OSNO

Orthopaedic Specialists of New Orleans, APMC

Dr. Richard L. Meyer, JR., M.D.
Board Certified Orthopaedic Surgeon
Dr. Scott A. Tucker, M.D.
Board Certified Orthopaedic Sports Medicine

Date: _____

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____

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

Address: _____ City, State, Zip: _____

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

SS# _____ **Email Address:** _____

Primary Care Physician? _____ Who can we thank for referring you?: _____

Patients Employer: _____ Occupation: _____

Address: _____ City, State, Zip: _____

Insurance Information

Primary Insurance Company: _____ Policy Number: _____

Policy Holder Name: _____ Relation to Policy Holder: _____ Policy Holder Birthdate: _____

Secondary Insurance Company: _____ Policy Number: _____

Policy Holder Name: _____ Relation to Policy Holder: _____ Policy Holder Birthdate: _____

Is your visit a result of a **work injury** or **car accident**? YES NO

If so, where did your injury occur? _____ Date of Injury: _____

Are you or do you plan to be represented by an attorney? YES NO

Emergency Contact Information

Emergency Contact Name: _____ Phone #: _____

Relation to Emergency Contact: _____

Emergency Contact Address: _____ City, State, Zip: _____

Attorney Information

Attorney Name: _____

Phone#: _____ Fax #: _____

Workers Compensation

Workers Compensation Claim #: _____ Adjuster: _____

Insurance Name: _____

3434 Prytania St., Suite 310, New Orleans, LA 70115 * Office (504)897-7877 * Fax (504)897-7814

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Pharmacy Information

Pharmacy: _____ Pharmacy Phone#:_____

Pharmacy Address: _____ City, State, Zip: _____

*Medical Information Release Form **(HIPPA release form)**

Name:_____**DOB:**_____

[ ] I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

- Spouse-_____
- Child(ren)- _____
- Other-_____

[ ] Information is not to be released to anyone.

This ***Release of information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home_____ [ ] my work_____ or

[ ] my cell_____.

If unable to reach me

- You may leave a detailed messaged on my phone.
- Please leave a message asking me to return your call.
- Other: _____.

The best time to reach me is (day) _____ between (time) _____.

*Signed:*_____ Date:_____

Printed Name: _____

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Statement of Patient Financial Responsibility

Patient Name: _____ Date of Birth: ___/___/___

ORTHOPAEDIC SPECIALISTS OF NEW ORLEANS appreciates the consideration you have shown in choosing our practice to provide for your healthcare needs. The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. **However, you are ultimately responsible for payment of your bill.**

You are responsible for payment of any deductible and co-payment/ co- insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue past your approved period, you will be responsible for your balance in full. **I agree to pay any costs incurred by ORTHOPAEDIC SPECIALISTS OF NEW ORLEANS in collecting any amounts due including, without limitation, collection agency fees and attorney's fees.**

I have read the above policy regarding my financial responsibilities to ORTHOPAEDIC SPECIALISTS OF NEW ORLEANS, for providing medical services to the above names patient. I certify that the information is, to the best of my knowledge, accurate. I authorize my insurer to pay any benefits directly to ORTHOPAEDIC SPECIALISTS OF NEW ORLEANS, the full and entire amount of the bill incurred by the above names patient; or, if applicable any amount due after payment has been made by my insurance carrier.

**** All co-pays are due in full at time of appointment. ****

Patient/Guardian Signature _____ Date ___/___/___

Copay Policy

Health insurance carriers require the patient to pay a co-pay for services rendered. It is expected at the time the service is rendered for the patient to pay each visit. Thank you for your cooperation in this matter.

Patient/ Guardian Signature _____ Date ___/___/___

Self -Pay Policy

I do not have health insurance and will be responsible for services rendered ORTHOPAEDIC SPECIALISTS OF NEW ORLEANS. I agree to pay the practice the full and entire amount of the treatment given to the above named patient at each visit.

Patient/ Guardian Signature _____ Date ___/___/___

Workers Compensation Accident (Special Consideration):

Due to the issue of this accident (possible un-reported workers compensation injury). As a courtesy we will bill on your behalf, the charges incurred from ORTHOPAEDIC SPECIALISTS OF NEW ORLEANS, to your health insurance carrier. **If your carrier does not cover these expenses, the patient is 100% responsible for charges.**

Patient/Guardian Signature _____ Date___/ ____/____

Accident related injury:

Accident related injuries without the assistance of an Attorney will be considered on a case by case evaluation. A case will be considered Self-Pay and Medical Insurance will not be billed unless approved by Physician and or Administration. IF a CASE involves an attorney, the attorney must contact our office prior to the appointment for financial responsibility instructions.

Patient/Guardian Signature _____ Date___/ ____/____

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, diagnosis, 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 of 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 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 address provided.

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

_____

_____

_____

I understand that as a 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: _____

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory test, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose you health information to our business associate so that they can perform the job we've requested and bill you or your third party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We May use or disclose information to notify or assist in notifying family member, personal representative, or another person responsible for your care, your locations, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that persons involvement in your care or payment related to your care.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry our their duties.

