Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants • Electrodiagnostic Medicine

Atchison Patient Label

Orthopedic Specialist of Louisiana
2005 Landry Drive
Bossier City, LA 71111
318-752-7850

Orthopedic Specialist of Louisiana
1500 Line Avenue, Suite 100
Shreveport, LA 71101
318-635-3052

Dear New Patient,

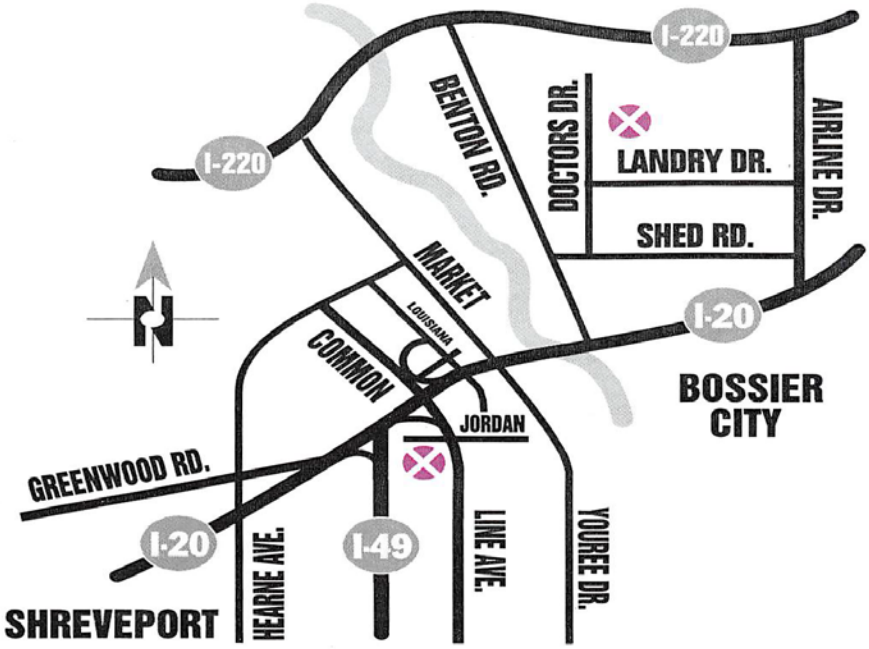
Thank you for choosing Orthopedic Specialist of Louisiana for your orthopedic care. Enclosed you will find your registration form, patient medical history questionnaire and our financial policy. Please fill out forms in their entirety, **BRING** them with you to your appointment.

We request that you bring the following information to your appointment:

- ☑ **Your Health Insurance card(s) and Driver's License**. Please contact your insurance company to verify if a referral from your Primary Care Physician is needed. If a referral is needed, please contact your physician and have a written referral **FAXED to 318-629-5163**. Also be prepared to pay your co-pay at the time of service.
- ☑ **CURRENT MEDICATION LIST**
- ☑ **Photo ID** from each patient or patient's guardian
- ☑ **X-rays, MRI, Bone scans, CT on disc and Reports** if any were taken prior to your visit please **"hand carry"** to your appointment.

Please arrive 15 minutes early for your appointment. If you are 15 minutes or more late for your appointment we may have to reschedule you for another day. If you are unable to keep your appointment please call 24 hours ahead to reschedule.

Directions



1500 Line Avenue Location:

I-20 Eastbound- From I-20, take Line Ave. exit. Merge right onto Line Ave. Orthopedic Specialists of Louisiana is at the corner of Line and Jordan, 1500 Line Ave. Turn right on Jordan then left on Elizabeth St. Take a left into parking lot. Patient drop off is at the glass doors under the breezeway. Check in is on the 1st floor in suite 100. Overflow parking is across Elizabeth St. in parking lot.

I-20 Westbound- Take Common St. exit. Bear right in circle, turn right onto Louisiana, right on Fairfield, and left onto Line Ave. Go under I-20 and uphill to 1500 Line Ave., Orthopedic Specialists of Louisiana is at the corner of Line Ave. and Jordan St. Turn right on Jordan then left on Elizabeth St. Take a left into parking lot. Patient drop off is at the glass doors under the breezeway. Check in is on the 1st floor in suite 100. Overflow parking is across Elizabeth St. in parking lot.

