PLEASE PRINT IN INK

LAFAYETTE BONE AND JOINT CLINIC, INC

PATIENT INFORMATION ACCOUNT #_____

TO SEE: **(circle one)** Dr. Blanda Dr. Hodges Dr. Muldowny Dr. Stubbs Dr. Trahan

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#:_____

RACE: _____ ETHNICITY_____ PREFERRED LANGUAGE:_____

HOME PHONE#:_____ CELL#:_____ OCCUPATION:_____

EMPLOYER:_____ EMAIL ADDRESS:_____

EMPLOYER ADDRESS:_____ WORK PHONE#:_____

SPOUSE'S NAME:_____

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

SPOUSE'S EMPLOYER:_____ OCCUPATION:_____

EMPLOYER ADDRESS:_____ WORK PHONE#:_____

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____ Dr. Sledge____ Dr. Trahan____

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 _____

DO YOU HAVE BLUE CROSS? YES_____ NO_____ **IF YES COMPLETE INSURANCE INFORMATION ON NEXT PAGE**

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#:_____

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. or Dr. Blanda, Dr. Hodges, Dr. Stubbs, Dr. Muldowny, and Dr. Trahan 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 in addition to a $35.00 returned check fee. 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.

Our office has implemented a two (2) business day" Cancellation Policy". If you need to cancel or re-schedule your appointment, please notify us two (2) business days prior to your scheduled appointment. Lack of prior notification will result in a **$15.00 cancellation fee**. Please be advised, our office will NOT be able to reschedule your appointment until the $15.00 cancellation fee is paid in full.

I have read all the above information.

SIGNED:_____ DATE:_____

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. (1945-2011)
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.

NEUROLOGICAL SURGERY
JAYME TRAHAN, M.D.

AUTHORIZATION AND RELEASE

Insurers and managed care companies occasionally review medical charts to ensure 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, Stubbs, and Trahan

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

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)

III. I, _____ hereby authorize John E. Cobb Marital Trust, Dr. Louis C. Blanda, Jr., Dr. Daniel L. Hodges, Dr. David S. Muldowny, Dr. Malcolm J. Stubbs, and/or Dr. Jayme Trahan 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

DISCLOSURE OF FINANCIAL INTEREST
as Required by R.S. 37:1744 and
LAC 46:XLV.4211-4215

Louis Blanda Jr., M.D., Daniel Hodges, M.D., David Muldowny, M.D., Malcolm Stubbs, M.D., Jayme Trahan, M.D.

Date: _____

Patient Name: _____

Louisiana law requires Dr. Blanda Jr., Dr. Muldowny, Dr. Hodges, Dr. Stubbs and Dr. Trahan of Lafayette Bone and Joint Clinic, 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. One of the physicians listed above may refer you, or the named patient for whom you are legal representative, to:

Facility/Business	Purpose	Provider with Financial Interest
Lafayette Surgical Specialty Hospital	Surgical/Hospital Services	Drs. Blanda Jr., Muldowny, Stubbs, & Trahan
Practical Healthcare Supply Inc	Surgical Instrumentation	Dr. Blanda Jr., Dr. Muldowny, Dr. Stubbs, Dr. Trahan
Ambulatory Surgery Center of Opelousas	Surgical/Hospital Services	Dr. Stubbs
Falcon Pharmacy LLC	Prescription Services	Dr. Blanda Jr., Dr. Muldowny, Dr. Stubbs, Dr. Hodges
Acadian Neurological Monitoring LLC	Neuromonitoring	Dr. Trahan
Neurosurgical Applications LLC	Surgical Instrumentation	Dr. Trahan
Camber Spine Technologies	Surgical Instrumentation	Dr. Trahan

There is a financial interest in the health care provider to whom you are being referred to, the nature and extent of which are as stated above.

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.

PATIENT ACKNOWLEDGEMENT

I, the above-named patient, or legal representative of such patient, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

_____
(Signature of Patient or Patient's Representative)

Print Name: _____

Date: _____

Welcome to Lafayette Bone and Joint Clinic, office of Dr. Daniel Hodges. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner. Below are a few guidelines and a reminder of what you will need to bring for your first visit:

- Bring any imaging that you have had performed within the last 6 months to a year, including x-rays, CT scans and MRIs. They **MUST** be brought to your appointment or it will be rescheduled.

