OSNO

Orthopaedic Specialists of New Orleans, APMC

Dr. Richard L. Meyer, Jr., M.D.
Board Certified Orthopaedic Surgeon

PATIENT INFORMATION

Date: _____ First Name: _____

Middle Initial: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact: Name: _____ Number: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

SS#: _____ Who can we thank for referring you? _____

Patient's Employer: _____

Address: _____ City, State, Zip: _____

Occupation: _____ How long at present job? _____

Spouse's Name (If applicable): _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

Policy Holder Name: _____ Policy Holder Birthdate: _____

Policy Number: _____

SECONDARY INSURANCE COMPANY: _____

Policy Holder Name: _____ Policy Holder Birthdate: _____

Policy Number: _____

Responsible Party (If not insurance): _____

Is this the result of a work injury or car accident? ☐ Yes ☐ No Date of Injury: _____

WORKER'S COMPENSATION OR ATTORNEY INFORMATION

Worker's Compensation Claim #: _____ Contact: _____

Company Name: _____

Address: _____ City, State, Zip: _____

Orthopaedic Specialists of New Orleans

Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, Orthopaedic Specialists of New Orleans, AMPC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

I understand that Orthopaedic Specialists of New Orleans, APMC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that refusing to sign this consent or revoking this consent, this organization may refuse to treat permitted by sec. 164.506 of the Code of Federal Regulations.

I further understand that Orthopaedic Specialists of New Orleans, APMC reserves the right to change their notice and practices and prior to implementation, in accordance with Sec. 164.520 of the Code of Federal Regulations. Should Orthopaedic Specialists of New Orleans, APMC change their notice, they will send a copy of any revised notice to the address provided.

I request the following restrictions to the use or disclosure of my health information:

_____
_____
_____
_____
_____
_____
_____

I understand that as part of this organization's treatment, payment, or healthcare operation it may become necessary to disclose my protected health information to another entity, therefore I, _____, consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____Accepted _____ Denied

Signature_____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

For office use only:

Patient Name:_____
File Record #:_____
Date of Intake: _____

By signing this form, you acknowledge that Orthopaedic Specialists of New Orleans has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us. This includes the situation where your first date of service occurred.

I understand the contents of the notice, and request the following restrictions concerning the use of my personal medical information:_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

_____
Patient's Name – Please Print

_____
Patient's Signature

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

¨ Patient/Individual refused to sign (Date of refusal)_____

¨ Other _____

Attempt was made by: _____ date: _____