Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

Patient Label

Orthopedic Specialist of Louisiana
2005 Landry Drive
Bossier City, LA 71111
318-752-7850

Orthopedic Specialist of Louisiana
1500 Line Avenue, Suite 100
Shreveport, LA 71101
318-635-3052

Dear New Patient,

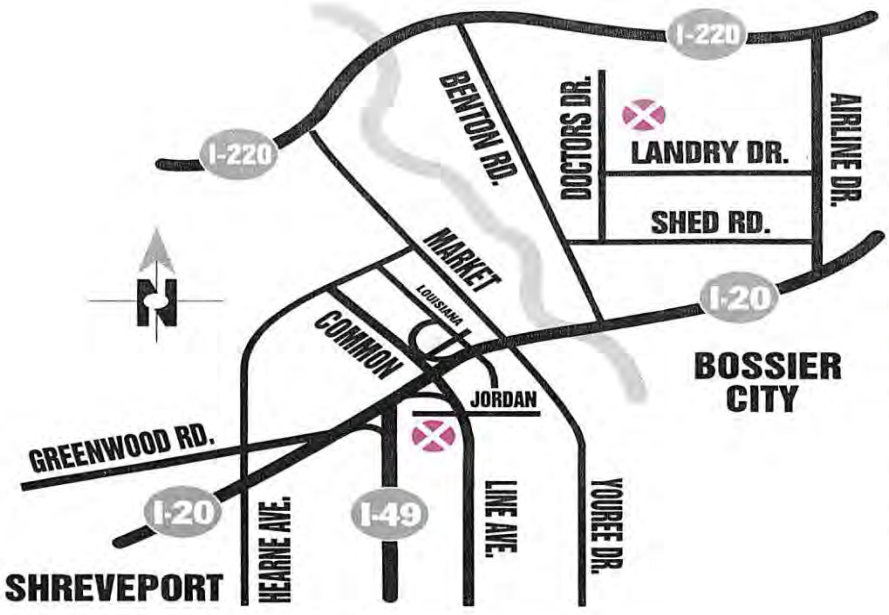
Thank you for choosing Orthopedic Specialist of Louisiana for your orthopedic care. Enclosed you will find your registration form, patient medical history questionnaire and our financial policy. Please fill out forms in their entirety, **BRING** them with you to your appointment.

We request that you bring the following information to your appointment:

- **Your Health Insurance card(s) and Driver's License**. Please contact your insurance company to verify if a referral from your Primary Care Physician is needed. If a referral is needed, please contact your physician, and have a written referral **FAXED to 318-629-5163**. Also be prepared to pay your co-pay at the time of service.
- **CURRENT MEDICATION LIST**
- **Photo ID** from each patient or patient's guardian
- **EMG, X-rays, MRI, Bone scans, CT on disc and Reports** if any were taken prior to your visit please **"hand carry"** to your appointment.

Please arrive 15 minutes early for your appointment. If you are 15 minutes or more late for your appointment, we may have to reschedule you for another day. If you are unable to keep your appointment, please call 24 hours ahead to reschedule.

Directions



1500 Line Avenue Location:

I-20 Eastbound- From I-20, take Line Ave. exit. Merge right onto Line Ave. Orthopedic Specialists of Louisiana is at the corner of Line and Jordan, 1500 Line Ave. Turn right on Jordan then left on Elizabeth St. Take a left into parking lot. Patient drop off is at the glass doors under the breezeway. Check in is on the 1st floor in suite 100. Overflow parking is across Elizabeth St. in parking lot.

I-20 Westbound- Take Common St. exit. Bear right in circle, turn right onto Louisiana, right on Fairfield, and left onto Line Ave. Go under I-20 and uphill to 1500 Line Ave., Orthopedic Specialists of Louisiana is at the corner of Line Ave. and Jordan St. Turn right on Jordan then left on Elizabeth St. Take a left into parking lot. Patient drop off is at the glass doors under the breezeway. Check in is on the 1st floor in suite 100. Overflow parking is across Elizabeth St. in parking lot.

2005 Landry Drive Location:

I-20 Eastbound- From I-20, take Airline Drive Exit. Turn left on Airline Drive under I-20 heading North for approximately 1 mile to Airline Drive and Shed Road through the intersection and turn onto the first street on the left which is Landry Drive.