Food and Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Orthopaedic Specialist of New Orleans

3434 PRYTANIA ST

STE. 310

NEW ORLEANS, LA

70115

Phone: 504-897-7877

Fax: 504-897-7814

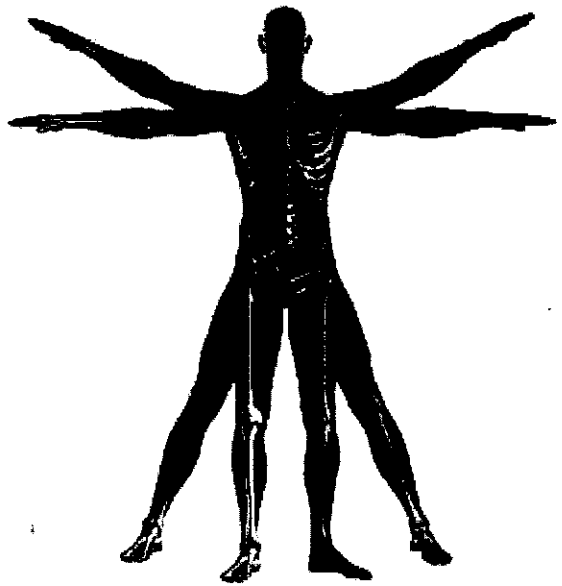
E-mail: osnoinfo@gmail.com

osno

Orthopaedic Specialists of New Orleans, APMC

NOTICE OF PRIVACY POLICIES

THIS NOTICE IS TO DESCRIBE HOW INFORMATION ABOUT YOUR HEALTH MAY BE USED AND DISCLOSED. ALSO, HOW YOU CAN GET ACCESS TO THIS INFORMATION AS WELL. PLEASE REVIEW IT CAREFULLY.



PRIVACY POLICIES

At Orthopaedic Specialists of New Orleans, APMC, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices, describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective as of October 14, 2002, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record
Each time you visit OSNO, APMC, a record of your visit is made. Typically this record contains your current symptoms, examination, test results, diagnoses, treatment, and a plan for your future care or treatment. This information, often referred to as your health or medical record, serves as a:

•Basis for planning your care or and treatment

•Means of communication among the many health professionals who contribute to your care

•Legal documents describing the care you received

•Means by which you or a third party payer can verify that services billed were actually provided

•A tool in educating health professionals

•A source of data for medical research

•A source of information for public health officials charged with improving the health of this state and nation

•A source of data for planning and marketing

•A tool with which we can asses and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to endure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights
Although your health record is the physical property of Orthopaedic Specialists of New Orleans, APMC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities
Orthopaedic Specialists of New Orleans, APMC is required to:

•Maintain the privacy of your health information

•Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

•Abide by the terms of this notice

•Notify you if we are unable to agree to a requested restriction, and

•Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've provided us, or if you agree, we will email the advised notice to you.
We will not use or disclose your health information without your authorization, except as described in the notice. We will discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem
If a patient has and questions and would like additional information, you may contact the practices assigned Privacy Officer Karen Mathews at (504)897-7877, during office hours.

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either. The address for the Office for Civil Rights is listed below:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your health information for treatment.
Example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that would be best for you, the patient. Your physician will document in your record his or her expectations of the members of your health care team. Members of your healthcare team will then record the actions that they took in the observations. In this way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.
Example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.
Example: Members of the medical team or quality improvement manager, or members of the quality improvement team may use information in your record to asses the care and outcomes in your case and others like it. This information will be used in effort to approve our quality and effectiveness.

Acknowledgment 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 if service with us. This includes the situation where your first date of service occurred.

I understand the consents 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 acknowledgment of receipt of the Notice of Privacy Practices. Acknowledgment could not be obtained for the following reason(s):

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

Other _____

Attempt was made by: _____ Date: _____

Patient Name: **Date:**

Medical disorders: If you have had any of the following, Place Mark inside Circles

- ○ No Medical History
- ○ AIDS/HIV
- ○ **Alcoholism**
- ○ **Alzheimer's**
- ○ **Anemia**
- ○ **Rheumatoid Arthritis**
- ○ **Asthma**
- ○ **Blood Clot Leg**
- ○ **Blood Clot Lung**
- ○ **Other Disease** (list below)
- ○ Stroke
- ○ Cancer Breast
- ○ Cancer **Colon**
- ○ Cancer **Lung**
- ○ Cancer **Prostate**
- ○ **COPD**
- ○ **Depression**
- ○ **Diabetes**
- ○ **Drug Abuse**
- ○ **Blood thinners (Coumadin, Plavix, aspirin, etc)**
- ○ Sleep Apnea
- ○ Gout
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Hepatitis
- ○ Kidney Disease
- ○ Osteoarthritis
- ○ Seizures
- ○ Ulcers, Bleeding

Surgical History: If you have had any of the following, Place Mark inside Circles