2005 Landry Drive Location:

I-20 Eastbound- From I-20, take Airline Drive Exit. Turn left on Airline Drive under I-20 heading North for approximately 1 mile to Airline Drive and Shed Road through the intersection and turn onto the first street on the left which is Landry Drive.

I-20 Westbound- From I-20, take Airline Drove Exit. Turn right and go approximately 1 mile to Airline Drive and Shed Road through the intersection and turn onto the first street on the left which is Landry Drive.

I-220- Take Airline Drive Exit. Drive South on Airline Drive for approximately 3 miles. Go over railroad tracks and turn onto the first street on the right which is Landry Drive.

Patient Registration Form

Patient Information

Name: _____ Social Security Number: _____

Street Address: _____ Date of Birth: _____ Age: _____

City/State/Zip: _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Email: _____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan Number: _____

Policy/I.D. Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan Number: _____

Policy/I.D. Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Employer: _____ Date of initial injury: _____

Work Comp Contact: _____ Phone Number: _____

Workers Comp Carrier: _____ Claim Number: _____

Adjuster Name: _____ Phone number: _____

Law Firm (if applicable)

Complete this section only if your visit today is related to a personal injury legal claim

Law Firm: _____ Lawyer Name: _____

Phone Number: _____ Paralegal/Representative: _____

Fax Number: _____ Date of initial injury: _____

Referral

Referring Physician: _____ Primary Care Physician: _____

How did you hear about us? ❑ Family Member ❑ Friend ❑ Yellow Pages ❑ Other: _____

Have you or any member of your immediate family been treated by our physicians before? ❑ Yes ❑ No

Name of Physician: _____ Name of Family Member: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

Authorization to Release Information Concerning Your Care

We at **Musculoskeletal Institute of Louisiana** take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below.

❑ **I do not authorize anyone to receive information regarding my medical care.**

Per my request, release the following information on myself: (Check each that apply)

❑ Appointments ❑ Account/Bill ❑ Lab/Test Results ❑ Medical Care/Treatment

Person: _____ Relationship:_____
Phone number(s): _____

Person: _____ Relationship:_____
Phone number(s): _____

Person: _____ Relationship:_____
Phone number(s): _____

Person: _____ Relationship:_____
Phone number(s): _____

This will not include copies of your medical records. If you wish someone else to pick up a copy of your medical records, please fill out our Authorization to Use or Disclose Protected Health Information Form

Medical History and Consent for Treatment

I certify that the information I have supplied is accurate, complete and true.

I authorize ***Orthopedic Specialists of Louisiana*** and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for ***Orthopedic Specialists of Louisiana*** to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review ***Musculoskeletal Institute of Louisiana*** Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize ***Orthopedic Specialists of Louisiana*** to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize ***Orthopedic Specialists of Louisiana*** to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that ***Orthopedic Specialists of Louisiana*** will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

Signature: _____ Date: _____

Dr. Atchison

Patient Questionnaire

Date: _____ (Office Use Only) Person #: _____

Patient Name: _____ DOB: _____ Age: _____

Referring Doctor: _____ Phone #: _____

Family/Primary Doctor: _____ Phone #: _____

Family/Primary Doctor's Address: _____

Gender: ❑ Male ❑ Female Height: _____ Weight: _____ Are you pregnant? ❑ Yes ❑No

What body part are you seeing the physician for today? _____

Allergies

Do you have any known metal allergies such as nickel allergy? ❑Yes ❑No

Do you have any known drug allergies? ❑Yes ❑No

If Yes, please select below the medications you are allergic to.

❑ Penicillin ❑ Tetracycline ❑ Sulfa ❑ Morphine ❑ Erythromycin ❑ Codeine

❑ Radiographic Dyes ❑ Other _____

Topical Allergies: ❑ Iodine/Betadine ❑ Latex ❑ Tape Are you allergic to shellfish? ❑Yes ❑No

Current Medications

Please list *all* medications you are currently taking. Please include any vitamins, tonics, muscle relaxants, anti-inflammatories, pain relievers, nerve medications, and sleeping pills you are taking, both prescription and non-prescription. Attach an additional sheet, if required.

