



John L Ledbetter, M.D.
 Vince R. Forte, M.D.
 J. Hardy Gordon, M.D.
 Pat Pennington, FNPC
 Andy Austin, FNPC
 Judy Rogers, FNPC
 Donna Courson, FNPC

Board Certified
 Pain Medicine
 Anesthesiology

Patient's Last Name _____ First _____ MI _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ - _____ - _____ Age _____ Social Security # _____

Circle One Male Female Circle One: Single Married Divorced Widowed

Employer _____ Address _____ Phone _____

Spouse Name _____ Social Security # _____ Spouse DOB _____ - _____ - _____

Who may we thank for referring you to our clinic today? _____

INSURANCE COVERAGE:

Private or Medicare

Primary Insurance Co: _____ Policy # _____

Policy holder if other than self _____ Policy holder Date of Birth _____

Secondary Insurance Co: _____ Policy # _____

Workers Compensation

WC Carrier _____ Address _____

Phone _____ Claim # _____ Adjustor _____

Personal Injury

Is your pain the result of an accident? Yes No Date of Injury _____

Are you currently involved in a lawsuit related to this accident? Yes No

If yes, Attorney _____ Phone _____

Personal contact in case of emergency: _____ Relationship: _____ Phone _____

As a courtesy, our office files insurance for the patient. Some companies pay fixed allowances for certain procedures; and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. Even though our insurance department pre-certifies surgeries and test, it is the primary responsibility of the patient to notify their insurance company of pending surgery or tests. (This does not pertain to Medicare patients).

I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Louisiana Pain Care and the associated Physicians to release all information necessary to secure payment. I hereby authorize my insurance benefits to be paid directly to Louisiana Pain Care and ArkLaMiss Surgery Center.

If payment in full is not made within 30 days of my first statement, I agree to the payment conditions set by Louisiana Pain Care, LLC or its extended business office, CompleteCare for my balance due. I consent to and agree with all conditions disclosed on the back of my CompleteCare statement including the charging of a fee and/or interest at a rate not to exceed the maximum rate in effect pursuant to the laws of the State of Louisiana, Arkansas, and applicable federal laws at the time services are rendered.

I hereby authorize and direct Drs. Ledbetter and Forte or any member of the LPC staff, under the orders of my physician, to provide medical service to (the patient) as he / she may deem reasonable and necessary to treat the identified illness, condition or disease. I further authorize the release of my medical records to my attending/referring physician. I further consent to allow LPC personnel to take an instant developing photograph of me as part of my registration process. I understand that these photos will be used to help in my care. This does not give consent for any other use of the photograph.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

SIGNATURE _____ **Date** _____



WWW.LAPAINCARE.COM

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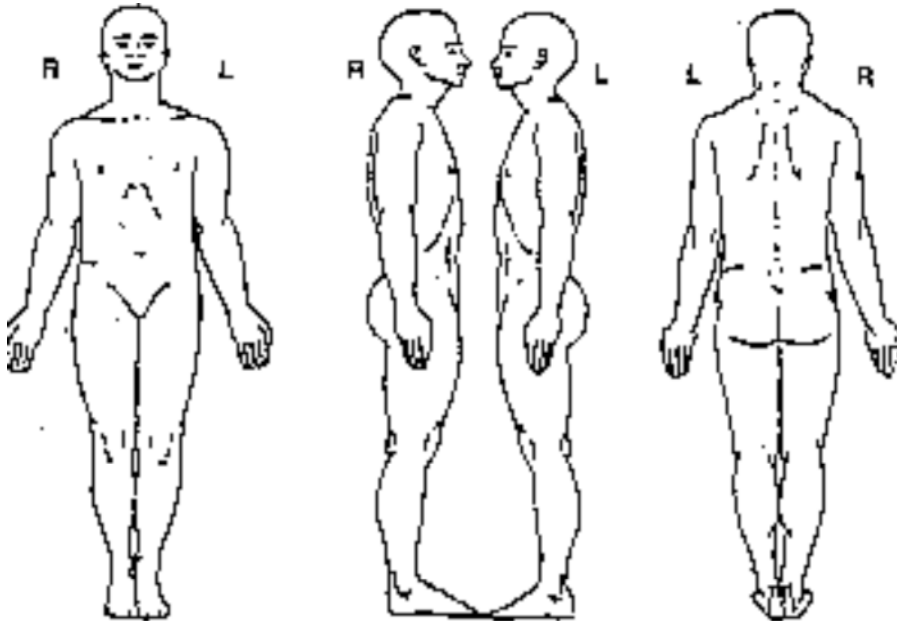
NAME: _____ **DATE:** _____

