FLEX INSTITUTE

Dear New Patient,

Thank you for choosing FLEX Institute for your orthopedic care. Enclosed, you will find your registration form, patient medical history questionnaire and our financial policy. Please fill out the 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.

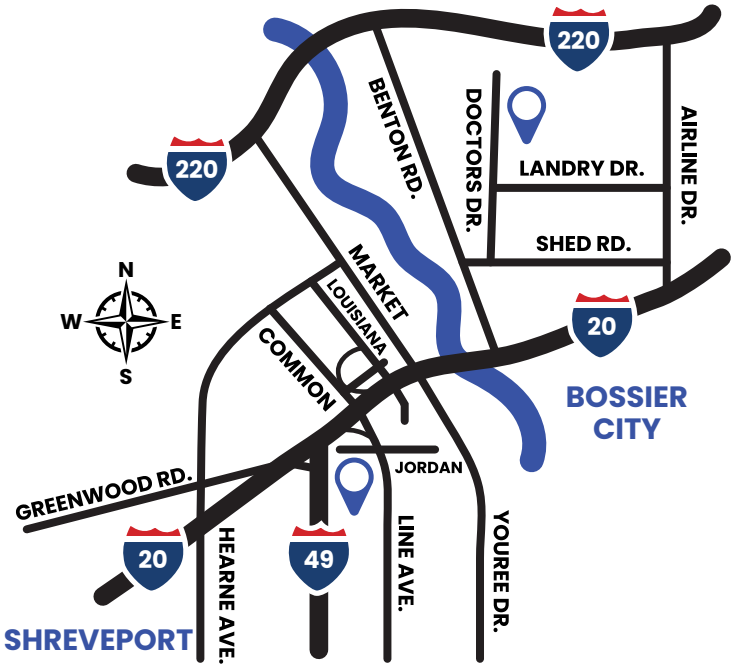
Please arrive 15 minutes early for your appointment. If you are 15 minutes or more late for your appointment, we may have to reschedule you for another day. If you are unable to keep your appointment, please call 24 hours ahead to reschedule.

DIRECTIONS

1500 LINE AVENUE LOCATION

I-20 Eastbound: From I-20, take Line Avenue Exit. Merge right onto Line Ave. FLEX Institute is at the corner of Line and Jordan: 1500 Line Ave. Turn right on Jordan, then left on Elizabeth Street. Take a left into parking lot. Patient drop-off is at the glass doors under the breezeway. Check-in is on the First Floor in Suite 100. Overflow parking is across Elizabeth Street 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. FLEX Institute 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 First Floor in Suite 100. Overflow parking is across Elizabeth Street in parking lot.



2005 LANDRY DRIVE LOCATION

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

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

I-220 Westbound: From I-220, take Airline Drive Exit. Drive south on Airline Drive for approximately 3 miles. Go over the railroad tracks. Turn onto the first street on the right, which is Landry Drive.

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/ID Number: _____ Group Number: _____

SECONDARY INSURANCE PLAN (IF ANY)

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

Policy/ID 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 LIABILITY (MVA OR SLIP & FALL)

Is your visit today related to 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 FLEX Institute is **NOT** a participating provider in the MEDICAID/MEDICAID REPLACEMENT programs, and FLEX Institute **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 FLEX Institute, 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 FLEX Institute, 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 FLEX Institute, LLC.

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

_____ _____

Signature (Patient or Responsible Party) Date

FLEX INSTITUTE

PATIENT QUESTIONNAIRE

Date: _____ (Office Use Only) Person #: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Referring Doctor: _____ Phone #: _____

Family/Primary Doctor: _____ Phone #: _____

Family/Primary Doctor's Address: _____

Gender: ☐Female ☐Male Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Hand Dominance: ☐Right ☐Left ☐Height: _____ Weight: _____

Instructions: Please complete the following questionnaire before you see the doctor. Check the word or phrase that best describes your situation. You may select more than one answer per question. Answer the question in as much detail as possible. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. Thank you.