- We will do our best to provide you with the best care. You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information, address, or phone number changes since your last appointment.

- We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 30 minutes late. We will strive to stay on time. In the event of your appointment being late you will have the option to re-schedule or stay to be seen and we attempt to keep you informed of how long of a delay you may experience.

- Our office policy for a missed appointment is:

    - If it is an appointment for a new patient, the appointment will need to be rescheduled.
    - For each missed appointment there is a $15 fee.
    - Two (2) no-show appointments may result in dismissal from the practice.
    - We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

- Dr. Hodges has asked that only the patient be seen in the examination room. Other guests, spouses, children 18 or older and friends are asked to stay in the waiting room. *Please let us know if you require a caregiver to accompany you.*

- Please do not use your cell phones once in the examination room. We strive to give everyone the best care and treatment; this is best done without distractions.

Welcome to our practice and thank you for choosing Lafayette Bone and Joint Clinic for all your health care needs.

Please fill out the attached forms to the best of your ability. Please use details of any accidents or injuries.

All forms must be completely filled out in order to avoid rescheduling your appointment.

New Patient Information Sheet

******Please complete and bring to your first appointment*****

Patient's Name:_____ **Date of Birth**_____ **Date Completed**_____

Home Phone_____ **Cell Phone**_____

Date of Injury_____ **Who Referred you**_____

Type of Injury (On the Job, car accident, fall, etc.)_____

Describe in detail when/how your pain began: (Please include the following – was it a fall, accident, or injury? What hurt? Did you have pain right after it happened? What did you land on, hit, have injured?) Use page 4 for additional information if needed.

_____

_____

_____

_____

_____

If you were in a work accident, please circle the following:

Did you notify your supervisor? YES NO

Was an accident report completed? YES NO

If you were in a car accident, please circle the following:

Were the police called? YES NO

Were you able to get out of the car? YES NO

Was the car able to start after the accident? YES NO UNKNOWN

Did the airbags deploy? YES NO

Were you wearing your seatbelt? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

_____

PATIENT NAME

New Patient Information Sheet

Did you go to the hospital or seek treatment anywhere? (How did you get there? By ambulance, friend, drove yourself) _____

What hospital did you go to or where did you seek treatment? _____

How long after the accident did you go to the hospital or seek treatment? (Circle one)

Immediately Couple hours later Next day Next week Other: _____

Did the hospital do any of the following? (Circle all that apply)

X-rays Give medication CT scan MRI Surgery Injection

Treatment (Circle all that apply)

Chiropractic Care: Yes No Injections: Yes No Physical Therapy: Yes No

Please list all surgeries and injections you had: (Include the year they were performed and the doctor's name)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have: High Blood pressure_____ Diabetes_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

_____

PATIENT NAME

New Patient Information Sheet

What is your height:_____ What is your weight_____

Are you currently working? Yes No Retired Disabled Not working due to injuries

Circle which helps your symptoms: Ice Heat Rest Medication

Circle what makes your symptoms worse: Bending Sitting Standing Weather Changes

Do you have the following due to the pain? Depression Anxiety Sleeping problems

Describe your pain: Constant Come and Go

Since you last saw a doctor is your pain: Worse The same

Check all that describe your pain:

_____Sharp _____Aching _____Stinging

_____Dull _____Burning _____Throbbing

_____Deep _____Shooting

_____Crampy _____Stabbing

Allergies to Medication: _____

_____ _____

_____ _____

_____ _____

_____ _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

_____

PATIENT NAME

New Patient Information Sheet

Please list ALL Medications that you are currently taking. List the name, frequency and dosage:

MEDICATIONS:

Additional information:

