NEW ORLEANS
ORTHOPEDIC
INSTITUTE

Patient information

Last name: _____First name: _____Middle initial:_____

Date of birth: _____Social Security #_____-_____-_____Gender: ❑ F ❑ M

Marital Status: ❑ Single ❑ Married ❑ Widower ❑ Divorced

Preferred language: ❑ English ❑ Spanish ❑ Other _____

Address:_____

Apartment #:_____ City:_____State:_____Zip code:_____

Primary contact #:_____ Secondary contact #: _____

Email address: _____ Patient portal access? ❑ Yes ❑ No

Referral source:_____

Emergency Contact

Full name: _____ Phone #: _____

Relationship: ❑ Spouse ❑ Child ❑ Parent ❑ Other: _____

Disclosure of Medical Information: Other than emergency contact

❑ I hereby give permission to New Orleans Orthopedic Institute to disclose and discuss any information related to my medical conditions to/with the following individuals (relatives or close personal friends):

Full name: _____ Relationship: _____

Full name: _____ Relationship: _____

Full name: _____ Relationship: _____

❑ I do not wish to give permission for New Orleans Orthopedic Institute to disclose and discuss any information related to my medical conditions to/with relatives or close personal friends.

HIPAA Notice of Privacy Act

_____ (Initial) I have been provided an oppurtunity to review the Notice of Privacy Act and I have been provided an opportunity to receice a copy.

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Medical Insurance Information

1. Will you be filing today's visit through your personal health insurance? If so, complete section I if responsible party is other than self.
2. Is this a job related injury? If so, complete section II.
3. Is your visit today related to a legal or liability related insurance? If so, complete section III.

I. Insurance:

Resonsible party name if other than self: _____

Relationship to patient: _____ Date of birth: _____

Social Security #: _____-_____-_____ Contact #: _____

Address: _____

City: _____ State: _____ Zip code: _____

Employer: _____

II. Workmen's Compensation Claims:

Date of injury/accident: _____ Occupation: _____

Employer: _____ Are you currently working? ❑ Yes ❑ No

If yes, part time with restrictions? ❑ Yes ❑ No

If no, full time with no restrictions? ❑ Yes ❑ No

Do you have an attorney representing you? ❑ Yes ❑ No If yes, who?

_____

III. Legal/Liability Claims:

Date of injury/accident: _____ Attorney name: _____

Phone #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

OFFICE POLICIES

APPOINTMENTS

_____ **(Initial)** I acknowledge that there is a **$40 fee for a missed appointment or late cancellation.** The no show fee will be enforced if an appointment is not cancelled withing 24 hours prior to the appointemnt time. The no show fee WILL BE expected to be paid PRIOR to being seen by the doctor at each visit.

PAIN MEDICAIONS

_____ **(Initial)** I acknowledge that New Orleans Orthopedic Institute does not prescribe narcotics for pain management of acute/chronic pain. Our providers will refer to pain management as needed. Post-operative pain prescriptions are discussed at the time of procedure/surgery recommendation. Also, I further acknowledge that pain medications will not be given to me WITHOUT an appointment.

NO refills will be given over the phone. So, please make sure you check your prescriptions prior to leaving the office. NO EXCEPTIONS WILL BE MADE.

PAYMENTS

_____ **(Initial)** I understand that I am responsible for keeping my account up to date. Co-pays and co-insurances are expected at the time of each visit, and I understand that is a contract between myself and my insurance company. I further understand that if I have a balance for any reason, it will be expected to be PAID IN FULL prior to or at my next appointment, unless prior arrangements have been made. If no prior arrangements have been made and you are unwilling to pay the balance at the appointment, you will be asked to reschedule and possible incur the $40 late cancellation charge.

FORMS

_____ **(Initial)** I acknowledge that there will be a $25 form fee for ANY forms that need to be completed by the office. This includes, but is not limited to, short term disability forms, FMLA forms, insurance or employer forms. Forms will not be released if the fee is not paid. **Paperwork will be addressed within 7-10 business days of receipt.**

I have read and understand all of the above office policies and procedures.

Patient Signature: _____ Date: _____

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Social History

Do you use tobacco products? ❑Yes ❑ No
If yes, ❑ Current everyday smoker ❑ Current some day smoker ❑ Former smoker ❑ Smokeless
How many packs per day? _____ Years of smoking: _____
Level of alcohol consumption? ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

Medications:

_____
_____
_____

Surgeries:

_____
_____
_____
_____

Allergies:

Yes, please list medication/reaction below ❑ No

_____
_____
_____

Medical History

❑ Anemia
❑ Asthma
❑ Arthritis
❑ Bleeding disorder
❑ Blood clots
❑ Cancer
❑ Congestive heart failure
❑ Diabetes
❑ Heart attack
❑ High blood pressure
❑ Hepatitis
❑ HIV or AIDS
❑ High cholesterol
❑ Kidney problems
❑ Lung problems
❑ Mental illness
❑ Stroke
❑ Other
_____
_____
_____
_____

Family History

❑ Bleeding disorder
❑ Blood clots
❑ Cancer
❑ Congestive heart failure
❑ Diabetes
❑ Heart attack
❑ High blood pressure
❑ High cholesterol
❑ Kidney problems
❑ Lung problems
❑ Mental illness
❑ Stroke
❑Other: _____
_____
_____
_____
❑Unknown

Occupation/employer: _____

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)	DOB

ADDRESS	SSN

CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:	ENTITY RECEIVING THE PHI:
	NAME: New Orleans Orthopedic Institue
	ADDRESS: 1810 LINDBERG DR. SUITE 1400
	CITY: SLIDELL / STATE: LA / ZIP: 70458
	ATTENTION:

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed.

Date: Event:

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
☐ All PHI in the record		
☐ Progress Notes		
☐ Laboratory Tests		
☐ X-Ray Tests / Reports		
☐ History and Physical Examination		
☐ Discharge Summary		
☐ Consultation Reports		
☐ Itemized Billing Statement		
☐ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Alcohol, drug or substance abuse treatment
[ ] Psychiatric or mental care / treatment
[ ] Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE REDISCLOSED.
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

Signature of Patient:	Date:
Signature of Patient's Representative (if necessary):	Date:
Personal Representative's Relationship to Patient:	

*** There may be a fee charged to process your request ***