CHIEF COMPLAINT – HISTORY OF PRESENT ILLNESS

Symptom Location: ☐Right ☐Left

☐ Arm ☐ Back/Neck ☐ Elbow ☐ Finger ☐ Foot/Ankle ☐ Hand/Wrist ☐ Hip ☐ Knee

☐ Leg ☐ Shoulder ☐ Toe ☐ Other: _____

Quality:

Is your pain? ☐ Burning ☐ Constant ☐ Dull ☐ Intermittent ☐ Radiating ☐ Sharp

What symptoms are you experiencing?

☐ Catching ☐ Grinding ☐ Instability ☐ Locking ☐ Popping ☐ Numbness/Tingling

☐ Stiffness ☐ Other: _____

Severity: Please rate your discomfort on a scale of 1 (mild) to 10 (severe): At Rest _____ At its Worst _____

Since your pain began, how has it changed? ☐Decreased ☐Increased ☐Stayed the Same

Duration: Approximately when did this pain begin? Date: _____

The pain has lasted _____ Weeks _____ Months _____ Years

Timing: When do the symptoms occur, or do they occur with any particular activity? _____

_____

Context: How did your current pain episode begin? ☐Gradual ☐Sudden ☐Unknown ☐Other: _____

What caused your current pain episode? ☐ Accident at Work ☐ Following Surgery ☐ Pain "Just Began" ☐ Cancer

☐ Accident at Home ☐ Motor Vehicle Accident ☐ Other: _____

Describe the event that caused your pain _____

_____

Modifying Factor: What makes your symptoms better? ☐Ice ☐Heat ☐Rest ☐Elevation ☐Other: _____

What makes your symptoms worse? _____

Associated Signs/Symptoms: What else bothers you when this problem occurs? _____

_____

Would you be interested in taking part in a research study? ☐Yes ☐No

PREVIOUS AND/OR CURRENT TREATMENTS FOR THIS CONDITION

Previous injury to this area? ☐Yes ☐No If yes, when? _____

Have you been treated by any other physician and/or hospital for THIS problem? ☐Yes ☐No

If yes, physician _____

What treatments have you tried, and when? _____ ☐None

X-rays/Tests: ☐Regular X-ray ☐MRI Scans ☐CAT Scan ☐Myelogram ☐Nerve Tests (EMG, NCV)

☐Other: _____ Did you bring your X-rays/tests with you? ☐Yes ☐No

Medications: ☐Anti-inflammatories ☐Muscle Relaxants ☐Pain Medication ☐Other: _____

Therapies: ☐Physical Therapy ☐Chiropractic ☐Injection ☐Other: _____

Are you pregnant? ☐Yes ☐No

MEDICAL HISTORY

Are you affected by any of the following? *(Check all that apply)* ☐I HAVE NOT HAD ANY KNOWN MEDICAL PROBLEMS

☐Anemia	☐Asthma	☐Arthritis	☐Blood Clots	☐Cancer
☐COPD/Lung Problems	☐Coronary Artery Disease	☐Depression	☐Diabetes	☐Emphysema
☐Fibromyalgia	☐Gout	☐Heart Attack	☐Heart Disease	☐High Blood Pressure
☐Hepatitis - Type	☐Immune Disorder	☐Kidney Disease	☐Liver Disease	☐Osteoarthritis
☐Osteomyelitis	☐Overweight	☐Rheumatoid Arthritis	☐Seizures	☐Sleep Apnea
☐Stroke	☐Thyroid Disease	☐Tuberculosis	☐Ulcers	☐Vascular Disease

☐Other medical history: _____

Do you have: ☐Brain Clip ☐Cardiac Stent/Pacemaker ☐Internal Metal ☐Joint Replacement

FAMILY HISTORY

Mark all appropriate diagnoses as they pertain to your immediate family (mother, father, sister, brother, children) only.

