

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,

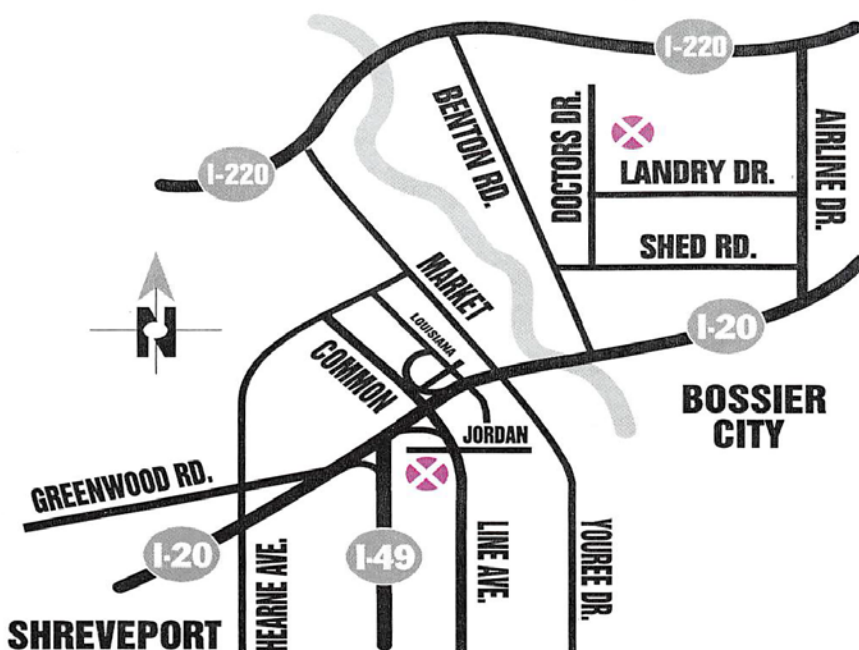
Thank you for choosing Orthopedic Specialist of Louisiana for your orthopedic care. Enclosed you will find your registration form, patient medical history questionnaire and our financial policy. Please fill out forms in their entirety, **BRING** them with you to your appointment.

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 Drive 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

<input type="checkbox"/> Alcoholism F M B S Gpa Gma	<input type="checkbox"/> Cancer F M B S Gpa Gma	<input type="checkbox"/> COPD F M B S Gpa Gma	<input type="checkbox"/> Gout F M B S Gpa Gma	<input type="checkbox"/> Osteoporosis F M B S Gpa Gma	<input type="checkbox"/> Thyroid Disorder F M B S Gpa Gma
<input type="checkbox"/> Anemia F M B S Gpa Gma	<input type="checkbox"/> Cardiovascular Disease F M B S Gpa Gma	<input type="checkbox"/> Coronary Artery Disease F M B S Gpa Gma	<input type="checkbox"/> Hypertension F M B S Gpa Gma	<input type="checkbox"/> Peripheral Vascular Disease F M B S Gpa Gma	<input type="checkbox"/> Other _____ F M B S Gpa Gma
<input type="checkbox"/> Arthritis F M B S Gpa Gma	<input type="checkbox"/> Colitis F M B S Gpa Gma	<input type="checkbox"/> Depression F M B S Gpa Gma	<input type="checkbox"/> Liver Disease F M B S Gpa Gma	<input type="checkbox"/> Renal Disease F M B S Gpa Gma	<input type="checkbox"/> Other _____ F M B S Gpa Gma
<input type="checkbox"/> Asthma F M B S Gpa Gma	<input type="checkbox"/> Congenital Heart Disease F M B S Gpa Gma	<input type="checkbox"/> Diabetes F M B S Gpa Gma	<input type="checkbox"/> Muscle Disease F M B S Gpa Gma	<input type="checkbox"/> Seizure Disorder F M B S Gpa Gma	<input type="checkbox"/> Other _____ F M B S Gpa Gma
<input type="checkbox"/> Blood Disorder F M B S Gpa Gma	<input type="checkbox"/> Congestive Heart Failure F M B S Gpa Gma	<input type="checkbox"/> Drug Abuse F M B S Gpa Gma	<input type="checkbox"/> Obesity F M B S Gpa Gma	<input type="checkbox"/> Stroke F M B S Gpa Gma	<input type="checkbox"/> 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 History