I-20 Westbound- From I-20, take Airline Drove Exit. Turn right and go approximately 1 mile to Airline Drive and Shed Road through the intersection and turn onto the first street on the left which is Landry Drive.

I-220- Take Airline Drive Exit. Drive South on Airline Drive for approximately 3 miles. Go over railroad tracks and turn onto the first street on the right which is Landry Drive.

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Patient Registration Form

Date _____

Patient Information

Name: _____ Social Security Number: _____

Street Address: _____ Date of Birth: _____ Age: _____

City/State/Zip: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Email: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Race: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ Communication Needs: _____

Preferred Phone: _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Work

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan Number: _____

Policy/I.D. Number: _____ Group Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan Number: _____

Policy/I.D. Number: _____ Group Number: _____

Workers Compensation Claim Information

Is your visit today a Work Related Injury? ☐ Yes ☐ No If **Yes** have you reported to your employer? ☐ Yes ☐ No

Employer: _____ Phone Number: _____

Third Party Liabilty (MVA or Slip & Fall)

Is your visit today related to a MVA or Slip & Fall? ☐ Yes ☐ No If **Yes** have you contacted an attorney? ☐ Yes ☐ No

Attorney Name: _____ Date of Accident: _____

Referral

Referring Physician: _____ Primary Care Physician: _____

Medicaid/Medicaid Replacement

Please be advised that Musculoskeletal Institute of Louisiana (d/b/a Orthopedic Specialists of Louisiana and Pain Care Consultants) is **NOT** a participating provider in the MEDICAID/MEDICAID REPLACEMENT programs and Musculoskeletal Institute of Louisiana **WILL NOT** file MEDICAID/MEDICAID REPLACEMENT. If you request treatment by one of our physicians, you must agree to be personally responsible for payment IN FULL for all charges related to your treatment.

I agree that Musculoskeletal Institute of Louisiana, LLC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

I Hereby Authorize Musculoskeletal Institute of Louisiana, LLC to release any medical information and/or medical records maintained at this clinic as needed to my insurance company, to the social security administration or carriers, to my attorney, or to the attorney responsible for the payment for medical services or evaluation to be provided. I permit a copy of this authorization to be used in place of the original. I hereby assign to the facility listed above all Insurance Company or Medicare reimbursements for medical and/or surgical expenses. Regulations pertaining to Medicare assignment of benefits apply. I have been given a copy of the Notice of Private Practices of Musculoskeletal Institute of Louisiana, LLC.

I have been informed that Musculoskeletal Institute of Louisiana, LLC is NOT a participating provider in MEDICAID/MEDICAID REPLACEMENT programs and that Musculoskeletal Institute of Louisiana WILL NOT file MEDICAID/MEDICAID REPLACEMENT.

_____ _____

Signature (Patient or Responsible Party) Date

MEDICAL HISTORY FORM

PATIENT NAME: First _____ MI _____ Last _____

Age: _____ Height: _____ Weight: _____ Date of Birth: _____

Gender: ☐ Female ☐ Male I am: ☐ Left Hand Dominant ☐ Right Hand Dominant

Primary Care Physician: _____

CHIEF COMPLAINT: Why are you here? _____

_____ _____

Date of Injury or Onset of Symptoms: _____ **Body Part to be Examined:** _____ ☐ **Left** ☐ **Right**

(Check all that apply)

Main Problem: ☐ pain ☐ numbness ☐ weakness ☐ stiffness ☐ unstable ☐ swelling ☐ popping/grinding ☐ other: _____

Where complaint/injury occurred: ☐ work ☐ at home ☐ sports/recreational ☐ car accident ☐ at school ☐ other: _____

How complaint/injury occurred: ☐ gradual ☐ onset ☐ sudden/traumatic ☐ unknown ☐ other: _____

PREVIOUS AND/OR CURRENT TREATMENTS FOR THIS CONDITION: *(Check all that apply)* ☐ **None**

Medications: ☐ Anti-inflammatories ☐ Muscle relaxants ☐ Pain medication ☐ Other: _____

Therapies: ☐ Physical therapy ☐ Chiropractic care ☐ Injections ☐ Other: _____

ARE YOU PREGNANT? ☐ **YES** ☐ **NO**

GENERAL MEDICAL HISTORY:

Are you affected by any of the following? *(Check all that apply)* ☐ **No medical problems**

