LOS
LOUISIANA ORTHOPAEDIC SPECIALISTS

PATIENT INFORMATION

PATIENT NAME Last First M.I.		Social Security Number	
ADDRESS Street		DATE OF BIRTH	SEX Female Male
City State Zip	Home Phone	Cell Phone	Work Phone
EMAIL		Marital Status ☐Single ☐Widowed ☐Divorced ☐Married	

PREFERRED METHOD OF CONTACT ☐Home Phone ☐Cell Phone ☐Work Phone

RACE ☐African American ☐Asian ☐Hispanic ☐Caucasian ☐Native American ☐Other

ETHNICITY ☐Hispanic ☐Non-Hispanic

EMPLOYER	PATIENTS OCCUPATION
PHARMACY NAME	PHARMACY PHONE

HOW DID YOU HEAR ABOUT US ☐ Community Event ☐LOS Patient/Friend/Family ☐Employer ☐ High School/Sport ☐Hospital/Urgent Care ☐ Insurance ☐Magazine or Newspaper ☐Physician ☐Radio or Television ☐Website or Online

PERSON RESPONSIBLE FOR CHARGES

NAME	SOCIAL SECURITY NUMBER
ADDRESS Street	DATE OF BIRTH
City State Zip	CONTACT PHONE NO.
EMPLOYER	EMPLOYER PHONE NO.

If this is a job related injury, is this the employer you were working for at the time of injury? ☐ Yes ☐No
If due to an injury, date of loss: _____/_____/_____
Will an attorney or Liability Carrier be involved in payment of charges? ☐ Yes ☐ No If yes, please explain: _____

Is injury related to: ☐Accident ☐Job Related ☐Other: _____

If job related: Claim # _____Case Manager: _____Phone No. _____

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	NAME OF REFERRING PHYSICIAN

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME	RELATIONSHIP	PHONE NO.
ADDRESS Street	City State	Zip

INSURANCE INFORMATION

PRIMARY	SECONDARY
Insured Name: _____	Insured Name: _____
Insurance Name: _____	Insurance Name: _____
Policy ID #: _____	Policy ID #: _____
Group/Account #: _____	Group/Account #: _____
Social Security #: _____	Social Security #: _____
Relation to Patient:	Relation to Patient:

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while LOS contracts with many insurance companies, it is my responsibility to verify with my plan that LOS is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I hereby authorize LOS to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of my insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guideline.

Patient Signature: _____ Date: _____

LOUISIANA ORTHOPAEDIC SPECIALISTS

Privacy and Disclosure Statement

Your treatment, payment, enrollment or eligibility for benefits at Louisiana Orthopaedic Specialists ("LOS") is not dependent upon whether you sign this Privacy and Disclosure statement. You have the right to revoke this Privacy and Disclosure Statement at any time by sending a written notice of revocation LOS at 108 Rue Louis XIV, Lafayette, LA 70508, Attn: Privacy Officer. Our Practice Manager and front office staff will be glad to discuss these acknowledgements and authorizations with you.

By signing below, I acknowledge that I have received the Notice of Privacy Practices of LOS, which explains its legal duties and privacy practices with respect to my protected health information. I understand that if I have indicated my preferred method of contact is by cell phone, I may receive text message communications regarding my scheduled appointments, appointment reminders and missed appointment notifications. I understand that standard message and data rates may apply.

I understand if I choose to opt-out of receiving text message reminders, I am responsible of changing my preferred method of contact with LOS.

I hereby agree that LOS may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care.

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Signature of Patient/Patient's Representative: _____ Date: _____

Printed Name of Patient/Patient's Representative: _____

LOUISIANA ORTHOPAEDIC SPECIALISTS

Financial Policy

Louisiana Orthopaedic Specialists ("LOS") places its patients' needs first; however, we must be financially responsible to continue to serve.

- I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at LOS. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your medical plan prior to your visit to fully understand your anticipated out of pocket costs.
- I understand that co-payments, deductibles, co-insurance and non-covered services are paid at or before the time of service. LOS accepts cash, checks, major credit cards, debit cards, HSA/FSA and Care Credit. You may also pay your bill online from the Patient/Bill Payment section of our website.
- I understand that I may be contacted by the telephone regarding my outstanding balance with LOS.
- I understand that if I do not have my insurance and, referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
- I understand that LOS will collect, prior to any surgery or procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned surgical procedure. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and LOS. If the full deductible is not applied to your claim by your insurance company, LOS will refund any overpayment to you when we receive overpayment.
- I understand if my account has a patient responsibility amount that is not paid in full within 90 days then my account may be placed with an outside collection agency. No additional appointments will be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.
- I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-Sufficient Fund checks must be redeemed with certified funds (credit card or cash).
- I understand that I have until 5 p.m. the day before my appointment to cancel or reschedule. If I do not show up for my appointment and did not cancel in time, a $40 no-show fee will be charged to my account.
- I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

Statement of Financial Responsibility: I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my insurance plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I have read and I understand the above Financial Policy and I agree to abide by its terms.

