LGMD
PHYSICIAN GROUP

LGMD Patient Information

Date_____

Which Physician are you seeing today: _____

Patient Name (Last, First, M): _____ Maiden: _____

Sex: _____ Date of Birth:_____ Preferred Language: _____

Race: _____ Ethnicity: _____ Marital Status: _____

Home Address: _____ City: _____, State: _____ Zip: _____

Social Security: _____ Email address: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Primary Care Physician: _____ May we contact you at work? ____ Yes ____ No

If injury is related to an accident, what type? Work Auto Other Date of Injury:_____

Responsible Party (if different from above)

Guarantor Name (Last, First, M): _____ Maiden: _____

Sex: _____ Date of Birth: _____ Social Security:_____

Mailing Address: _____ City: _____, State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Emergency Contact (Other than living with)

Name: _____ Relationship: _____ Phone: _____

DOB:_____

Insurance Information

Primary Insurance: _____ Card Holder:_____ DOB:_____

Secondary Insurance: _____ Card Holder:_____ DOB:_____

Release of Information

I, _____, give LGMD permission to release/disclose my medical records to the following persons/entities: (i.e. Spouse, son/daughter etc…) _____,

_____, _____, _____

_____ _____

Patient's Signature Date

_____ _____ _____

Guardian or Representative Relation to Patient Date

New Patient History Form
Acadiana Orthopedic Center of Southwest

Symptoms – Check all the symptoms you currently have.

General	Gastrointestinal	Respiratory
☐ Chills	☐ Diarrhea	☐ Cough
☐ Fever	☐ Vomiting	☐ h/o COPD
☐ Loss of Weight	☐ Stomach Pain	☐ h/o Asthma
☐ Nervousness	☐ Indigestion	☐ Shortness of Breath
☐ Sweats	☐ Nausea	☐ Sleep Apnea

Muscle/Joint/Bone		Neurological	Psychiatric
Pain, weakness, numbness in:		☐ Numbness	☐ Anxiety
☐ Arm	☐ Hips	☐ Tingling	☐ Depression
☐ Back	☐ Legs	☐ Concussion	☐ Hallucinations
☐ Feet	☐ Neck	☐ Head Aches	☐ Sleep Disturbance
☐ Hands	☐ Shoulders	☐ Strokes	

EYE, EAR, NOSE, THROAT	Cardiovascular
☐ Blurred Vision	☐ Chest Pain
☐ Sinus Problems	☐ Irregular Heart Beat
☐ Hoarseness	☐ Low Blood Pressure
☐ Loss of Hearing	☐ Poor Circulation
☐ Loss of Hearing	☐ Rapid Heart Beat
☐ Ringing in Ears	☐ Swelling of Ankles
☐ Vision – Halos	☐ Swelling of Ankles
☐ Vision - Flashes	☐ Varicose Veins

Preferred Pharmacy: _____

Name and Address

Pharmacy Phone: _____

*I certify that the above information is correct to the best of my knowledge; I will not hold my doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature **Date**

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CONSENT AND FINANCIAL AGREEMENT

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:
I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Lafayette Health Ventures, Inc. or its designee. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I understand there is a $15.00 charge for all NSF Checks.

CONSENT TO TREATMENT:
I hereby voluntarily and knowingly consent to and authorize my physician or other health care professional, or his or her designee, other members of Lafayette General Medical Doctors (hereinafter the "Clinic") professional staff and its employees, either severally or collectively, to carry out, or cause to be carried out, diagnostic testing, examination and/or medical treatment, including any and all procedures which my physician or his or her designee, in their best judgment, may deem proper for my health care. I acknowledge that no guarantees have been made as to the result of treatments or examinations.
I hereby grant permission for the Clinic to view external prescription history and/or external health information documents and incorporate these into my medical record.

WAIVER OF LIABLILTY FOR PROSSESSIONS:
I hereby agree and it is understood that the Clinic is not responsible for the damage, loss and/or theft of any personal property I may retain in my possession while a patient.

AUTHORIZATION FOR RELEASE OF INFORMATION:
For purposes of expediting payment of my account and processing of benefit claims resulting from my visit and for the assessment of damage claims or potential claims against the Clinic, the hereinafter listed Health Care Providers, my attending or consulting physicians and their insurers, I hereby expressly waive my rights and privilege under Louisiana Revised Statute 13:3734 (said Statute) and authorize the release of my patient information directly to my insurer(s), worker's compensation carrier or other medical compensation benefit provider(s) as well as to insurer(s) of Clinic, to my attending physician, or their insurers, or the legal representatives of any of them as well as to any collection agency or attorney if my account is not paid within a reasonable time. This authorization includes all medical, administrative and financial records, information and transactions, including all personal and insurance data, photographs, drawings or other graphic representations contained therein, as well as the "communication" of such information as defined by said Statute, regardless of whether such payment information is in oral, written or printed form or is mechanically stored on microfilm, magnetic tapes or other audio and/or visual media. I further authorize, and agree to be bound by, the use of carbon or photostatic reproductions of this assignment.

INSURANCE PRE-CERTIFICATION
I hereby expressly understand I am responsible for the notification to my insurance company to obtain authorization before service is rendered. I understand if this is not done, insurance benefits may be reduced.