☐ Abnormal heart rhythm ☐ Bleeding disorders ☐ Depression ☐ Heart attack ☐ High blood pressure ☐ Lung Problems
☐ Sleep apnea ☐ Acid Reflux ☐ Blood clots ☐ Diabetes ☐ Heart failure ☐ HIV
☐ Osteoporosis ☐ Stomach ulcers ☐ Asthma ☐ Cancer ☐ Gout ☐ Hepatitis
☐ Kidney problems ☐ Rheumatoid arthritis ☐ Stroke

If you checked any of the above, please explain: _____

SOCIAL HISTORY: *(Check all that apply)*

A. Occupation: _____

B. Smoking/Smokeless Tobacco Status: ☐ Never Smoked ☐ Current Smoker ☐ Former Smoker ☐ Smokeless Tobacco ☐ Unknown

The amount and how often you use tobacco: _____

C. Do you use alcohol? ☐ no ☐ occasionally ☐ daily

D. What is your living status? ☐ alone ☐ with spouse ☐ with parents ☐ with roommate ☐ assisted living/nursing home

PREVIOUS SURGERIES: ☐ **None**

Please list the type and date the surgery was performed.

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

Have you ever had a problem with a general anesthetic? *(Check one)* ☐ Yes, explain below ☐ No

If yes, describe any problems: _____

CURRENT MEDICATION: ☐ **None**

Pharmacy Preference and Phone #:_____

Please list any prescriptions, drugs, and/or non-prescription medications, including vitamins, nutritional supplements, or anything taken orally.

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

ALLERGIES: Do you have any known drug allergies? *(Check one)* ☐ Yes (*Explain below)* ☐ No

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

Are you allergic to metal ? ☐ **Yes** ☐ **No**

FAMILY HISTORY: Please indicate if anyone in your family has had the following: *(Check all that apply)*

☐ Cancer (Type): _____ ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Scoliosis ☐ Heart Disease

☐ Other: _____ ☐ None apply

REVIEW OF SYMPTOMS:

Are you experiencing any of the following? *(Check all that apply)*

☐ Blackouts/fainting	☐ Difficulty with balance	☐ Joint Pain	☐ Stomach pain or ulcers
☐ Burning with urination	☐ Fevers, chills, sweats	☐ Nausea or vomiting	☐ Stress
☐ Back Pain	☐ Frequent rashes	☐ Neck or Shoulder Pain	☐ Unexplained weight loss
☐ Cough	☐ Heart or chest pain	☐ Seizures	☐ Urinary incontinence, frequency, urgency
☐ Depression	☐ Heartburn	☐ Shortness of breath	☐ None apply

_____ _____

Signature of patient, parent, or guardian Date Physician's signature Date

Authorization to Release Information Concerning Your Care

We at **Musculoskeletal Institute of Louisiana** take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below.

❑ **I do not authorize anyone to receive information regarding my medical care.**

Per my request, release the following information on myself: (Check each that apply)

❑ Appointments ❑ Account/Bill ❑ Lab/Test Results ❑ Medical Care/Treatment

Person: _____ Relationship:_____
Phone number(s): _____

Person: _____ Relationship:_____
Phone number(s): _____

Person: _____ Relationship:_____
Phone number(s): _____

Person: _____ Relationship:_____
Phone number(s): _____

This will not include copies of your medical records. If you wish someone else to pick up a copy of your medical records, please fill out our Authorization to Use or Disclose Protected Health Information Form

Medical History and Consent for Treatment

I certify that the information I have supplied is accurate, complete and true.

I authorize ***Orthopedic Specialists of Louisiana*** and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for ***Orthopedic Specialists of Louisiana*** to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review ***Musculoskeletal Institute of Louisiana*** Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize ***Orthopedic Specialists of Louisiana*** to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize ***Orthopedic Specialists of Louisiana*** to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that ***Orthopedic Specialists of Louisiana*** will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

Signature: _____ Date: _____

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FINANCIAL POLICY and CONTRACT WITH PATIENT

Thank you for choosing us as your health care provider. We are committed to providing our patients with the best treatment possible. We hope that you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this vital health care facility for our patients and community.

Our charges for your care are considered to be the usual and customary charges in line with what other specialists in this geographical area charge their patients. You are responsible for payment of your bill in full, regardless of your insurance company's determination of usual and customary charges for this area. The only exceptions for this are if you are covered by Medicare or you are covered by a PPO or HMO for which we are a provider of services.

