TOC
THE ORTHOPAEDIC CLINIC

MEDICAL HISTORY

Patient Name:				Date:	
Physician:	Referring MD:		Family MD:		
DOB:	Age:	☐ Right Handed	☐ Left handed	Height:	Weight:
Address:					
Home Phone:	Work Phone:		Cell Phone:		

HISTORY OF PRESENT ILLNESS

Describe your problem or reason for your visit:		
Is this the result of an injury?	Date of Injury:	Where did injury occur?
☐ YES ☐ NO	How did the injury occur?	

EVALUATION OF PAIN / DISCOMFORT

What body part is affected?

When did the problem start?

When does the problem occur?

What makes it feel better?

What makes it feel worse?

How long does it last?

Pain Scale	MILD			MODERATE			SEVERE				(circle one number)
	No Pain	1	2	3	4	5	6	7	8	9	10

What activities are you unable to do?

Does the pain wake you from sleep?	☐ YES	☐ NO	Is pain activity related?	☐ YES ☐ NO

PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing:	☐ X-Ray	☐ CT	☐ MRI	☐ EMG	☐ Other:
Medications:					
Anti-inflammatories:	☐ Helpful	☐ Not Helpful	Chiropractics:	☐ Helpful	☐ Not Helpful
Injections:	☐ Helpful	☐ Not Helpful	Accupuncture:	☐ Helpful	☐ Not Helpful
Physical Therapy:	☐ Helpful	☐ Not Helpful	Where?		
Other treatment for this injury:					
Have other doctors seen you for this condition?	☐ NO	☐ YES	Whom?		
Is this condition covered by Worker's Compensation?		☐ YES	☐ NO		
Is there a lawsuit or litigation pending in regard to this injury?		☐ YES	☐ NO		

PAST MEDICAL HISTORY (check all that apply)

☐ Diabetes	☐ Ulcers	☐ Rheumatoid arthritis
☐ High Blood pressure	☐ HIV / AIDS	☐ Seizures
☐ Stroke	☐ Hepatitis	☐ Asthma
☐ Heart Disease	☐ Vascular disease	☐ Anemia
☐ Bleeding tendencies	☐ Tuberculosis	☐ Cancer
☐ Blood clots	☐ Osteoarthritis	☐ Phlebitis
☐	☐	☐

Do you have any: ☐ Internal Metal ☐ Joint Replacement ☐ Cardiac stent / pacemaker ☐ Brain Clip

Patient Name:	DOB:	Page 2

PAST SURGICAL HISTORY (list all surgeries, hospitalizations and/or serious injuries)

	Year:		Year:
	Year:		Year:
	Year:		Year:

MEDICATIONS (list all prescription and non-prescription)

Name of Medication	Dose	How Often	Name of Medication	Dose	How Often

ALLERGIES / ADVERSE REACTIONS

List:

FAMILY HISTORY (check all that apply)

☐ Cancer (type)_____	☐ Phlebitis	☐ Musculoskeletal disease
☐ Heart Disease	☐ Rheumatoid Arthritis	☐ Seizures
☐ Stroke	☐ Diabetes	☐ Asthma
☐ Tuberculosis	☐ Malignant hyperthermia	☐ Anemia
☐ Osteoarthritis	☐ Bleeding disorder	☐ Anesthesia difficulties

SOCIAL HISTORY (check all that apply)

☐ Married	☐ Single	☐ Divorced	☐ Widowed
☐ Live alone	☐ Live with family	☐ Live with friends	☐ Nursing home
Do you feel safe in your environment?	☐ YES ☐ NO		
Smoking ☐ YES ☐ NO	How many packs per day?	How many years?	
Alcohol ☐ NONE	☐ MINIMAL	☐ MODERATE	☐ HEAVY
Occupation:	Employer:	Last day worked:	
Current dental problems?	☐ Abscess	☐ Infection	☐ Other
Date of last menstrual period:	Are you Claustrophobic?	☐ YES	☐ NO

REVIEW OF SYSTEMS (check all that apply)

Skin	☐ Rash	Throat	☐ Sore throat	GI	☐ Weight loss or gain
	☐ Psoriasis		☐ Hoarseness		☐ Abdominal pain
Heme	☐ Bleeding Tendencies		☐ Snoring		☐ Liver disease
	☐ Bruise easily	CV	☐ Heart attack		☐ Constipation
Eyes	☐ Vision loss		☐ Irregular heartbeat	GU	☐ Kidney stones
	☐ Double vision		☐ Chest pain or pressure		☐ Bladder infections
Ears	☐ Decreased hearing	Lungs	☐ Shortness of breath		☐ Blood in urine
	☐ Ringing in ears		☐ Asthma	Endo	☐ Diabetes
Nose	☐ Sinus problems		☐ Bronchitis		☐ Thyroid
	☐ Breathing problems		☐ Pulmary emboli / DVT	Skeletal	☐ Osteoporsis
Psych	☐ Depression	Neuro	☐ Seizures		☐ Rheumatoid Arthritis
	☐ Hallucinations		☐ Headaches		☐ Gout