Patient or Guarantor Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Patient Name: _____ Patient DOB: _____

ALLERGIES	
Please list all allergies below: ☐None	

MEDICATIONS	
Please list all medications you are currently taking below: ☐None	

PAST SURGICAL HISTORY		
Please list all past surgeries or hospitalizations		

PATIENT PAST MEDICAL HISTORY		
☐ Abused during childhood	☐ Gout	☐ Kidney or Liver disease
☐ Ankle Swelling	☐ Heart attack	☐ Obsessive Compulsive Disorder
☐ Anxiety Disorder	☐ Heart failure	☐ Osteoarthritis
☐ Asthma	☐ Hep (A B C)	☐ Osteoporosis
☐ Attention Deficit Disorder	☐ High Blood Pressure	☐ Peptic Ulcer Disease
☐ Blood Clots	☐ High Cholesterol	☐ Recent Infection
☐ Cancer	☐ HIV/AIDS	☐ Rheumatoid Arthritis
☐ Depression	☐ Hyperlipidemia	☐ Schizophrenia
☐ Diabetes	☐ Hypothyroidism	☐ Stroke
☐ Fibromyalgia	☐ Kidney Failure	☐ Other: _____

FAMILY HISTORY

Check one is someone in your family has/has any of the following

	Mother	Father	Sibling(s)	Grandparent(s)
Anesthetic Reaction	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Malignant Hyperthermia	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐

Patient Name: _____ Patient DOB: _____

SOCIAL HISTORY

☐ L Handed
Occupation: _____When was the last time you worked? _____ ☐ R Handed

☐Restricted or light duty ☐ Temporary ☐ Permanent disability ☐Retired ☐Unemployed/Seeking Job

Are you currently under worker's compensation? ☐Yes ☐No
Is there an ongoing lawsuit related to today's visit? ☐Yes ☐No
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Tobacco: ☐No ☐Yes How many packs per day? _____ How many years? _____ ☐Quit _____yrs ago
Alcohol: ☐No ☐Yes How much do you drink daily? _____☐Quit _____ yrs ago
Have you ever drank heavily or abused alcohol? ☐No ☐Yes
Drugs: Have you ever used any illicit substances? ☐No ☐Yes Type: _____
Have you ever been addicted to or misused prescription drugs? ☐No ☐Yes

REVIEW OF SYSTEMS

Are you currently experiencing any of the following? ☐check here if unknown

	Yes	No		Yes	No		Yes	No
GENERAL			**CARDIOVASCULAR**			**GASTROINTESTINAL**		
Loss of appetite	☐	☐	Chest pain	☐	☐	Nausea or vomiting	☐	☐
Recent weight loss	☐	☐	Palpitations	☐	☐	Blood in stool	☐	☐
Fever or chills	☐	☐	**EYES**			Heartburn	☐	☐
RESPITORY			Blurred vision	☐	☐	Constipation	☐	☐
Shortness of breath	☐	☐	Double vision	☐	☐	**NEUROLOGICAL**		
Chronic Cough	☐	☐	Loss of vision	☐	☐	Headaches	☐	☐
KIDNEY/BLADDER/URINE			**SKIN**			Seizures	☐	☐
Painful Urination	☐	☐	Frequent rashes	☐	☐	Dizziness	☐	☐
Blood in urine	☐	☐	Skin ulcers	☐	☐	**HEAD/EARS/NOSE/THROAT**		
Kidney problems	☐	☐	Lumps	☐	☐	Hoarseness	☐	☐
HEMATOLOGICAL/LYMPHATIC			**ENDOCRINE**			Trouble swallowing	☐	☐
Easy bruising	☐	☐	Thyroid disease	☐	☐	Hearing loss	☐	☐
Easy bleeding	☐	☐	Heat/Cold intolerance	☐	☐			
PSYCHIATRIC			**HEAD/EARS/NOSE/THROAT**					
Depression	☐	☐	Hoarseness	☐	☐			
Drug/Alcohol addiction	☐	☐	Trouble swallowing	☐	☐			
Suicidal Thoughts	☐	☐	Hearing loss	☐	☐			

PRESENT MEDICAL INFORMATION

Height: _____ Weight: _____

What body part is involved? (please check all that apply)

	R	L		R	L		R	L		R	L
Ankle:	☐	☐	Arm:	☐	☐	Back:	☐	☐	Elbow:	☐	☐
Finger: _____	☐	☐	Foot:	☐	☐	Hand:	☐	☐	Hip:	☐	☐
Knee:	☐	☐	Leg:	☐	☐	Neck:	☐	☐	Pelvis:	☐	☐
Shoulder:	☐	☐	Toe:	☐	☐	Wrist:	☐	☐	Other: _____		

How long ago did this problem start? _____☐Days ☐Weeks ☐Months ☐Years

Were you seen in the ER for this problem? ☐ Yes ☐No If yes, which ER? _____

On a scale of 0-10 (10 being the worst) how severe is your pain?

What is the quality of your pain: ☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10

Do you have any of the following? ☐Bruising ☐Joint Instability ☐Hands Feel Clumsy ☐Locking/Catching ☐Weakness

☐Numbness ☐Poor Balance ☐Loss of Control of Bladder ☐Tingling ☐Swelling