STATEMENT OF RESPONSIBILITY

By signing below, I hereby enter into a contract with MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC, for the furnishing of medical and/or surgical procedures for illness or injury. I understand that I am contractually responsible for the total bill incurred as a result of treatment received. Although I may have insurance coverage, I understand that this is an agreement between me and my insurance carrier to pay certain amounts for my medical care. The obligation to pay my doctor bill is an obligation by me to my doctor. I am totally responsible for payment of my doctor bill in full. This is regardless of the status of any pending insurance claim or the insurance company's determination of usual and customary rates or amount of assignment. I accept full responsibility for payment of the account, and depending upon the circumstances, I may be expected to pay in full at time of service. I hereby acknowledge that I should coordinate personally with my health insurance carrier. I hereby grant MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC, its agents and attorneys the right to disclose my confidential health care information for purposes of collection of my bill through contact with any third party or through a lawsuit.

In the event that I am covered by a managed care PPO or HMO for which my doctor is a provider of services, I understand that the clinic will accept the allowable charges and will write off any amount that is disallowed by insurance. **I accept responsibility for payment of my co-pay and/or deductible at time of service, any allowable amount not paid by insurance, and/or treatment my policy does not cover.** I understand that you do accept assignment on Medicare and I will not owe any disallows that are written off of my account. **However, I understand that I am responsible for my deductible, co-pay and any charges not covered by Medicare.**

If I am here as the result of a liability claim, I understand that my doctor cannot wait for settlement of my claim in order to be paid and that payment is due at the time services are rendered. My attorney and/or insurance carrier will be provided with an itemized statement for my reimbursement.

If I am here as the result of an on the job injury and my workman's compensation claim is denied, I understand that I am personally responsible for payment of the bill in full.

In the event that credit is extended to me, I understand that any bill rendered by MUSCULOSKSLETAL INSTITUTE OF LOUISIANA, LLC is due and payable upon receipt of statement. If payment in full creates a financial hardship, the clinic will consider an extended payment plan arrangement. I also understand that I may pay my bill in full at any time by cash, check, or any major credit card. **There is a fee (currently $25) for any checks returned by the bank**. In the event of default in the payment of any amount due and this account is turned over to an agency or attorney for collection or legal action, **I hereby agree to be held liable for my outstanding balance plus, attorney fees of 25% of my balance over 30 days in arrears if the account is forwarded to collection, and all court costs, and judicial interest.** I, the undersigned, have read and understand this contract, and hereby agree to the terms herein.

Date: _____ Signature: _____

PATIENT/RESPONSIBLE PARTY

ASSIGNMENT OF BENEFITS/AUTHORITY TO RELEASE INFORMATION

I have this date, assigned to MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC the benefits due me under my existing policy or policies of insurance. I understand, in so far as they are necessary to cover such expenses, that the above assignment of insurance is accepted by MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC as a convenience to me. Said company is hereby given my consent to file claims on said policy and to do such other actions as it deems necessary in connection therewith so as to promptly obtain payment to the company, direct, and without payment to me.

I authorize the release of all medical records to the referring and family physicians, to my insurance carrier, and/or my attorney at law. I allow fax transmittal of my records, if necessary.

Date: _____ Signature: _____

PATIENT

_____ _____

PARENT/GUARDIAN RELATIONSHIP TO PATIENT

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Disclosure of Financial Interest
As required by R.S. 37:1744 and LAC 46:XLV.4211-4215

Louisiana law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to another health care provider or facility in which the physician has a significant financial interest.

Our physicians have a financial interest in these facilities:

Specialists Hospital Shreveport
Specialists Outpatient Therapy
1500 Line Avenue, Suite 206
Shreveport, LA 71101
318-213-3800

The nature and extent of each physician's interest is that they are one of multiple physicians who own an interest in the facility to which a patient may be referred for the purpose of surgical procedure, pain management procedure, physical therapy evaluation and treatment or prescriptive needs.

Patient Acknowledgement

By signing this Disclosure of Financial Interest, you acknowledge that you have read and understand the foregoing notice and understand that your physician has an ownership interest in above mentioned facilities.

_____ _____

Patient/Personal Representative Signature Date Signed

_____ _____

Please Print Patient's Name Date of Birth

_____

Relationship to Patient if Personal Rep.