❑ NONE

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Family History

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY. ❑ I AM ADOPTED (No Medical History Available).

Circle each family member the condition applies per disease:

Father = F Mother = M Brother = B Sister = S Grandfather = Gpa Grandmother = Gma

❑ Alcoholism F M B S Gpa Gma	❑ Cancer F M B S Gpa Gma	❑ COPD F M B S Gpa Gma	❑Gout F M B S Gpa Gma	❑ Osteoporosis F M B S Gpa Gma	❑ Thyroid Disorder F M B S Gpa Gma
❑ Anemia F M B S Gpa Gma	❑ Cardiovascular Disease F M B S Gpa Gma	❑ Coronary Artery Disease F M B S Gpa Gma	❑ Hypertension F M B S Gpa Gma	❑Peripheral Vascular Disease F M B S Gpa Gma	❑ Other_____ F M B S Gpa Gma
❑ Arthritis F M B S Gpa Gma	❑ Colitis F M B S Gpa Gma	❑ Depression F M B S Gpa Gma	❑ Liver Disease F M B S Gpa Gma	❑ Renal Disease F M B S Gpa Gma	❑ Other_____ F M B S Gpa Gma
❑ Asthma F M B S Gpa Gma	❑ Congenital Heart Disease F M B S Gpa Gma	❑ Diabetes F M B S Gpa Gma	❑ Muscle Disease F M B S Gpa Gma	❑ Seizure Disorder F M B S Gpa Gma	❑ Other_____ F M B S Gpa Gma
❑ Blood Disorder F M B S Gpa Gma	❑ Congestive Heart Failure F M B S Gpa Gma	❑ Drug Abuse F M B S Gpa Gma	❑ Obesity F M B S Gpa Gma	❑ Stroke F M B S Gpa Gma	❑ Other_____ F M B S Gpa Gma

Social History

Have you ever used tobacco: ❑ No/Never ❑ Yes ❑ Former Tobacco User Ever tried to quit: ❑ No/Never ❑ Yes
Smoking: (circle one) Cigarette / Cigar Non-smoking: (circle one) Chewing / Snuff Daily Use:_____Years used: _____

Do you drink alcohol: ❑ No ❑ Yes ❑ Formerly
Type:_____ Frequency: _____ Amount: _____
Do you drink caffeine: ❑ No ❑ Yes
Type:_____ _____ Caffeine per day:_____ oz_____cups
Hand Dominance: ❑ Right ❑ Left
Highest level of education: ❑ Grammar school ❑ High School ❑ Trade School ❑ College ❑ Post-graduate
Degree Type:_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed
Do you have children at home? ❑ Yes ❑ No
Who do you live with? ❑ Alone ❑ Spouse ❑ Parents ❑ Roommate ❑ Other: _____

Employer (name of company):_____ ❑ Current Military ❑ Previous Military
Occupation:_____ ❑ Full Time ❑ Part Time ❑ Self Employed ❑ Permanently Disabled
❑ Retired – From what occupation?_____ Since When? _____
Activity Level: Sedentary Moderate Vigorous Health Club Member: Now Previous Never
Type of Exercise:_____ Frequency:_____ x Weekly _____Total hours per week

Medical Histroy

Are you affected by any of the following? Check all that apply ❑ I HAVE NOT HAD ANY KNOWN MEDICAL PROBLEMS

❑ Alzheimer's	❑ COPD	❑ Drug Abuse	❑Lyme Disease	❑ Renal Disease	❑ Systemic Lupus Erythematous (SLE)
❑ Anemia	❑ Coronary Artery Disease	❑ Fibromyalgia	❑ Myocardial Infarction/Heart Attack	❑Scoliosis	❑ Thyroid Disorder
❑ Angina	❑ Crohn's disease	❑ Gout	❑ Obesity	❑ Seizure Disorder	❑ Valvular Disease
❑ Arthritis	❑ DVT	❑Headaches/Migraines	❑ Osteoporosis	❑ Sleep Apnea	❑ Other_____
❑ Asthma	❑ Degenerative Joint Disease	❑ Hepatitis/Liver Disease	❑ Parkinson's Disease	❑ Spinal Stenosis	❑ Other_____
❑ Cancer	❑ Depression	❑ Hypertension/High Blood Pressure	❑ Peptic Ulcer	❑ Spondyloarthropathy	❑ Other_____
❑ Congestive Heart Failure	❑ Diabetes	❑ Inflammatory Bowel Disease	❑ Psoriasis	❑ Stroke	❑ Other_____