Please read these sheets carefully and answer all the questions to the best of your ability. They will assist us in better treating your pain. Thank you for your time and cooperation.

REFERRING PHYSICIAN(S): _____ **AGE:** _____ **HEIGHT:** _____

Please list all surgeries you have had in the past: _____

WHERE IS YOUR PAIN? USING THESE PICTURES, SHADE IN THE AREA ON THE DIAGRAMS WHERE YOUR PAIN IS LOCATED. MARK AN X AND DRAW AN ARROW TO WHERE THE PAIN GOES.



MARK AN X ON THE LINE BELOW TO INDICATE THE DEGREE OF PAIN YOU ARE FEELING NOW.

RATE YOUR PAIN:

0=none



10=extreme

210 LAYTON AVE., SUITE 20, MONROE, LOUISIANA 71201

318-323-6405 (voice); 318-807-0205 (fax)
Fellowship Trained Physicians Committed to Pain Solutions

1. Is your pain the result of an: YES NO If yes, explain and give dates.
 Illness _____
 Accident _____

2. Are you presently involved in litigation or a lawsuit resulting from this accident? YES NO
 If yes, what is the name of your attorney? _____

3. How many hours do you sleep at night? _____

4. Do you smoke? NO YES, How much and for how long? _____

5. How much coffee or caffeinated beverages (tea, cola, etc.) do you drink daily? _____

6. How much beer or alcoholic beverages do you drink daily? Specify. _____

7. What is your usual occupation? _____

8. Are you retired? YES NO

9. Are you on disability? YES NO

10. Are you presently working? YES NO

11. Please list *all* medications (prescription and non prescription) you are currently taking.

MEDICATION	REASON TAKEN	HOW OFTEN	DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Please check the appropriate box if you have had or presently have any of the following health problems.
- | | | | |
|-------------------|--------------------------|--------------|--------------------------|
| DIABETES | <input type="checkbox"/> | EMPHYSEMA | <input type="checkbox"/> |
| HYPERTENSION | <input type="checkbox"/> | EPILEPSY | <input type="checkbox"/> |
| HEART DISEASE | <input type="checkbox"/> | CVA (STROKE) | <input type="checkbox"/> |
| VASCULAR PROBLEMS | <input type="checkbox"/> | SHINGLES | <input type="checkbox"/> |
| KIDNEY PROBLEMS | <input type="checkbox"/> | TUBERCULOSIS | <input type="checkbox"/> |
| AIDS | <input type="checkbox"/> | DEPRESSION | <input type="checkbox"/> |
| HEPATITIS | <input type="checkbox"/> | OTHER _____ | <input type="checkbox"/> |
| ASTHMA | <input type="checkbox"/> | OTHER _____ | <input type="checkbox"/> |

SIGNATURE OF PATIENT _____

THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM.