- ○ No Surgical History Reported
- ○ Carpal Tunnel Left Wrist
- ○ Arthroscopy Left Elbow
- ○ Arthroscopy Left Shoulder
- ○ Arthroscopy Left Ankle
- ○ Arthroscopy Left Knee
- ○ Arthroscopy Left Hip
- ○ Left Hip Replacement
- ○ Left Knee Replacement
- ○ Spinal Fusion
- ○ Other Surgery (list in the box below)
- ○ Cardiac (Heart)
- ○ Carpal Tunnel Right Wrist
- ○ Arthroscopy Right Elbow
- ○ Arthroscopy Right Shoulder
- ○ Arthroscopy Right Ankle
- ○ Arthroscopy Right Knee
- ○ Arthroscopy Right Hip
- ○ Right Hip Replacement
- ○ Right Knee Replacement
- ○ Laminectomy
- ○ Fracture Surgery

Patient Name: **Date:**

Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- ○ **AIDS/HIV**
- ○ **Anemia**
- ○ **Blood Clots**
- ○ **Cancer**
- ○ **Coronary Artery Disease**
- ○ **Diabetes**
- ○ **Gout**
- ○ **Heart Attack**
- ○ Hemophilia
- ○ **Hypertension**
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Mother Medical History

- ○ **AIDS/HIV**
- ○ **Anemia**
- ○ **Blood Clots**
- ○ **Cancer**
- ○ **Coronary Artery Disease**
- ○ **Diabetes**
- ○ **Gout**
- ○ **Heart Attack**
- ○ Hemophilia
- ○ **Hypertension**
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Sibling Medical History

- ○ **AIDS/HIV**
- ○ **Anemia**
- ○ **Blood Clots**
- ○ **Cancer**
- ○ **Coronary Artery Disease**
- ○ **Diabetes**
- ○ **Gout**
- ○ **Heart Attack**
- ○ Hemophilia
- ○ **Hypertension**
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Patient Name: **Date:**

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- ○ Weight Loss/Gain
- ○ Weakness
- ○ Fatigue
- ○ Fever

Cardiovascular
- ○ High Blood Pressure
- ○ Chest Pain
- ○ Rheumatic Fever
- ○ Palpitations
- ○ Has Pacemaker

Musculoskeletal
- ○ Joint Pain
- ○ Arthritis
- ○ Muscular Weakness
- ○ Stiffness
- ○ Muscular Pain

Eyes
- ○ Glasses or Contacts
- ○ Blurred Vision
- ○ Glaucoma
- ○ Cataracts
- ○ Excessive Tearing

Skin
- ○ Rashes
- ○ Sores
- ○ Lumps
- ○ Dryness
- ○ Itching

Blood or Lymph
- ○ Anemia
- ○ Easy Bruising
- ○ Easy Bleeding
- ○ Swollen Glands

Ear Nose Mouth Throat:
- ○ Ears Ringing
- ○ Earaches
- ○ Hearing Aid
- ○ Frequent Colds
- ○ Nasal Discharge
- ○ Hay Fever
- ○ Nosebleeds
- ○ Dentures
- ○ Bleeding Gums
- ○ Frequent Sore throats

Neurological
- ○ Headache
- ○ Dizziness
- ○ Seizures
- ○ Loss of Sensation
- ○ Vertigo

Gastrointestinal
- ○ Heart Burn
- ○ Rectal Bleeding
- ○ Abdominal Pain
- ○ Gallbladder trouble
- ○ Hepatitis

Respiratory
- ○ Shortness of Breath
- ○ Cough
- ○ Wheezing
- ○ Asthma
- ○ Bronchitis

Genitourinary
- ○ Blood in Urine
- ○ Urinary Infections
- ○ Kidney Stones
- ○ Burning Urination
- ○ Sexual Disease

Endocrine
- ○ Thyroid Trouble
- ○ Excessive Sweating
- ○ Excessive thirst

Immunologic
- ○ Reactions to Drugs
- ○ Skin Rashes
- ○ Reactions to Foods

Psychological
- ○ Nervousness
- ○ Depression
- ○ Mood Changes

Patient Name: **Date:**

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco?	O Yes	O No	O Former
Use Alcohol?	O Yes	O No	
Use Caffeine?	O Yes	O No	
Use Illicit Drugs?	O Yes	O No	

I do not use any of the above O

Hand Dominance? O Right Handed O Left Handed

Females Only:

Could you be pregnant? O Yes O No

Allergies: Do you have allergies to any of the following medications or substances

O No Known Allergies	O Aspirin	
O Penicillin	O Amoxil	O Tegretol
O Codeines	O Keflex	O Bactrim
O Sulpha Drugs	O Cefzil	O Pediazole
O Iodine / Shellfish	O Ceftin	O Dilantin
O Ampicillin	O Suprax	O Novacaine
O Vantin	O Septra	O Insulin
O Depakene	O Lamictal	O Lidocaine

Other Allergies:

O Latex O IVP/X-Ray Dye O Metal O Egg/Avian (Bird)

List any other allergies in this box