Past Surgical History

Please list any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

❑ I HAVE NEVER HAD ANY SURGICAL PROCEDURES

Have you ever had a blood transfusion? ❑ Yes ❑No

Please indicate which (if any) of the following anti-inflammatory medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

❑Advil ❑ Arthrotec ❑ Daypro ❑Ibuprofen ❑ Lodine ❑ Mobic ❑ Motrin ❑ Naprelan ❑ Naproxen
❑ Oruvail ❑ Tylenol ❑ Ultram ❑ Other _____

Please indicate any of the following side effects while you were currently taking any of the above anti-inflammatory medications.

❑Nausea ❑ Diarrhea ❑ Gastric ❑Ulcers ❑ Upset Stomach ❑ Vomiting ❑ Other _____

Are you currently taking any of the following on a regular basis?

❑Aspirin ❑ Axid ❑ Azathioprine (Imuran) ❑ Cimzia ❑ Coumadin ❑ Cyclophophamide (Cytoxan)
❑ Cytotec ❑ Embrel ❑ Gold (Ridaura, Solganal, Myochrysine) ❑ Heparin ❑ Humira ❑ Kineret
❑ Leflunomide ❑ Methotrexate (Rheumatrex, Trexall) ❑ Maalox ❑ Mylanta ❑ Orencia ❑ Pepcid
❑ Plaqenil ❑ Prevacid ❑ Prilosec ❑ Remicade ❑ Sulfazalazine ❑ Tagamet ❑ Zantac

Chief Complaint – History of Present Illness

Symptom Location: ❑ Right ❑ Left
❑Arm ❑Back/Neck ❑ Elbow ❑Finger ❑Foot/Ankle ❑Hand/Wrist ❑Hip ❑Knee
❑Leg ❑Shoulder ❑Toe ❑Other _____

Quality: Is your pain? ❑ Burning ❑Constant ❑Dull ❑Intermittent ❑Radiating ❑Sharp
What symptoms are you experiencing? ❑ Catching ❑Grinding ❑Instability ❑Locking ❑Numbness/Tingling
❑ Popping ❑ Stiffness Other_____

Severity: Please rate your discomfort on a scale of 1 (mild) to 10 (severe): At Rest_____At its Worst _____
Since your pain began, how has it changed? ❑Decreased ❑Increased ❑Stayed the same
Duration: Approximately when did this pain begin? Date:_____ The pain has lasted_____Weeks_____Months_____Years
Timing: When do the symptoms occur or do they occur with any particular activity? _____

_____

Context: How did your current pain episode begin? ❑ Gradual ❑ Sudden ❑ Unknown Other_____
What caused your current pain episode? ❑ Accident at work ❑ Following surgery ❑ Pain "just began" ❑ Cancer
❑ Accident at home ❑Motor Vehicle Accident ❑Other:_____
Describe the event that caused your pain _____

_____

Modifying Factor: What makes your symptoms better? ❑ Ice ❑ Heat ❑ Rest ❑ Elevation ❑Other_____
What makes your symptoms worse?

