisiana, LLC

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Sports Medicine Spine Joint Replacement Pediatrics Trauma Hand Foot Fracture Care

500 South Sixth St., Leesville, LA 71446 Phone: 337-239-8000 Fax: 337-239-8003
5408 Provine Place, Alexandria, LA 71302

Professional Staff:
J. David DeLapp, M.D. Tiffany N. Hayes P.A.-C

In order to help maintain our compliance with HIPPA Privacy Regulations, we need the following information to keep your health information private and protected. Please help us by answering the questions below.

- Name_____
- Date of Birth_____
- What telephone number do you want us to call when we need to contact you?
  _____
- When we call you and you are unavailable, can we:
  Leave a message on your answering machine? Yes No
  Leave a message with someone? Yes No
  If yes, who? _____
- Can we leave information regarding:
  Our name and telephone number? Yes No
  Dates of appointments scheduled for you? Yes No
  Dates of tests scheduled for you? Yes No
  Dates of surgery scheduled for you? Yes No
- Can we mail you correspondence concerning appointments?
  Yes No
- _____ give the Orthopedic Center of Louisiana permission to discuss my medical care with: (please mark one)

  _____ No one
  _____ Those individuals listed below:

  Name _____ Relationship _____
  Name _____ Relationship _____
  Name _____ Relationship _____

_____ _____
Patient or guardian signature Date

Orthopedic Center of Louisiana, LLC

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its notice of Privacy Practices from the time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

……

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

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PRESCRIPTION/NARCOTIC MEDICATION AGREEMENT

I, _____ AGREE TO THE FOLLOWING:
Prescription/Narcotic drugs will sometimes be prescribed during the course of treatment by Dr. J. David De Lapp and/or Tiffany Hayes, PA-C.

I agree to advise Dr. J. David DeLapp and/or Tiffany Hayes, PA-C in advance of being presented with a prescription, of any narcotics that I am currently taking or may take:

_____
(name of narcotic medication)

And it is currently being prescribed for me by Dr. _____

NOTE: You must complete this form for each prescription/narcotic you are currently taking or may take during your treatment with Dr. J. David DeLapp and/or Tiffany Hayes, PA-C. **Your failure to disclose all information via this form of in writing to Dr. J. David DeLapp and/or Tiffany Hayes, PA-C may result in serious health risks.**

I agree not to seek narcotic medication from any other source without consulting, Dr. J. David Delapp and/or Tiffany Hayes, PA-C, once the narcotic has been prescribed for me. I will not increase my prescribed medication without prior approval from Dr. J. David DeLapp and/or Tiffany Hayes, PA-C. I understand that these prescriptions will not be refilled by phone.

I will submit to drug testing on a random basis. If drugs not prescribed or an excessive amount of drugs are found in my blood or urine, I understand that all medication will be weaned and discontinued and I will be discharged from the care of Dr. J. David DeLapp and/or Tiffany Hayes, PA-C and I will have to find another physician.

Signature: _____ Date: _____

Physician: _____ Date: _____

Witness: _____ Date: _____

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5408 Provine Place, Alexandria, LA 71302

Dr. J. David DeLapp, M.D., Board Certified-FAAOS

Tiffany Hayes, PA-C

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?
We accept payment by cash, check, VISA, Mastercard, American Express and Discover.

Do I Need A Referral?
If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, you will need to call your primary care physician to obtain it. <u>If you are unable to obtain the referral at that time, you will be rescheduled</u>.

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance."	Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles, copayments and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	<u>If the services you receive are covered by the plan</u>: All applicable copays and deductibles are requested at the time of the office visit. <u>If the services you receive are not covered by the plan</u>: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you. File an insurance claim on your behalf.
HMO with which we are <u>not contracted</u>.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.

If You Have...	You Are Responsible For...	Our Staff Will...
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services. File an insurance claim on your behalf.
Medicare	If you have Regular Medicare, and have not met your $186 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. <u>If you have Regular Medicare as primary, and also have secondary insurance</u>: No payment is necessary at the time of the visit. <u>If you have Regular Medicare as primary, but no secondary insurance</u>: Payment of your 20% copay is requested at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Medicare HMO	All applicable copays and deductibles at the time of the office visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Worker's Compensation	<u>If we have verified the claim with your carrier</u> No payment is necessary at the time of the visit. <u>If we are not able to verify your claim</u> Payment in full is requested at the time of the visit.	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
Attorney Pay	<u>If we have verified the case with your attorney</u> No payment is necessary at the time of the visit.	Call your attorney ahead of time to verify your case. Bill your attorney on your behalf.
Medicaid	No payment is necessary at the time of the visit.	Call your insurance company ahead of time to verify coverage. File an insurance claim on your behalf.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

Surgery

If surgery is recommended, you will see the Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Surgery Coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Surgery Coordinator.

What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to the Orthopedic Center of LA.

I authorize the Orthopedic Center of LA to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____	_____	_____
Date	***Signature of Patient/Legal Guardian***	***Printed Name***

Orthopedic Center of LA, LLC
J. David DeLapp, MD
Tiffany Hayes, PA-C

500 South 6th St, Leesville, LA 71446
5408 Provine Place, Alexandria, LA 71302
Phone #: (337) 239-8000

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

January 23, 2017

This Notice of Privacy Practices applies to the following organizations.

Orthopedic Center of LA, LLC

Orthopedic Center of La, LLC, 500 South 6th St, Leesville, LA 71446 *Phone # 337-239-8000*
5408 Provine Place, Alexandria, LA 71302