WILLIS-KNIGHTON HEALTH SYSTEM

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
METHODS OF COMMUNICATION

2600 Greenwood Road Shreveport LA 71103 (318) 212–4000

Willis–Knighton Health System (WKHS) and our medical staff will use and disclose your personal health information ***to treat you, to receive payment for the care we provide and for other healthcare operations***. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities and on our website and have copies available for distribution.

Occasionally we may communicate with patients via text or email regarding things such as **appointment reminders, requests to share your opinion of providers and services, news and notices about providers, treatments, technology, medications or other services/information that could benefit your health**. (In some instances, depending on your mobile plan, text and data rates may apply.) Willis–Knighton will communicate for Willis–Knighton purposes only and will not sell or share your mobile number or email with companies not contracted with Willis–Knighton.

I hereby acknowledge the receipt of Willis–Knighton Health System's Notice of Privacy Practices and have been provided an opportunity to review it.

_____ _____
Patient's Name (Please Print) **Date of Birth**

_____ _____
Patient/Representative Signature **Date**

If you are not the patient, indicate your relationship below:

☐ parent or legal guardian of the minor ☐ spouse

☐ personal representative of the patient ☐ other _____

Name _____

Address _____ Phone Number _____

Willis–Knighton takes your medical confidentiality very seriously. We will not and cannot release information without your written authorization. This authorization allows our staff to speak with an individual(s) you designate in the event you are not available to receive phone calls or you have another adult who helps coordinate your medical care.

☐ I DO NOT authorize anyone to receive information regarding my medical care

☐ I authorize my physician and employees of Willis–Knighton to speak with the following:

Person _____ Relationship _____ Phone _____

Person _____ Relationship _____ Phone _____

Person _____ Relationship _____ Phone _____

If you wish to opt out of electronic communications as noted in the second paragraph of this document, you may do so by checking this box: ☐

If at some point in the future you wish to receive these communications, you may request a new form to update your preferences at any registration desk at Willis–Knighton.

DR0005

WILLIS-KNIGHTON HEALTH SYSTEM

ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x–ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third–party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third–party payors for the purpose of performing pre–certification, concurrent and/or retrospective review and/or other utilization review of any kind. I hereby authorize the hospital to release all test results to my insurer(s).

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis–Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness''). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co–insurance, non–covered charges and other items not paid by insurance or other third–party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third–party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third–party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment. WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date:

Admission Time:

WILLIS-KNIGHTON HEALTH SYSTEM

ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one–third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis–Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis–Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

Signature of Patient/Guardian	Date/Time	Guarantor	Date/Time	Witness	Date/Time

Print Name	Date of Birth	Print Name	Print Name

If Patient/Guarantor is unable to sign, I, _____ , do hereby state that I have been given the authority to sign for

_____ , either expressed or implied and that he or she is fully aware of this authority.

Signature of Authorized Party	Authorized Party's Relationship to the Patient	Date/Time	Witness	Date/Time

Admission Date:

Admission Time:

AD0005

WILLIS-KNIGHTON HEALTH SYSTEM

Clinic Patient Information Record

Patient Name/Last:	First:	Middle:	SSN:
Residence Address:	City:	State:	Zip:
Mailing Address: (Check here if same as above) ☐			
Home Telephone Number:	Cell Phone Number:	Email Address:	
Date of Birth/Month: Day: Year:	☐ Male ☐ Female	Race:	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Employer's Name:	Work Telephone Number:		Ext:
Preferred Language: ☐ English ☐ Spanish ☐ Other Communication Needs	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced		
Responsible Party: (check here if same as above) ☐			
Name/Last: First:	Middle:	Responsible party's SSN:	Date of birth:
Mailing Address:	City:	State:	Zip:
Home Telephone Number:	Relationship to Patient:		
Employer's Name:	Work Telephone Number:		Ext:
Responsible Party's Spouse's Name (if applicable):	SSN:		
In Case of an Emergency, who may we notify (other than someone living with you)	Relationship to Patient:		
Name:	Date of Birth:	Telephone Number:	
Address: City:	State:	Zip:	
Who referred you to our office?	Telephone Number:		
Insurance Coverage	Is your Illness/injury due to an Auto/Work Accident? Yes ☐ No ☐		
Insurance #1 Name of Insurance Company:			
Policy Number	Group Number:		
Employer:	Guarantor:		
Insurance # 2 Name of Insurance Company:			
Policy Number	Group Number:		
Employer:	Guarantor:		
Insurance # 3 Name of Insurance Company:			
Policy Number	Group Number:		
Employer:	Guarantor:		
Preferred Pharmacies:			

FS0005

Welcome to the Orthopaedic Clinic. Below are some important office procedures that we would like you to acknowledge and agree to with your signature.