_____

Associated Signs/Symptoms: What else bothers you when this problem occurs? _____

_____

Would you be interested in taking part in a research study? ❑ Yes ❑ No

Previous and/or Current Treatments for this Condition

Previous injury to this area? ❑ Yes ❑ No If Yes, When? _____
Have you been treated by any other physician and/or hospital for THIS problem? ❑ Yes ❑ No
If Yes, Physician_____When _____
What treatments have you tried? ❑ None
Xrays/Tests: ❑Regular X-ray ❑ MRI scans ❑ CAT scan ❑ Myelogram ❑ Nerve tests (EMG, NCV)
❑Other_____Did you bring your X-rays/Tests with you? ❑ Yes ❑ No
Medications: ❑ Anti-inflammatories ❑ Muscle relaxants ❑ Pain Medication ❑Other _____
Therapies: ❑ Physical Therapy ❑ Chiropractic ❑ Injection ❑Other _____
Are you pregnant? ❑ Yes ❑ No

Review of Symptoms

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/Diseases should be noted under Past Medical History, above.

Constitutional ❑ Normal

❑ Chills	❑ Fever	❑ Night Sweats	❑ Weight Loss
❑ Fatigue	❑ Malaise	❑ Weakness	❑ Weight Gain

Head/Ears/Eyes/Nose/Throat ❑ Normal

❑ Dysphagia / Nose Bleeds	❑ Hearing Loss	❑ Vertigo
❑ Headache	❑ Ringing in Ears	❑ Vision Loss

Respiratory ❑ Normal

❑ Chest Pain (respiratory)	❑ Dyspnea	❑ Known TB exposure
❑ Cough	❑ Recent Infections	❑ Wheezing

Cardiovascular ❑ Normal

❑ Chest Pain	❑ Leg Swelling	❑ Irregular Heart Beat
❑ Heart Murmur	❑ Syncope	❑ Heart Palpitations

Gastrointestinal ❑ Normal

❑ Abdominal Pain	❑ Diarrhea	❑ Nausea
❑ Constipation	❑ Heart Burn	❑ Vomiting

Genitourinary ❑ Normal

❑ Painful Urination	❑ Hematuria
❑ Frequent Urination	❑ Prostate Problems

Metabolic / Endocrine ❑ Normal

❑ Cold Intolerant	❑ Hair Loss	❑ Heat Intolerant

Neurological ❑ Normal

❑ Difficulty Walking	❑ Memory Loss	❑ Seizures
❑ Dizziness	❑ Muscle Weakness	❑ Tremors
❑ Poor Coordination	❑ Paresthesia	

Psychiatric ❑ Normal

❑ Anxiety	❑ Depression

Integumentary ❑ Normal

❑ Contact Allergy	❑ Rash	❑ Skin Infections

Musculoskeletal ❑ Normal

❑ Bleeding	❑ Back Pain	❑ Joint Swelling
❑ Bruising	❑ Muscle Weakness	❑ Joint Stiffness

Immunological ❑ Normal

❑ Asthma	❑ Environmental Allergies
❑ Contact Dermatitis	❑ Food Allergies

Vascular ❑ Normal

❑ Lower Extremity Swelling	❑ Varicose Veins	❑ Redness of Extremities
❑ Blood Clots	❑ Skin Ulcers	❑ Coolness of Extremities

Rheumatologic Review of Symptoms

Do you have now or have you ever had:

❑ Gout ❑ Kidney Stones ❑ Loss of Hair ❑ Mouth Ulcers ❑ Raynaud Syndrome (Poor Circulation)

❑ Rheumatoid Arthritis ❑ Sensitivity of your skin to the sun ❑ Scleroderma ❑ Sicca Syndrome

Everything I have answered is true and correct, to the best of my knowledge.

Patient Signature_____ Date_____

Physician Signature_____ Date_____

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FINANCIAL POLICY and CONTRACT WITH PATIENT

Thank you for choosing us as your health care provider. We are committed to providing our patients with the best treatment possible. We hope that you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this vital health care facility for our patients and community.

Our charges for your care are considered to be the usual and customary charges in line with what other specialists in this geographical area charge their patients. You are responsible for payment of your bill in full, regardless of your insurance company's determination of usual and customary charges for this area. The only exceptions for this are if you are covered by Medicare or you are covered by a PPO or HMO for which we are a provider of services.

