# LAFAYETTE BONE AND JOINT CLINIC

**PATIENT INFORMATION**

**PLEASE PRINT**

TO SEE: (circle one) Dr. Cobb Dr. Blanda Dr. Hodges Dr. Muldowny Dr. Stubbs Account#_____

NAME OF PATIENT:_____
Last First Middle

ADDRESS:_____
Number and Street, Apt.# City State Zip

SOCIAL SECURITY#_____ AGE:_____ DATE OF BIRTH:_____

SEX:_____M _____F MARITAL STATUS:_____M _____S DRIVERS LICENSE#_____

HOME PHONE# _____ CELL# _____ OCCUPATION _____

EMPLOYER:_____

EMPLOYER ADDRESS:_____ WORK PHONE#_____

SPOUSE'S NAME:_____

SOCIAL SECURITY#_____ AGE:_____ DATE OF BIRTH:_____

SPOUSE'S EMPLOYER:_____ OCCUPATION _____

EMPLOYER ADDRESS:_____ WORK PHONE# _____

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EMERGENCY CONTACT:_____PHONE#_____
**(NOT LIVING WITH YOU)**

NEAREST RELATIVE OR FRIEND:_____PHONE#_____
**(NOT LIVING WITH YOU)**

REFERRED TO OUR OFFICE BY:_____PHONE#_____

HAVE YOU EVER BEEN TREATED BY: Dr. Cobb___ Dr. Blanda___ Dr. Muldowny___ Dr. Hodges___ Dr. Stubbs___

IF YES, PLEASE EXPLAIN WHEN AND WHAT FOR:_____

_____

WHAT ARE YOU SEEING THE DOCTOR FOR?_____

DESCRIBE INJURY:_____

DATE OF INJURY:_____

WAS THIS CAUSED BY AN AUTO ACCIDENT?_____YES_____NO IS THIS A WORKERS' COMP INJURY?_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?_____

DO YOU HAVE MEDICARE? YES _____ NO _____ MEDICARE NUMBER _____

IF WORKERS' COMP, IS IT A LOUISIANA OR TEXAS CLAIM LONGSHORE & HARBOR JONES ACT
(Please Circle One)

DO YOU HAVE AN ATTORNEY FOR THIS INJURY?_____YES_____NO

ATTORNEY'S NAME: _____PHONE# _____

NAME OF PATIENT:_____

****IF THE PATIENT IS A MINOR OR STUDENT, PLEASE COMPLETE****

MOTHER'S NAME:_____

ADDRESS:_____ HOME PHONE# _____

DATE OF BIRTH: _____OCCUPATION:_____ SS # _____

MOTHER'S EMPLOYER:_____WORK PHONE#_____

FATHER'S NAME:_____

ADDRESS:_____ HOME PHONE# _____

DATE OF BIRTH: _____OCCUPATION:_____ SS # _____

FATHER'S EMPLOYER:_____WORK PHONE#_____

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**INSURANCE INFORMATION**

(Please give receptionist all insurance cards as proof of coverage)

1. INSURANCE COMPANY NAME_____

   ADDRESS _____

   INSURED'S NAME_____SOCIAL SECURITY #_____

   POLICY #_____GROUP #_____

2. INSURANCE COMPANY NAME_____

   ADDRESS_____

   INSURED'S NAME_____SOCIAL SECURITY #_____

   POLICY #_____GROUP #_____

3. INSURANCE COMPANY NAME_____

   ADDRESS_____

   INSURED'S NAME_____SOCIAL SECURITY #_____

   POLICY #_____GROUP #_____

**Account # _____**

## AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Lafayette Bone and Joint Clinic, Inc. to furnish any and all insurance company(s) or referring physicians all information they may request concerning my present illness or injury. I authorize the release of any medical or other information necessary to process my claim(s). I hereby assign to the provider all money to which I am entitled for medical and/or surgical expenses. Any credit balance will be refunded to the rightful party.

SIGNED: _____ DATE: _____

Patient or Parent

I authorize payment of medical benefits to the physician or supplier for services.