Yes	No	
		SKIN/ INTEGUMENTARY COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	rashes _____
<input type="checkbox"/>	<input type="checkbox"/>	boils _____
<input type="checkbox"/>	<input type="checkbox"/>	itching _____
<input type="checkbox"/>	<input type="checkbox"/>	hives _____
		HEAD / NECK / EYES
<input type="checkbox"/>	<input type="checkbox"/>	frequent headaches _____
<input type="checkbox"/>	<input type="checkbox"/>	blurred vision _____
<input type="checkbox"/>	<input type="checkbox"/>	double vision _____
<input type="checkbox"/>	<input type="checkbox"/>	loss of vision _____
<input type="checkbox"/>	<input type="checkbox"/>	pain in eyes _____
<input type="checkbox"/>	<input type="checkbox"/>	neck pain _____
<input type="checkbox"/>	<input type="checkbox"/>	neck bumps _____
		EARS
<input type="checkbox"/>	<input type="checkbox"/>	dizziness _____
<input type="checkbox"/>	<input type="checkbox"/>	light-headed _____
<input type="checkbox"/>	<input type="checkbox"/>	earaches _____
<input type="checkbox"/>	<input type="checkbox"/>	discharge from ear _____
		NOSE / THROAT
<input type="checkbox"/>	<input type="checkbox"/>	frequent nosebleed _____
<input type="checkbox"/>	<input type="checkbox"/>	frequent head cold _____
<input type="checkbox"/>	<input type="checkbox"/>	sore throat _____
<input type="checkbox"/>	<input type="checkbox"/>	sinus problems _____
<input type="checkbox"/>	<input type="checkbox"/>	hoarseness _____
<input type="checkbox"/>	<input type="checkbox"/>	taste difficulty _____
<input type="checkbox"/>	<input type="checkbox"/>	smell difficulty _____
<input type="checkbox"/>	<input type="checkbox"/>	swallowing difficulty _____
<input type="checkbox"/>	<input type="checkbox"/>	problems with teeth _____
		RESPIRATORY
<input type="checkbox"/>	<input type="checkbox"/>	coughing up blood _____
<input type="checkbox"/>	<input type="checkbox"/>	wheezing _____
<input type="checkbox"/>	<input type="checkbox"/>	asthma _____
<input type="checkbox"/>	<input type="checkbox"/>	hay fever _____
<input type="checkbox"/>	<input type="checkbox"/>	bronchitis _____
<input type="checkbox"/>	<input type="checkbox"/>	pneumonia _____
<input type="checkbox"/>	<input type="checkbox"/>	chronic cough _____
		METABOLIC / ENDOCRINE
<input type="checkbox"/>	<input type="checkbox"/>	thirst (excessive) _____
<input type="checkbox"/>	<input type="checkbox"/>	urinary (excessive) _____
<input type="checkbox"/>	<input type="checkbox"/>	diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	thyroid low _____
<input type="checkbox"/>	<input type="checkbox"/>	thyroid high _____
<input type="checkbox"/>	<input type="checkbox"/>	cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	chills _____
<input type="checkbox"/>	<input type="checkbox"/>	fever _____
<input type="checkbox"/>	<input type="checkbox"/>	night sweats _____
		NEUROLOGIC
<input type="checkbox"/>	<input type="checkbox"/>	fainting spells _____
<input type="checkbox"/>	<input type="checkbox"/>	blackouts _____
<input type="checkbox"/>	<input type="checkbox"/>	convulsions _____
<input type="checkbox"/>	<input type="checkbox"/>	tremors/ shaking _____
<input type="checkbox"/>	<input type="checkbox"/>	poor coordination _____
<input type="checkbox"/>	<input type="checkbox"/>	loss of strength _____