STATEMENT OF RESPONSIBILITY

By signing below, I hereby enter into a contract with MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC, for the furnishing of medical and/or surgical procedures for illness or injury. I understand that I am contractually responsible for the total bill incurred as a result of treatment received. Although I may have insurance coverage, I understand that this is an agreement between me and my insurance carrier to pay certain amounts for my medical care. The obligation to pay my doctor bill is an obligation by me to my doctor. I am totally responsible for payment of my doctor bill in full. This is regardless of the status of any pending insurance claim or the insurance company's determination of usual and customary rates or amount of assignment. I accept full responsibility for payment of the account, and depending upon the circumstances, I may be expected to pay in full at time of service. I hereby acknowledge that I should coordinate personally with my health insurance carrier. I hereby grant MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC, its agents and attorneys the right to disclose my confidential health care information for purposes of collection of my bill through contact with any third party or through a lawsuit.

In the event that I am covered by a managed care PPO or HMO for which my doctor is a provider of services, I understand that the clinic will accept the allowable charges and will write off any amount that is disallowed by insurance. **I accept responsibility for payment of my co-pay and/or deductible at time of service, any allowable amount not paid by insurance, and/or treatment my policy does not cover.** I understand that you do accept assignment on Medicare and I will not owe any disallows that are written off of my account. **However, I understand that I am responsible for my deductible, co-pay and any charges not covered by Medicare.**

If I am here as the result of a liability claim, I understand that my doctor cannot wait for settlement of my claim in order to be paid and that payment is due at the time services are rendered. My attorney and/or insurance carrier will be provided with an itemized statement for my reimbursement.

If I am here as the result of an on the job injury and my workman's compensation claim is denied, I understand that I am personally responsible for payment of the bill in full.

In the event that credit is extended to me, I understand that any bill rendered by MUSCULOSKSLETAL INSTITUTE OF LOUISIANA, LLC is due and payable upon receipt of statement. If payment in full creates a financial hardship, the clinic will consider an extended payment plan arrangement. I also understand that I may pay my bill in full at any time by cash, check, or any major credit card. **There is a fee (currently $25) for any checks returned by the bank**. In the event of default in the payment of any amount due and this account is turned over to an agency or attorney for collection or legal action, **I hereby agree to be held liable for my outstanding balance plus attorney fees of 25% of my balance over 30 days in arrears. I also understand that I will be held liable for all court costs and judicial interest.** I, the undersigned, have read and understand this contract, and hereby agree to the terms herein.

Date: _____ Signature: _____

PATIENT/RESPONSIBLE PARTY

ASSIGNMENT OF BENEFITS/AUTHORITY TO RELEASE INFORMATION

I have this date, assigned to MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC the benefits due me under my existing policy or policies of insurance. I understand, in so far as they are necessary to cover such expenses, that the above assignment of insurance is accepted by MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC as a convenience to me. Said company is hereby given my consent to file claims on said policy and to do such other actions as it deems necessary in connection therewith so as to promptly obtain payment to the company, direct, and without payment to me.

I authorize the release of all medical records to the referring and family physicians, to my insurance carrier, and/or my attorney at law. I allow fax transmittal of my records, if necessary.

Date: _____ Signature: _____

PATIENT

_____ _____

PARENT/GUARDIAN RELATIONSHIP TO PATIENT

Musculoskeletal Institute of Louisiana

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Advice to Patient Regarding Office Policy on Third Party Liability Issues and Contractual Health Insurance Coverage

Please check one of the following:

- ☐ I WAS injured in an accident – **PLEASE READ BELOW AND SIGN AT BOTTOM.**
- ☐ I WAS NOT injured in an accident – **PLEASE SIGN AT BOTTOM.**

If you have been injured in an accident for which a third party is or may be involved. Additionally, you have health insurance with or through a carrier with which Musculoskeletal Institute of Louisiana (MSIL) have an agreement to provide services on a reduced fee or other special basis. Unfortunately, this agreement does not apply in cases where the treatment is for injuries sustained in an accident involving a third party who is, or may be held, liable for the injuries to you resulting from the accident.

Under the circumstances, and as a courtesy to you, however, we will abide by the terms or our agreement with your carrier as to benefits and fees for services, with the understanding that if, and when, a settlement or judgment is made in your favor, the proceeds awarded there from will go first toward the payment of all fees charged by Musculoskeletal Institute of Louisiana (MSIL) in connection with this matter, including any and all amounts which may have been written off or otherwise not allowed or covered under the terms of your health insurance policy.