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

<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> COPD	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Renal Disease	<input type="checkbox"/> Systemic Lupus Erythematosus (SLE)
<input type="checkbox"/> Anemia	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Myocardial Infarction/Heart Attack	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Angina	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Gout	<input type="checkbox"/> Obesity	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Valvular Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> DVT	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Degenerative Joint Disease	<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Spinal Stenosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypertension/High Blood Pressure	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Spondyloarthropathy	<input type="checkbox"/> Other _____
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Inflammatory Bowel Disease	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Stroke	<input type="checkbox"/> 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. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
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 Cyclophosphamide (Cytoxan)
 Cytotec Embrel Gold (Ridaura, Solganal, Myochrysin) Heparin Humira Kineret
 Leflunomide Methotrexate (Rheumatrex, Trexall) Maalox Mylanta Orencia Pepcid
 Plaquenil Prevacid Prilosec Remicade Sulfasalazine 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

<input type="checkbox"/> Chills	<input type="checkbox"/> Fever	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Malaise	<input type="checkbox"/> Weakness	<input type="checkbox"/> Weight Gain

Head/Ears/Eyes/Nose/Throat Normal

<input type="checkbox"/> Dysphagia / Nose Bleeds	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Headache	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Vision Loss

Respiratory Normal

<input type="checkbox"/> Chest Pain (respiratory)	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Known TB exposure
<input type="checkbox"/> Cough	<input type="checkbox"/> Recent Infections	<input type="checkbox"/> Wheezing

Cardiovascular Normal

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Irregular Heart Beat
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Syncope	<input type="checkbox"/> Heart Palpitations

Gastrointestinal Normal

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nausea
<input type="checkbox"/> Constipation	<input type="checkbox"/> Heart Burn	<input type="checkbox"/> Vomiting

Genitourinary Normal

<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Hematuria
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Prostate Problems

Metabolic / Endocrine Normal

<input type="checkbox"/> Cold Intolerant	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Heat Intolerant
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Neurological Normal

<input type="checkbox"/> Difficulty Walking	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Seizures
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Tremors
<input type="checkbox"/> Poor Coordination	<input type="checkbox"/> Paresthesia	

Psychiatric Normal

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression
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Integumentary Normal

<input type="checkbox"/> Contact Allergy	<input type="checkbox"/> Rash	<input type="checkbox"/> Skin Infections
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Musculoskeletal Normal

<input type="checkbox"/> Bleeding	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Joint Swelling
<input type="checkbox"/> Bruising	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Joint Stiffness

Immunological Normal

<input type="checkbox"/> Asthma	<input type="checkbox"/> Environmental Allergies
<input type="checkbox"/> Contact Dermatitis	<input type="checkbox"/> Food Allergies

Vascular Normal

<input type="checkbox"/> Lower Extremity Swelling	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Redness of Extremities
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Coolness of Extremities

Rheumatologic Review of Symptoms

Do you have now or have you ever had:

- | | | | | |
|-----------------------------------------------|--------------------------------------------------------------|---------------------------------------|-----------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Mouth Ulcers | <input type="checkbox"/> Raynaud Syndrome (Poor Circulation) |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Sensitivity of your skin to the sun | <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Sicca Syndrome | |

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

Patient Signature _____

Date _____

Physician Signature _____

Date _____

Musculoskeletal Institute of Louisiana

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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 MUSCULOSKELETAL 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

Orthopedic Specialists of Louisiana • Pain Care Consultants • Electrodiagnostic Medicine

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 of 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

Musculoskeletal Institute of Louisiana

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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

Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants • Electrodiagnostic Medicine

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



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