☐Alcoholism	☐Arthritis	☐Asthma	☐Bleeding Tendency	☐Cancer - Type
☐Colitis	☐Coronary Artery Disease	☐Diabetes	☐Heart Disease	☐High Blood Pressure
☐High Cholesterol	☐Hypothyroidism	☐Kidney Problems	☐Leukemia	☐Osteoporosis
☐Rheumatoid Arthritis	☐Rheumatic Fever	☐Seizures	☐Stroke	☐Tuberculosis

☐Other medical problems: _____

☐I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ☐I AM ADOPTED (No Medical History Available)

SOCIAL HISTORY

Who do you live with? ☐Alone ☐Spouse ☐Parents ☐Roommate ☐Other: _____

Highest level of education: ☐Grammar School ☐High School ☐College ☐Postgraduate

Occupation: _____ Employer: _____

☐Retired – From what occupation? _____ Since when? _____

☐Disability - ☐Permanent ☐Partial since (date) _____ due to _____

Tobacco Use: ☐Has Never Used Tobacco ☐Current Tobacco User - Packs Per Day _____ I have smoked for _____ years.

☐Former Tobacco User - How many years did you smoke? _____

Alcohol Use: ☐Never Drinks Alcohol ☐Current Alcoholism ☐History of Alcoholism ☐Drinks Alcohol Socially

☐Daily Limited Use - How many drinks per day? _____

Illegal Drug Use: ☐Denies Any Illegal Drug Use ☐Cocaine ☐Marijuana ☐Recreational

☐Formerly Used Illegal Drugs (not currently using) Which: _____

Are there any substance abuse issues in your household? ☐Yes ☐No

PAST SURGICAL HISTORY

Please list any surgical procedures you have had in the past, including the date, type and any pertinent details.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

☐ I HAVE NEVER HAD ANY SURGICAL PROCEDURES ☐ Have you ever had a blood transfusion? ☐ Yes ☐ No

CURRENT MEDICATIONS

Please list *all* medications you are currently taking. Please include any vitamins, tonics, muscle relaxants, anti-inflammatories, pain relievers, nerve medications and sleeping pills you are taking (prescription and non-prescription). Attach an additional sheet, if required.

☐ None

Medication Name	**Dose**	**Frequency**	**Medication Name**	**Dose**	**Frequency**

Please indicate which (if any) of the following anti-inflammatory medications listed below that you have taken in the past. Please include all prescription and non-prescription medication and samples that were provided.

☐ Advil ☐ Arthrotec ☐ Daypro ☐ Ibuprofen ☐ Lodine ☐ Mobic ☐ Motrin ☐ Naprelan ☐ Naproxen ☐ Oruvail ☐ Tylenol

☐ Ultram ☐ Other: _____

Please indicate any of the following side effects while you were currently taking any of the above anti-inflammatory medications.

☐ Nausea ☐ Diarrhea ☐ Gastric ☐ Ulcers ☐ Upset Stomach ☐ Vomiting ☐ Other: _____

Are you currently taking any of the following on a regular basis?

☐ Aspirin ☐ Axid ☐ Azathioprine (Imuran) ☐ Cimzia ☐ Coumadin ☐ Cyclophosphamide (Cytoxan) ☐ Cytotec

☐ Enbrel ☐ Gold (Ridaura, Solganal, Myochrysine) ☐ Heparin ☐ Humira ☐ Kineret ☐ Leflunomide

☐ Methotrexate (Rheumatrex, Trexall) ☐ Maalox ☐ Mylanta ☐ Orencia ☐ Pepcid ☐ Plaquenil ☐ Prevacid ☐ Prilosec

☐ Remicade ☐ Sulfasalazine ☐ Tagamet ☐ Zantac

ALLERGIES

Do you have any known drug allergies? ☐ Yes ☐ No

If yes, please select the medications below that you are allergic to:

☐ Penicillin ☐ Tetracycline ☐ Sulfa ☐ Morphine ☐ Erythromycin ☐ Codeine ☐ Radiographic Dyes

☐ Other: _____

Topical Allergies: ☐ Iodine/Betadine ☐ Latex ☐ Tape

Are you allergic to shellfish? ☐ Yes ☐ No

REVIEW OF SYMPTOMS

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History section.