In summary, until such time as a settlement or judgment is reached in connection with your accident, you will be expected to pay for services rendered at the time of service in accordance with the terms of your health insurance policy as to deductibles, co-pays, and co-insurance. Additionally, we will file all claims with your carrier, and accept their payment of fees in accordance with our agreement with them, and write off any non-allowed portion of the charges. If and when, a settlement or judgment is reached insurance plan shall be restored, and the full amount of all charges recovered out of the proceeds awarded in the case. The patient and carrier would then be reimbursed to the extent of any prior payments made on the account.

Please signify your understanding of the matter by signing in the space provided below.

_____	_____
Patient/Personal Representative Signature	Please Print Patient's Name
_____	_____
Clinic Representative	Date Signed

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Workers Compensation Acknowledgement Form

Name: _____ Social Security Number: _____

Street Address: _____ Date of Birth: _____ Age: _____

City/State/Zip: _____ Phone Number: _____

Please check one of the following:

Is your visit today the result of a work-related injury? ☐ YES ☐ NO - **PLEASE SIGN AT BOTTOM**

Was the accident reported to your employer? ☐ YES ☐ NO

If YES Name of person you reported the accident to _____

Do you have an attorney? ☐ YES ☐ NO

If Yes, Name of Attorney_____ Phone Number_____

Please be advised that if you are seeing one of our physicians today for a work-related injury you **MUST NOTIFY the front desk receptionist immediately.** If you fail to notify us of such a claim, your health insurance may deny coverage and you will ultimately be responsible for all charges related to medical care you receive at Musculoskeletal Institute of Louisiana (d/b/a Orthopedic Specialists of Louisiana, Pain Care Consultants and Electrodiagnostic Medicine).

In the event that your Workers Compensation denies your case, you will be responsible for all charges related to medical care that you receive in this case and as a courtesy, we will file your primary health insurance company for payment, if applicable. If your insurance company denies due to their timely filing requirements, you will also be responsible.

We maintain strict guidelines on the processing of work-related claims. In order to process paperwork in a timely manner please provide us with the following information.

Employer Information

Employer: _____ Phone Number: _____

Employer Address: _____ City/State/Zip: _____

Supervisor Name: _____ Phone number: _____

Work Comp Information

Date of injury: _____ Claim Number: _____

Injured Body Part(s): _____

Workers Comp Carrier: _____ Phone Number: _____

Carrier Address: _____ City/State/Zip: _____

Adjuster Name: _____ Adjuster Phone #: _____

Please signify your understanding of the matter by signing in the space provided below.

_____ _____

Patient's Name (Please Print) Date

_____

Patient/Personal Representative Signature

1/12/2015

Musculoskeletal Institute of Louisiana

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Medicaid/Medicaid Replacement Waiver of Benefits Acknowledgement Form

Please check one of the following:

- ☐ I DO NOT have Medicaid/Medicaid Replacement – **PLEASE SIGN AT BOTTOM**
- ☐ I HAVE Medicaid/Medicaid Replacement Primary – **PLEASE READ SECTION A BELOW AND SIGN AT BOTTOM**
- ☐ I HAVE Medicaid/Medicaid Replacement Secondary – **PLEASE READ SECTION B BELOW AND SIGN AT BOTTOM**

Please be advised that Musculoskeletal Institute of Louisiana (d/b/a Orthopedic Specialists of Louisiana, Pain Care Consultants and Electrodiagnostic Medicine) is **NOT** a participating provider in the MEDICAID/MEDICAID REPLACEMENT programs and Musculoskeletal Institute of Louisiana WILL NOT file MEDICAID/MEDICAID REPLACEMENT.

SECTION A

If you request treatment by one of our physicians, you must agree to be personally responsible for payment **IN FULL** for all charges related to your treatment.

I have voluntarily chosen to be treated by Musculoskeletal Institute of Louisiana and acknowledge that in doing so I am aware that MEDICAID/MEDICAID REPLACEMENT **WILL NOT** be filed.

