* For office use only: MRN# _____ *

LOS™
LOUISIANA ORTHOPAEDIC SPECIALISTS

Please ensure paperwork is fully completed. Incomplete forms will be returned for completion.

Patient Information

Patient Name (including MI):			**Social Security Number:**
Address: Street	**City:**	**State:**	**Zip:**
Date of Birth:	**Sex:** Female ☐ Male ☐	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Cell Phone:	**Home Phone:**	**Email Address:**	
Preferred Method of Contact: ☐ Cell Phone ☐ Home Phone ☐ Email			
Race: ☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian ☐ Native American ☐ Other _____			
Ethnicity: ☐ Hispanic ☐ Non Hispanic	**Preferred Language:** ☐ English ☐ Spanish ☐ Other: _____		
Veteran Status: ☐ Currently Serving ☐ Veteran ☐ Never Served ☐ Decline to Answer			
Low Vision: ☐ No ☐ Yes	**Hard of Hearing:** ☐ No ☐ Yes	**Interpreter Needed:** ☐ No ☐ Yes	
Primary Care Provider:			

Guarantor Information- Person Responsible for Charges (If different from patient.)

Name:		**Social Security Number:**
Address: Street		**Date of Birth:**
City:	**State:** **Zip:**	**Contact Phone Number:**
Employer:		**Employer Phone Number:**
Relationship to Patient: ☐ Spouse ☐ Father ☐ Mother ☐ Other: _____		

Employer Information

Employment Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Disabled ☐ Self Employed ☐ Other: _____		
Employer:	**Occupation:**	**Employer Contact:**
Employer Address:		**Employer Phone:**

Emergency Information: (In case of emergency, please notify the following)

Name:	**Relationship:**	**Phone Number:**	
Address: Street	**City:**	**State:**	**Zip:**

Insurance Information

Primary:		**Secondary:**	
Insurance Name:	_____	**Insurance Name:**	_____
Policy ID#:	_____	**Policy ID#:**	_____
Group/Account #:	_____	**Group/Account #:**	_____
Relationship to Patient if not Self:	_____	**Relationship to Patient if not Self:**	_____
Name of Subscriber:	_____	**Name of Subscriber:**	_____
DOB of Subscriber:	_____	**DOB of Subscriber:**	_____
Address of Subscriber:	_____	**Address of Subscriber:**	_____

I hereby certify the above information is true and correct to the best of my knowledge.

Patient Signature: _____ **Date:** _____

LOUISIANA ORTHOPAEDIC SPECIALISTS

Privacy and Disclosure Statement

Your treatment, payment, enrollment, or eligibility for benefits of 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 to 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 practice 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 for 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 to be paid at or before the time of service. LOS accepts checks, major credit cards, debit cards, HSA/FSA and Care Credit. You may also pay your bill online or through the MyChart app.
- I understand that I may be contacted by 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. Surgeries will include physician assist fees that can be billed after your surgery. Payment in full and expected co-insurance 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 payment.
- 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 $35.00 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.
- I understand that I must cancel or reschedule my appointment 24 hours prior to my scheduled appointment. If I do not show up for my appointment and do not cancel in time, a $40.00 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.

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 ID's taken are used to assist in patient recognition per HIPAA guideline.

Statement of Financial Responsibility: I acknowledge that I am responsible for all charges for services provided, including any amount not paid by 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: _____**

* For office use only: MRN # _____ Date: _____ *

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Patient Medical History- Please fill out and bring with you to see the provider!

Patient Name (including MI):
Dominant Hand: ▢ Right ▢ Left ▢ Ambidextrous
Preferred Pharmacy (With Address);

Chief Complaint (What are you being seen for today?)