I certify that I have read the foregoing legal instrument and that I understand each of the provisions contained therein. I agree that the terms of this agreement are binding upon me until the end of this calendar year unless I expressively revoke any or all of them in writing directed to and received by the Clinic.

Patient	Date
Representative Signature	Relationship to Patient
Witness	Guarantor Signature Required (For Minor in non-emergent situation)

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LAFAYETTE GENERAL MEDICAL DOCTORS
Acknowledgment of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices. This includes the situation where your first date of service occurred electronically.

If your first date of service with us was due to an emergency, we will try to give you our Notice of Privacy Practices and get your signature acknowledging receipt of the Notice as soon as we can after the emergency.

I have received a copy of **LAFAYETTE GENERAL MEDICAL DOCTORS** Notice of Privacy Practices.

_____
Patient's Name - Print

_____ _____
Patient's Signature or Personal Representative's Signature **Date**

If signed by Patient's Personal Representative:

_____ _____ _____
Personal Representative's Name - Print **Relation to Patient/Role** **Date**

LAFAYETTE GENERAL MEDICAL DOCTORS USE ONLY

Date Acknowledgement Received: _____

If Acknowledgement was NOT received:

1. The patient or his/her Personal Representative did not sign this Acknowledgment Form because:

   - ☐ Patient/Personal Representative did not respond
   - ☐ Patient/Personal Representative declined to sign
   - ☐ Emergency treatment and patient left before signature obtained
   - ☐ E-mail receipt verification
   - ☐ Other: _____

2. The following good faith efforts were made to obtain signature:

   - ☐ Face to face presentation
   - ☐ Telephone contact
   - ☐ Mailings
   - ☐ E-mail
   - ☐ Other: _____

Staff Signature: _____
Print Name: _____

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Patient Bill of Rights

Your rights and responsibilities

At LGMD, we view health care as a partnership between you and your health care team. Good health care delivery depends upon a cooperative relationship between you and your physician, as well as between you and the Clinic. We respect your rights, values, and dignity. You will receive safe, high-quality medical care regardless of your race, color, national origin, religion, gender, age, or disability. In exchange, we ask that you recognize the responsibilities that come with being a patient, both for your own well-being, and that of your fellow patients and health care providers.

Patient responsibilities

You are responsible for providing us with as much information as possible about your health, medical history, and insurance benefits. Patients and families, as appropriate, must provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matters relating to their health. Patients and their families must report perceived risks in their care and unexpected changes in their condition. They can help the hospital understand their environment by providing feedback about service needs and expectations.

You are responsible for asking your care provider for help or clarification when you do not understand medical words or details about your care plan.

You are responsible for following your care plan/instructions. Patients and their families must follow the care, treatment, and service plan developed. They should express any concerns about their ability to follow the proposed care plan or course of care, treatment, and services. The providers/clinic makes every effort to adapt the plan to the specific needs and limitations of the patients. When such adaptations to the care, treatment, and service plan are not recommended, patients and their families are informed of the consequences of the care, treatment, and service alternatives and not following the proposed course.

You are responsible for asking questions. Patients and families, as appropriate, must ask questions when they do not understand their care, treatment, and service or what they are expected to do.

You are responsible for accepting consequences. Patients and their families are responsible for the outcomes if they do not follow the care, treatment, and service plan. This includes compliance with medication regimen including narcotics.

You are responsible for following the clinic's rules and regulations.

You are responsible for acting in a manner that is respectful of other patients, staff, and clinic property.

You are responsible for meeting your financial obligation to the clinic.

You are responsible for keeping scheduled appointments or to cancel at least 24 hours in advance.

Complaint Resolution

Our goal is to go above and beyond what's expected of us in meeting your health care needs. If we are not meeting your health care needs or expectations, we encourage you to speak with any member of our health care team.
If your concern cannot be promptly resolved, we encourage you to contact the leadership of the department and/or the Patient Representative at (337) 289-7280. Our Patient Representative serves as a liaison between you and the clinic, and helps you resolve any concerns, complaints or questions you may have regarding your care or service.

I have read the above and understand my rights and responsibilities as an active participant in my healthcare. I understand failure to comply with medical regimen and clinic policies may result in dismissal from practice.

_____	_____
Signature of Patient/Legal Representative	Date
_____	_____
Print name of the Patient/Legal Representative	Relationship to Patient
_____	_____
Witness	Witness

Patient Label

Lafayette General Health

Lafayette General Medical Center
University Hospital & Clinics
Lafayette General Surgical Hospital
Oil Center Surgical Plaza
Lafayette General Medical Doctors
Lafayette General Southwest
St. Martin Hospital
Abrom Kaplan Memorial Hospital
Acadia General Hospital
Cancer Center or Acadiana
Cyberknife Center of Louisiana
Lafayette General Imaging
Lafayette General Endoscopy

CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE

Patient Acknowledgement Form

I hereby consent to be photographed while receiving treatment at this healthcare organization. The term "photograph" includes video or still photography, in digital or any other formats, and any other means of recording or reproducing images.

I authorize the use or disclosure of such photograph(s) in order to assist with identification, scientific research, treatment, educational, medical records. I and my successors or assigns hereby hold this healthcare organization, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

_____ _____
Patient's Signature Date

_____ _____ _____
Guardian or Representative Relation to Patient Date

FORM TITLE: Consent to Photograph
CONSENTS

Form # 7660-000-172
Revision Date: 5/23/2016