SECTION B – PLEASE CHECK ONE OF THE FOLLOWING

☐ I HAVE Medicare Primary and Medicaid/Medicaid Replacement Secondary – I understand that I will NOT be responsible for any copayment or deductible after my claim(s) have been processed by Medicare.

☐ I HAVE OTHER INSURANCE PRIMARY AND MEDICAID/MEDICAID REPLACEMENT SECONDARY – I understand that I **WILL** be responsible for any copayment or deductible after my claim(s) have been processed by my Primary Insurance.

I have been informed that Musculoskeletal Institute of Louisiana is **NOT** a participating provider in the MEDICAID/MEDICAID REPLACEMENT programs and that Musculoskeletal Institute of Louisiana **WILL NOT** file MEDICAID/MEDICAID REPLACEMENT.

I understand that these services may be obtained elsewhere at NO COST from a Medicaid/Medicaid Replacement participating provider.

Please signify your understanding of the matter by signing in the space provided below.

_____ _____

Patient's Name (Please Print) Date of Birth

_____ _____

Patient/Personal Representative Signature Date

Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants • Electrodiagnostic Medicine

Disclosure of Financial Interest
As required by R.S. 37:1744 and LAC 46:XLV.4211-4215

Louisiana law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to another health care provider or facility in which the physician has a significant financial interest.

Our physicians have a financial interest in these facilities:

Specialists Hospital Shreveport
Specialists Outpatient Therapy
Specialists Retail Pharmacy
1500 Line Avenue, Suite 206
Shreveport, LA 71101
318-213-3800

The nature and extent of each physician's interest is that they are one of multiple physicians who own an interest in the facility to which a patient may be referred for the purpose of surgical procedure, pain management procedure, physical therapy evaluation and treatment or prescriptive needs.

Patient Acknowledgement

By signing this Disclosure of Financial Interest, you acknowledge that you have read and understand the foregoing notice and understand that your physician has an ownership interest in above mentioned facilities.

Patient/Personal Representative Signature	Please Print Patient's Name
Relationship to Patient if Personal Rep.	Date Signed

ORTHOPEDIC SPECIALISTS OF LOUISIANA

Michael T. Acurio, M.D.
Steven M. Atchison, M.D.
Ellis O. Cooper, M.D.
Stephen L. Cox, M.D.
David Googe, M.D.
G. Michael Haynie, M.D.
J. Marshall Haynie, M.D.
Val Irion, M.D.
James S. Lillich, M.D.
Charles Lobrano, M.D.
Marion E. Milstead, M.D.

Orthopedic Specialists of Louisiana Narcotic Pain Medication Policy

Due to the highly addictive nature of narcotic pain medications and the worsening prescription drug crisis in the United States, Orthopedic Specialist of Louisiana strictly limits their use in accordance with DEA and FDA guidelines. Narcotic pain medications include, but are not limited to: Vicodin, Lortab, Percocet, Hydrocodone, Oxycodone, Oxycontin, Tramadol, etc.

Narcotic pain medications will be prescribed for post-operative pain, or after an acute fracture. For those patients, the narcotic pain medication will be closely monitored, and discontinued after three (3) months. If you feel that you require additional narcotic pain medication after this time frame, you will have to find a pain management physician, or a physician specially trained in the treatment of chronic pain.

For those receiving narcotic pain medications for one of the above referenced situations, refills will be closely monitored. You must follow the directions on the bottle, and not take medications more frequently than indicated. Additionally, it is the patient's responsibility to request refills in advance of running out of the prescription. Refills may take up to three (3) business days to complete. Refills will not be filled on an urgent basis. **NO narcotic pain medication prescription will be called in after regular business hours or on weekends.**

Patients who are receiving chronic narcotic pain medications from another physician will have to return to that physician for any refills or changes to the prescription.

By signing this policy you, the patient, acknowledge that you have read and understand its contents and agree to the terms. If you do not agree, then we would be happy to assist you in finding another physician who can meet your needs.

_____ _____

Patient/Personal Representative Signature | Please Print Patient's Name

_____ _____

Relationship to Patient if Personal Rep. | Date Signed