Body Part:
Side: ▢ Right ▢ Left ▢ Both
Pain radiates from/to (Ex: low back to right leg.):
Description of Symptoms (Please select only ONE primary symptom that pertains to the reason for your VISIT TODAY.); ▢ Pain ▢ Numbness/Tingling ▢ Fracture ▢ Stiffness ▢ Other: _____
Is your problem the result of an injury of accident? ▢ No Injury ▢ Injury ▢ Injury at Work ▢ Auto Accident ▢ Sport Injury ▢ Prior Surgery How long have the symptoms been present (Ex: two weeks, one month): _____

Medical History

Allergies
Do you have any allergies? ▢ Yes ▢ No If yes, please list below:

Medication, Relevant Food, or "Seasonal"

Allergy:	Reaction:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Latex Allergy? ▢ Yes ▢ No	Glue/Tape/Adhesive Allergy? ▢ Yes ▢ No

Medications: ▢ None (I do not take any medications on a regular basis.)
Do you currently have a medical marijuana prescription? ▢ Yes ▢ No If yes, what condition is it for?: _____
Are you currently taking a GLP-1? ▢ Yes ▢ No If yes, what is the name of the medication? _____

Medication (taken by mouth, injectable, etc.)	Dosage & Frequency (5mg, once daily)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

If you take more than 10 medications, please inform your provider and continue writing them on the back of the page.

Medical History Continued

Previous Surgeries	▢ None		
▢ Aneurysm (Brain) Surgery	All other surgeries not listed: _____	Arthroscopic Surgery	
▢ Aortic Bypass/Vascular Surgery		▢ Shoulder ▢ Right ▢ Left	▢ Knee ▢ Right ▢ Left	▢ Hip ▢ Right ▢ Left
▢ Heart Surgery/Stents				
▢ Cholecystectomy (Gallbladder)		Replacement Surgery		
▢ Hysterectomy		▢ Shoulder ▢ Right ▢ Left	▢ Knee ▢ Right ▢ Left	▢ Hip ▢ Right ▢ Left
▢ LAP Band/Gastric Bypass Surgery				
▢ Malignancy/Cancer		Spinal Surgery Level:		

Medical Conditions Do you have a personal history of any of the following? ▢ None			
▢ Addiction ▢ Current ▢ Former ▢ Alcohol ▢ Drugs	▢ Chemotherapy/Radiation	▢ High Cholesterol	▢ Pulmonary Embolism
	▢ Clotting Disorder	▢ HIV/AIDS	▢ Reaction to Anesthesia
▢ Aneurysm	▢ Connective Tissue Disorder	▢ Hypertension	▢ Rheumatoid Arthritis
▢ Anxiety	▢ COPD	▢ Kidney disease	▢ Seizures with ▢ Epilepsy
▢ Asthma	▢ Diabetes Type:	▢ MRSA infection (STAPH)	▢ Stomach Ulcers
▢ Atrial Fibrillation	▢ Gout	▢ Muscular Dystrophy	▢ Stroke/TIA
▢ Bone or Joint Infections	▢ Heart Attack	▢ Osteoporosis/Osteopenia	▢ Thyroid Disorder
▢ Cancer; Type:	▢ Hepatitis Type:	▢ Pacemaker / ▢ Defibrillator	▢ Tuberculosis
Please list any other conditions or details of conditions marked above:			

Family Medical History ▢ None			
▢ Anesthesia Reactions ▢ Mother ▢ Father ▢ Sibling	▢ Diabetes (Type) ▢ Mother ▢ Father ▢ Sibling	▢ Osteoporosis ▢ Mother ▢ Father ▢ Sibling	All other pertinent family history not listed: _____ _____ _____ _____
▢ Blood/Clotting Disorders ▢ Mother ▢ Father ▢ Sibling	▢ Heart Disease ▢ Mother ▢ Father ▢ Sibling	▢ Rheumatoid Arthritis ▢ Mother ▢ Father ▢ Sibling	
▢ Cancer; Type: _____ ▢ Mother ▢ Father ▢ Sibling	▢ Hypertension ▢ Mother ▢ Father ▢ Sibling	▢ Seizures ▢ Mother ▢ Father ▢ Sibling	
▢ Connective Tissue Disorders ▢ Mother ▢ Father ▢ Sibling	▢ Muscular Dystrophy ▢ Mother ▢ Father ▢ Sibling	▢ Stroke ▢ Mother ▢ Father ▢ Sibling	

Social History	
Tobacco Cigarettes: ▢ Current; Packs per Day: _____ ▢ Former; Quit Date: _____ ▢ Never Smokeless: ▢ Current ▢ Former; Quit Date: _____ ▢ Never Vape/E-Cigarettes: ▢ Current ▢ Former; Quit Date: _____ ▢ Never	**Alcohol** Do you drink alcohol? ▢ Daily ▢ Occasionally ▢ Rarely ▢ Never

Signature: _____ Date: _____