Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, entitled, “Notice of Privacy Practices” which sets forth this Group’s privacy practices and my rights regarding privacy of my protected health information.

_____ _____

PATIENT SIGNATURE **DATE**
Or Personal Representative

ASSIGNMENT OF BENEFITS

Patient:_____
Primary Insurance_____ Policy Number_____
Secondary Insurance_____ Policy Number_____
Patient/Policyholder SS#/ID_____

I hereby assign and authorize payment made directly to the above health provider for covered insurance benefits. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. **Any payment made directly to me by my insurance company for services, will be endorsed by me and forwarded to the billing office above.** I fully understand that I am financially responsible for and agree to pay all charges not paid by my health coverage, including deductibles, co-insurance and payments from insurance companies sent directly to me. I hereby agree to pay the provider any balance due within 30 days from presentation of my bill. Should my account become delinquent and collection efforts become necessary, I agree to pay all collection or attorney's fees incurred.

I have disclosed the names of all my health insurance providers including secondary and any liability coverage and I represent that such health care coverage is in full force and effect at this time. I have indicated in the record if my pain is the result of an injury or motor vehicle accident. I agree to promptly notify your office of any change of address or changes of insurance coverage. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

This Assignment shall apply to all services now rendered and to be rendered in the future until it is revoked by myself in writing. A photocopy of this Assignment shall be considered as effective and valid as the original.

I have had an opportunity to discuss with the physician or his staff to my satisfaction the nature of the services provided. I acknowledge that no guarantees have been made to me as to the results. I am satisfied that I fully understand this assignment and its significance.

I hereby authorize on my behalf, the provider to appeal any disputed unpaid health claims with the party responsible for payment. I authorize my provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____
Signature of Policyholder/Patient Date

ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE

I hereby assign and authorize payment made directly to **Houma Radiology** of the covered insurance benefits, including major medical benefits, whether payable to me by Medicare, Medicaid, or Medigap. **I fully understand that I am financially responsible for and agree to pay all charges not paid by my health coverage, including deductibles, co-insurance, and payments from insurance companies sent directly to me. In consideration of the medical services furnished to me, I hereby agree to pay Houma Radiology any balance due within sixty days from presentation of my bill. If my account should become delinquent and collection efforts become necessary, I agree to pay any reasonable collection or attorney's fees incurred.**

This assignment shall apply to all services now rendered and to be rendered in the future until it is revoked.

I have disclosed the names of all my health insurance providers including secondary and tie-in coverage and I represent that such heath care coverage is in full force and effect at this time.

I authorize the release of medical information as may be required to process the claims for payment of the medical services rendered and it is expressly understood that the right of such information to be privileged is hereby waived.

If prior authorization or certification for medical services is required under my health care coverage, I agree to obtain and furnish such authorization or certification.

I have had an opportunity to discuss with the physician or his staff to my satisfaction the nature of the services provided. **I acknowledge that no guarantees have been made to me as to the results.** I am satisfied that I fully understand this assignment and significance.

I agree to promptly notify your office of any change of address or changes in insurance coverage.

A copy of this assignment shall be considered as valid as the original.

X_____ X_____

Signature of Patient **Signature of Guarantor (if applicable)**

Date _____ Date _____

Social Security # _____ Social Security # _____

Employer-Firm _____ Employer-Firm _____

Insurance
Company _____ Insurance
Company _____

(Primary) (Secondary)

SIGN BELOW IF YOU HAVE A MEDIGAP INSURANCE POLICY (A secondary policy to Medicare)

MEDICARE LIFETIME MEDIGAP ASSIGNMENT

I assign and authorize payment of Medigap benefits to Houma Radiology for any services furnished to me by them. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

X_____ Date _____

Signature of Patient

Medigap No. _____ Medigap Insurer _____

(This assignment covers the physician's charges for their services.
Surgicenter or Hospital charges are billed separately.)

REV- 11/09/09

Headache & Pain Center, AMC
Day Surgery, Inc. / One Day Surgery, LLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

The following questions allow us to communicate with you regarding your personal health for treatment, payment of treatment, and healthcare operations.

Home Phone #: _____

☐ DO / ☐ DO NOT Leave messages on my home answering machine or cell phone
☐ DO / ☐ DO NOT Leave messages with family members

Whom may we speak with _____

Cell Phone #: _____

☐ DO / ☐ DO NOT Contact me by cellular phone
☐ DO / ☐ DO NOT Text me with appointment confirmation

Work Phone #: _____

☐ DO / ☐ DO NOT Contact me at work

PRIMARY PHONE NUMBER TO CONTACT PATIENT: _____

MAIL:

Contact me at the following address: ☐ Same as mail address
☐ Other _____

Headache & Pain Center, AMC / Day Surgery, Inc. / One Day Surgery, LLC considers patient privacy extremely important. There are times that we need to speak with family members or significant others about your care. Your PHI can be redisclosed by these individuals without providers consent. We ask that you list those persons that take an active part in your healthcare. This list can be changed, altered, or revoked at any time by providing a written request of a change of authorization. I have read and understand this authorization.