Medication Refill Policy:

It is the policy of this office that medication will only be refilled during regular office hours. It is the patient's responsibility to monitor their medication and request refills **Monday through Thursday from 8:00am to 4:30 pm and on Friday from 8:00am to 12 noon. Please allow 24-48 hours for your prescription to be filled.**

Payment Policy:

Any Co-pay, deductible, or co-insurance will be collected on the date of your visit with us. We accept most forms of payment including cash, check, Visa and Mastercard, Discover and American Express.
We will be happy to file your insurance as a courtesy to you as long as the insurance information you provide is correct. In the event that your insurance carrier does not make payment or makes only partial payment for services rendered by The Orthopedic Clinic, the undersigned shall be obligated to pay all of such sums of the balance due within 60 days. If you have an HMO or PPO insurance, it is your responsibility to verify that the doctor you are seeing is a participating provider and that you will be receiving In Network benefits.

Potential Liability

Action against someone else is not a reason to delay payment. Charges incurred are the responsibility of the individual receiving treatment. If you are here as a result of any injury that you feel is not the responsibility of your personal health insurance, all fees will need to be paid in full at the time of service.

Time Consideration

We acknowledge that our patients' time is valuable and we are working towards reducing your wait time. In order to aid in this process, **please expect to be treated for the complaint for which you originally requested an appointment. If you or any family member have an additional complaint that needs treatment, please feel free to make a separate appointment at the checkout counter.**

MRI, EMG and other Studies

If the doctor requests a study such as an MRI, EMG, etc be conducted, please allow us 48 hours to make an appointment for you before calling the office. Sometimes this process is delayed while waiting on verification of benefits from your insurance and we are asking for your patience. Once your study is complete, allow another 48 hours to be called with your results.

Forms

There will be a charge of up to **$50.00 per form** for the following forms: Any and all disability forms, Any and all insurance forms including credit insurance forms, and FMLA forms. These forms will not be completed until the fee has been pre paid.

Welcome to the Orthopaedic Clinic. Below are some important office procedures that we would like you to acknowledge and agree to with your signature.

Medication Refill Policy:

It is the policy of this office that medication will only be refilled during regular office hours. It is the patient's responsibility to monitor their medication and request refills **Monday through Thursday from 8:00am to 4:30 pm and on Friday from 8:00am to 12 noon. Please allow 24-48 hours for your prescription to be filled.**

Payment Policy:

Any Co-pay, deductible, or co-insurance will be collected on the date of your visit with us. We accept most forms of payment including cash, check, Visa and Mastercard, Discover and American Express.
We will be happy to file your insurance as a courtesy to you as long as the insurance information you provide is correct. In the event that your insurance carrier does not make payment or makes only partial payment for services rendered by The Orthopedic Clinic, the undersigned shall be obligated to pay all of such sums of the balance due within 60 days. If you have an HMO or PPO insurance, it is your responsibility to verify that the doctor you are seeing is a participating provider and that you will be receiving In Network benefits.

Potential Liability

Action against someone else is not a reason to delay payment. Charges incurred are the responsibility of the individual receiving treatment. If you are here as a result of any injury that you feel is not the responsibility of your personal health insurance, all fees will need to be paid in full at the time of service.

Time Consideration

We acknowledge that our patients' time is valuable and we are working towards reducing your wait time. In order to aid in this process, **please expect to be treated for the complaint for which you originally requested an appointment. If you or any family member have an additional complaint that needs treatment, please feel free to make a separate appointment at the checkout counter.**

MRI, EMG and other Studies

If the doctor requests a study such as an MRI, EMG, etc be conducted, please allow us 48 hours to make an appointment for you before calling the office. Sometimes this process is delayed while waiting on verification of benefits from your insurance and we are asking for your patience. Once your study is complete, allow another 48 hours to be called with your results.

Forms

There will be a charge of up to **$50.00 per form** for the following forms: Any and all disability forms, Any and all insurance forms including credit insurance forms, and FMLA forms. These forms will not be completed until the fee has been pre paid.

Signature:_____Date:_____

If applicable, please enter the date and time of your injury or accident here:_____