Constitutional:

☐ Chills ☐ Fever ☐ Lack of Appetite ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss

Skin:

☐ Breast Lumps ☐ Changes in Moles ☐ Itching ☐ Rashes ☐ Varicose Veins

Head/Ears/Eyes/Nose/Throat:

☐ Blurred Vision ☐ Dizziness ☐ Double Vision ☐ Headaches ☐ Hearing Loss ☐ Loss of Vision ☐ Nosebleeds

☐ Recurrent Sore Throat ☐ Seizures

Cardiovascular:

☐ Asthma ☐ Chest Pain ☐ Fainting ☐ Irregular Heartbeat ☐ Palpitations ☐ Shortness of Breath During Sleep

☐ Swelling in the Feet

Respiratory:

☐ Dry Cough ☐ Productive Cough ☐ Shortness of Breath ☐ Wheezing

Gastrointestinal:

☐ Blood in Stool ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea ☐ Ulcers ☐ Vomiting

Genitourinary/Nephrology:

☐ Blood in Urine ☐ Frequent Urination ☐ Kidney Failure ☐ Painful Urination ☐ Prostate Problems (Males Only)

Musculoskeletal:

☐ Gout ☐ Joint Pain ☐ Muscle Weakness ☐ Osteoporosis ☐ Paralysis - where:_____

☐ Stiffness ☐ Rheumatoid Arthritis

Vascular:

☐ Emboli (Blood Clots) ☐ Swelling in Lower Extremities

Psychiatric:

☐ Anxiety ☐ Confusion ☐ Depression ☐ Memory Loss ☐ Sleep Disorders

Hematologic:

☐ Bruise Easily ☐ Bleeding Tendencies

RHEUMATOLOGIC REVIEW OF SYMPTOMS

Do you have now or have you ever had:

☐ Gout ☐ Kidney Stones ☐ Loss of Hair ☐ Mouth Ulcers ☐ Raynaud's Syndrome (Poor Circulation)

☐ Rheumatoid Arthritis ☐ Sensitivity of your skin to the sun ☐ Scleroderma ☐ Sicca Syndrome

Everything I have answered is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Thank you for completing this patient questionnaire. It will be a part of your permanent medical record.

We at **FLEX Institute** 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 if 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.

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

I authorize ***FLEX Institute*** and any associates, assistants and other healthcare 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 ***FLEX Institute*** 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 ***FLEX Institute*** 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 ***FLEX Institute*** 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 ***FLEX Institute*** to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that ***FLEX Institute*** 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: _____

FINANCIAL POLICY AND CONTRACT WITH PATIENT

Thank you for choosing us as your healthcare 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 healthcare 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 if 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 FLEX Institute, 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. 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 FLEX Institute, LLC, its agents and its attorneys the right to disclose my confidential healthcare 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 workers' 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 FLEX Institute, 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 OR RESPONSIBLE PARTY

ASSIGNMENT OF BENEFITS/AUTHORITY TO RELEASE INFORMATION

I have on this date assigned to FLEX Institute, LLC the benefits due me under my existing policy or policies of insurance. I understand, insofar as they are necessary to cover such expenses, that the above assignment of insurance is accepted by FLEX Institute, 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 OR RESPONSIBLE PARTY

_____ _____

PARENT/GUARDIAN RELATIONSHIP TO PATIENT

Disclosure of Financial Interest

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

Louisiana law requires physicians and other healthcare providers to make certain disclosures to a patient when they refer a patient to another healthcare 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 ACKNOWLEDGMENT

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 Representative