Yes	No	
		CARDIOVASCULAR
<input type="checkbox"/>	<input checked="" type="checkbox"/>	chest pains _____
<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	breath shortness _____
<input type="checkbox"/>	<input type="checkbox"/>	feet swelling _____
<input type="checkbox"/>	<input type="checkbox"/>	ankles swelling _____
<input type="checkbox"/>	<input type="checkbox"/>	circulation poor _____
<input type="checkbox"/>	<input type="checkbox"/>	blood clot _____
<input type="checkbox"/>	<input type="checkbox"/>	bleeding _____
<input type="checkbox"/>	<input type="checkbox"/>	irregular heart beat _____
<input type="checkbox"/>	<input type="checkbox"/>	thumping in heart _____
<input type="checkbox"/>	<input type="checkbox"/>	tightness in chest _____
		GASTROINTESTINAL
<input type="checkbox"/>	<input type="checkbox"/>	heartburn _____
<input type="checkbox"/>	<input type="checkbox"/>	indigestion _____
<input type="checkbox"/>	<input type="checkbox"/>	loss of appetite _____
<input type="checkbox"/>	<input type="checkbox"/>	recent weight gain _____
<input type="checkbox"/>	<input type="checkbox"/>	recent weight loss _____
<input type="checkbox"/>	<input type="checkbox"/>	stomach ulcer _____
<input type="checkbox"/>	<input type="checkbox"/>	nausea / vomiting _____
<input type="checkbox"/>	<input type="checkbox"/>	frequent constipation _____
<input type="checkbox"/>	<input type="checkbox"/>	frequent diarrhea _____
<input type="checkbox"/>	<input type="checkbox"/>	hemorrhoids / piles _____
<input type="checkbox"/>	<input type="checkbox"/>	painful bowel movements _____
<input type="checkbox"/>	<input type="checkbox"/>	chronic bloating _____
<input type="checkbox"/>	<input type="checkbox"/>	gas / belching _____
<input type="checkbox"/>	<input type="checkbox"/>	hepatitis _____
<input type="checkbox"/>	<input type="checkbox"/>	colitis _____
<input type="checkbox"/>	<input type="checkbox"/>	gallstones _____
<input type="checkbox"/>	<input type="checkbox"/>	diverticulitis _____
<input type="checkbox"/>	<input type="checkbox"/>	vomiting of blood _____
<input type="checkbox"/>	<input type="checkbox"/>	blood in stool _____
<input type="checkbox"/>	<input type="checkbox"/>	jaundice _____
		URINARY
<input type="checkbox"/>	<input type="checkbox"/>	urinary infections _____
<input type="checkbox"/>	<input type="checkbox"/>	blood in urine _____
<input type="checkbox"/>	<input type="checkbox"/>	inability to pass urine _____
<input type="checkbox"/>	<input type="checkbox"/>	urinating difficulty _____
<input type="checkbox"/>	<input type="checkbox"/>	kidney stones _____
<input type="checkbox"/>	<input type="checkbox"/>	inability to control urine _____
		MUSCULOSKELETAL
<input type="checkbox"/>	<input type="checkbox"/>	arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	swollen joints _____
<input type="checkbox"/>	<input type="checkbox"/>	muscular pain _____
<input type="checkbox"/>	<input type="checkbox"/>	joint pain _____
<input type="checkbox"/>	<input type="checkbox"/>	chronic back pain _____
<input type="checkbox"/>	<input type="checkbox"/>	shoulder pain _____
<input type="checkbox"/>	<input type="checkbox"/>	morning stiffness _____
<input type="checkbox"/>	<input type="checkbox"/>	trigger points _____
		MEN ONLY
<input type="checkbox"/>	<input type="checkbox"/>	hernia _____
<input type="checkbox"/>	<input type="checkbox"/>	prostate trouble _____
<input type="checkbox"/>	<input type="checkbox"/>	urethral trouble _____

Yes No

-
-
-

HEMATOLOGIC

- anemia
- bruising / bleeding
- past transfusion

COMMENTS

-
-
-
-
-

ALLERGIC

- foods
- drugs
- molds
- dust
- pollen

-
-
-
-
-

PSYCHIATRIC

- nervous
- insomnia
- nightmares
- depression
- mood

Yes No

-
-
-
-

CONSTITUTIONAL

- fever
- weight loss
- weakness
- fatigue

COMMENTS

-
-
-

WOMEN ONLY

- irregular periods
- severe menstrual cramps
- vaginal infections

Louisiana Pain Care, LLC
Notice of Health Information Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of health information privacy practices is effective