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

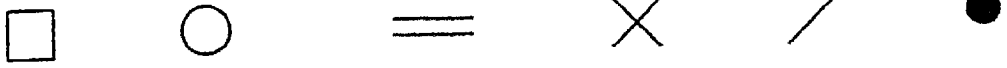
PATIENT NAME

PATIENT PAIN DRAWING

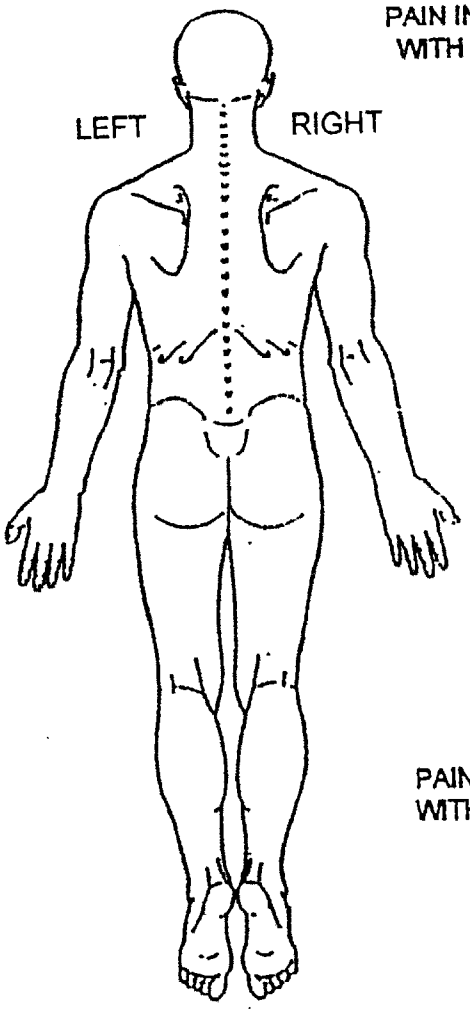
NAME:_____ DATE:_____

USING THE SYMBOLS GIVEN BELOW, MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. INCLUDE ALL AFFECTED AREAS. IT IS NOT NECESSARY TO USE ALL THE SYMBOLS, ONLY THE ONES WHICH MOST AFFECT YOU.

ACHING NUMBNESS PINS & NEEDLES BURNING STABBING OTHER



BACK



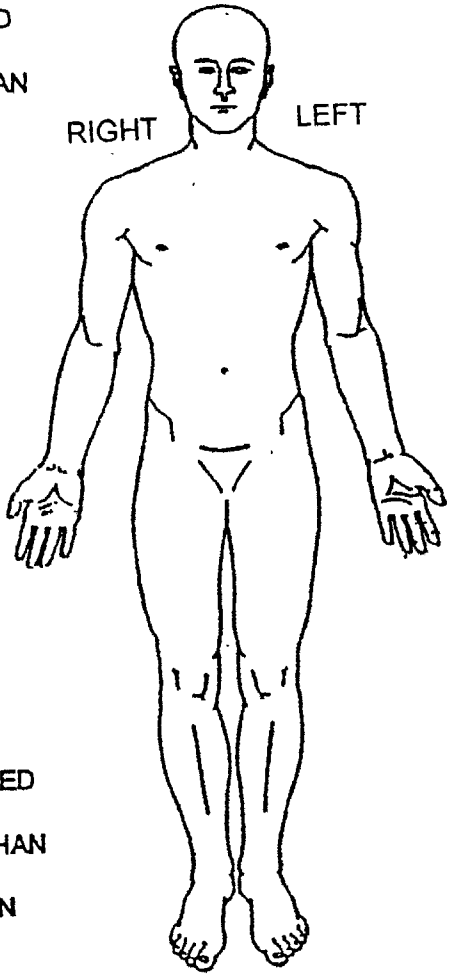
PAIN IN ARM(S) COMPARED WITH NECK:

WORSE THAN
SAME AS
LESS THAN

PAIN IN LEG(S) COMPARED WITH BACK:

WORSE THAN
SAME AS
LESS THAN

FRONT



CIRCLE THE QUALITY OF YOUR PAIN 0 1 2 3 4 5 6 7 8 9 10

NORMAL UNBEARABLE

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

_____

PATIENT SIGNATURE