SIGNED: _____ DATE: _____

Patient or Parent

NAME OF PATIENT (Please Print Name): _____

## ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have health insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We request that office visits be paid at the time the service is rendered. To assist you, we accept cash, checks, MasterCard, or Visa. There will be a non-negotiable fee charged when a check is returned due to insufficient/uncollectible funds. A receipt for services rendered will be given to you that will have all information needed to file with your insurance company. Our office, accepting assignment of insurance benefits, will file surgery charges.

Accounts not paid in 90 days are subject to interest at the rate of 1.5% per month (18% annually). Returned checks may be subject to additional collection fees. If any account is placed in the hands of an attorney and/or collection agency for collection after default, the undersigned agrees to pay all cost of collection including a reasonable attorney's and/or collection agency fee.

Most companies generally consider our fees usual, customary and reasonable. This may not apply to companies who reimburse based on an arbitrary "schedule" of fees.

As health care providers, our relationship is with you, not your insurance company or a third party such as an attorney or liability insurance. All charges are your responsibility from the date the services are rendered. If temporary financial problems arise, we encourage you to contact us promptly for assistance in the management of your account.

### Disclosure of Financial Interest (as required by LA. R.S. 37:1744)

In the course of treatment, it may be necessary that you be referred outside of Lafayette Bone & Joint Clinic for surgical/hospital services. For surgical or hospital services, you may be referred to Lafayette Surgical Specialty Hospital, Ambulatory Surgery Center of Opelousas and/or Practical Healthcare Supply, Inc., in which there exists a direct financial or economic interest. If you prefer that any of these services be arranged with another provider, please discuss this with the clinic personnel at the time the services are being arranged.

I have read all the above information.

SIGNED: _____ DATE: _____

Patient or Parent

# LAFAYETTE BONE AND JOINT CLINIC

(A PROFESSIONAL MEDICAL CORP.)
1103 KALISTE SALOOM RD, SUITE 100 & 102
LAFAYETTE, LA 70508

PHONE: (337) 234-5234 FAX: (337) 235-2121

**ORTHOPAEDIC SURGERY**
JOHN E. COBB, M.D.
LOUIS C. BLANDA, JR., M.D.
DAVID S. MULDOWNY, M.D.
MALCOLM J. STUBBS, M.D.

**PHYSICAL MEDICINE AND REHABILITATION**
DANIEL L. HODGES, M.D.

## AUTHORIZATION AND RELEASE

Insurers and managed care companies occasionally review medical charts to insure compliance with company procedures. I understand that my chart may be selected for such review and that the confidentiality of the information in my chart will be preserved and I hereby consent to such review and release this physician and any such insurer or managed care company from liability for any reasonable review of my chart.

_____ _____
Signature of Patient or Parent (if minor) Date

# RELEASE OF MEDICAL RECORDS

*I. TO: Drs. Cobb, Blanda, Hodges, Muldowny, and Stubbs*

I hereby authorize you to release to _____ any and all information including the diagnosis and records of any treatment or examination rendered to me by any of the above named physicians.

(attorney)

_____ _____
Signature of Patient Date

_____
Witness

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II. Louisiana's Workers' Compensation law allows a healthcare provider to give the claimant's attorney a copy of all reports relating to the work injury without the claimant's authorization. (LA R.S. 23:1127) Unless you check below, we will send a copy of these reports to the last attorney you have identified. If you change attorneys you must notify us; until you notify us of the change, we will continue to send copies to your last attorney.

_____ No, do not send copies to my attorney _____
(Initials)

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III. I, _____ hereby authorize Dr. John E. Cobb, Dr. Louis C. Blanda, Jr., Dr. Daniel L. Hodges, Dr. David S. Muldowny, Dr. Malcolm J. Stubbs, and/or Lafayette Bone & Joint Clinic to release copies of my medical records and/or x-rays to any referring physician and/or my spouse, daughter, son, or anyone else that I have listed below.

| Name | Relationship |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____ _____
Signature of patient Date