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record and serves as a basis for planning your care and treatment, a means of communication among the many health professionals who may contribute to your care, the means by which you or a third-party payer can verify that services billed were actually provided, and a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- ! request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, although this entity is not required to agree to any requested restriction
- ! receive confidential communications of protected health information as provided by 45 CFR 164.522
- ! obtain a paper copy of the notice of information practices upon request
- ! inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- ! amend your health record as provided in 45 CFR 164.526
- ! obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- ! request communications of your health information by alternative means or at alternative locations
- ! revoke your authorization to use or disclose health information except to the extent that action has already been taken

OUR RESPONSIBILITIES

This organization is required by law to:

- ! maintain the privacy of your health information
- ! provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- ! abide by the terms of this notice
- ! notify you if we are unable to agree to a requested restriction
- ! accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If have questions and would like additional information, please contact our designated Privacy Official:

Lisa Dalfiume, RN
210 Layton Avenue
Suite 20
Monroe, Louisiana 71201
318-323-6405

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Official either orally or in writing, or you may file with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use your health information for treatment. For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response

to a valid subpoena.

Oversight: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

We may also use your health information to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Patient consents to have his/her medical records from Louisiana Pain Care and ArkLaMiss Surgery Center combined into the medical charts of both entities for continuity of care purposes.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization, if given, as provided by 45 CFR ' 508(b)(5).

I, (patient name) _____, acknowledge receipt of this **Notice of Health Information Privacy Practices**.

By: _____

I, (Provider) _____, certify that I have made a good faith effort to obtain written acknowledgment of receipt of this **Notice of Health Information Privacy Practices**, but the acknowledgment was not obtained because :

_____.

By: _____

This ___ day of _____, 2006.

This document must remain in the patient's chart at all times.

This document must be retained for the longer of 6 years from the date of its creation or when it was last in effect.

LOUISIANA PAIN CARE, LLC
AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

1. I, _____, hereby authorize **LOUISIANA PAIN CARE, LLC** to disclose the following protected health information to:

_____ ¹

2. The specific information subject to this authorization is:

_____ ²

3. This protected health information is being used or disclosed for the following purposes:

_____ ³

4. This authorization shall be in force and effect until _____ at which time this authorization to disclose this protected health care information expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to this Health Care Provider. I understand that a revocation is not effective:

- a. to the extent that this Health Care Provider has relied on the use or disclosure of the protected health information; or
- b. if the authorization is obtained as a condition of obtaining insurance coverage, if some other law or the policy itself provides the insurer with the right to contest a claim under the policy.

6. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

7. I understand that this Health Care Provider may not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide this authorization for the requested use or disclosure.

8. I understand that I have the right to:

- a. Inspect or copy the protected health information to be used or disclosed as permitted under federal law, or state law to the extent the state law provides greater access rights; and
- b. Refuse to sign this authorization.

Signature of Patient or Representative

Date

Name of Patient or Representative

Description of Representative's authority

A copy of this document must be provided to the patient when executed!!

¹ Insert the name of the entity that is to receive the health information

² Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

³ Insert **at the request of the individual** if this authorization initiated by the individual and he or she elects not to provide a statement of the purpose.

Financial Responsibilities:

Bring a copy of your insurance card to your initial appointment. Without insurance, a cash payment in full is required at the time of service. As a courtesy, we will file our insurance for you, but the patient is responsible for payment of all fees, regardless of insurance coverage or the status of any insurance claim(s). **Louisiana Pain Care accepts most medical insurances, Workers' Compensation Insurance and Medicare.**

- All patients are financially responsible for all charges. We will bill Medicare or your primary and secondary insurance for you. **Please be sure to bring your most current Medicare or insurance card with you.**
- Be prepared to pay any deductibles or co-pays on the day of your appointment. Louisiana Pain Care accepts cash, cashiers checks, credit cards and personal checks with valid I.D.
- Payment plans can be arranged for patients that do not have insurance coverage, or whose procedure is not covered by insurance.
- Financial arrangements must be made **prior** to your appointment. Please feel free to contact our business office at 318-323-6405 if you have questions or concerns.