NAME:	RELATION:	PHONE:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature of Patient _____ **Date** _____

If not signed by the patient, please indicate Relationship: ☐ Parent or Guardian of Minor patient
☐Guardian or conservator of an incompetent patient ☐ Other _____

FOR OFFICE USE ONLY:

Signed Form received by: _____

Acknowledgment refused:
Efforts to obtain: _____
Reasons for refusal: _____

DISCLOSURE OF OWNERSHIP

The information provided is designed to disclose ownership and to answer any questions you may have regarding your medical care while you are a patient at Headache and Pain Center, AMC, Day Surgery, Inc. or One Day Surgery, LLC. Headache and Pain Center, AMC and all equipment therein is owned and operated by Jimmy N. Ponder, Jr., M.D. This includes open MRI, X-ray, and Bone Density testing. Your provider may order diagnostic tests during your treatment at Headache and Pain Center, AMC. Advanced Imaging will be performed at Headache and Pain Center, AMC unless you notify us on your first visit.

HOURS OF OPERATION

Headache and Pain Center, AMC operational hours are 7:00 a.m. to 5:00 p.m. Monday and Thursday, 8:00 a.m. to 5:00 p.m. Tuesday and Wednesday and 8:00 a.m. to 12:00 p.m. Friday. Except on occasion, Day Surgery, Inc. is closed Tuesday and Wednesday and open 8:00 a.m. to 4:00 p.m. Monday, Thursday, and Friday. Except on occasion, One Day Surgery, LLC is closed Monday, Thursday, and Friday and open Tuesday and Wednesday 8:00 a.m. to 4:00 p.m. We will make every effort to perform scheduled procedures on time.

FEES AND PAYMENT

You will receive separate statements which require separate payment to each company listed below if you are sedated for procedures performed at Day surgery, Inc. or One Day Surgery, LLC.

(1) Headache and Pain Center, AMC (physician's surgical/professional services).
(2) Day Surgery, Inc. (for use of the surgical facility in Gray, LA.).
(3) One Day Surgery, LLC (for use of the surgical facility in New Iberia, LA.).
(4) Advanced Anesthesia Services, LLC (if intravenous anesthesia is used for your procedure).

If you have insurance, including Medicare, we will help you receive maximum benefits by filing for you; however, we will expect payment of co-pays, co-insurance, and deductibles at the time of service. The undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim of any charges related to this account whether the above entity is in network or out of network. If charges remain unpaid, it may become necessary to turn the account over to a collection agency or attorney, these fees will be your responsibility.

PERSONAL VALUABLES AND MEDICATIONS

It is understood and agreed that Headache and Pain Center, AMC, Advanced Anesthesia Services, LLC, Day Surgery, Inc., or One Day Surgery, LLC will not be liable for any loss or damage to valuables, including but not limited to money, jewelry, glasses, dentures, fur items, documents, canes, or personal medical equipment or supplies, clothing, shoes or other apparel.

LIVING WILL/ADVANCED DIRECTIVES

Do you have a living will/advanced directives? __Yes__No. If yes, please provide a copy in the event you are transferred from our facility to another facility. If no, you may request information or forms regarding living will/advanced directives, alternative facilities, as well as Louisiana law and documents. I understand that the providers have not consented to honor a living will/advance directive and will not be liable for its terms.

I have read, or have had read to me, the above information and have received a copy of the Patient Rights and Responsibilities.

_____ _____

Patient Signature Date

DAY SURGERY, INC.

151 Frontage Road A
Gray, Louisiana 70359-6301

This letter is designed to assure that you receive the following information with each visit to Day Surgery, Inc.

1. LIVING WILL/ADVANCE DIRECTIVES

Do you have a living will (advance directives)? ____Yes ____No. If yes, please provide our staff with a copy in the event you are transferred from our facility to another facility; if no, you may request information and/or forms regarding living wills/advance directives. I understand that Day Surgery, Inc. has not consented to honor a living will/advance directive and will not be liable for its terms. Upon my request, Day Surgery, Inc. will provide information to me regarding Louisiana law and documents regarding advance directives, as well as alternative facilities that I may use.

2.PATIENT RIGHTS & RESPONSIBILITIES

A complete list of patient rights and responsibilities was provided to me prior to my initial visit to Day Surgery, Inc. I am aware that I may request an additional copy at any time.

3. DISCLOSURE OF OWNERSHIP

Day Surgery, Inc. is owned and operated by Jimmy N. Ponder, Jr., M.D.

I have read, or have had read to me, the above information.
I have received a copy of the Patient Rights and Responsibilities.

_____

Patient Signature Date

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, entitled, “Notice of Privacy Practices” which sets forth this Group’s privacy practices and my rights regarding privacy of my protected health information.

_____ _____

PATIENT SIGNATURE **DATE**
Or Personal Representative

Patient Intake Form

123 Frontage Rd A, Gray, LA 70359
Phone #: 985.580.1200 ● Fax #: 985.580.1218

531 Jefferson Terrace Blvd., New Iberia, LA 70560
Phone #: 337.560.0880 ● Fax #: 337.560.0870

●Today's date _____

●When did your pain begin? _____

● How did you find out about Headache & Pain Center? _____

● Who referred you to us? _____

● Who is your primary care physician (family doctor / PCP)?_____

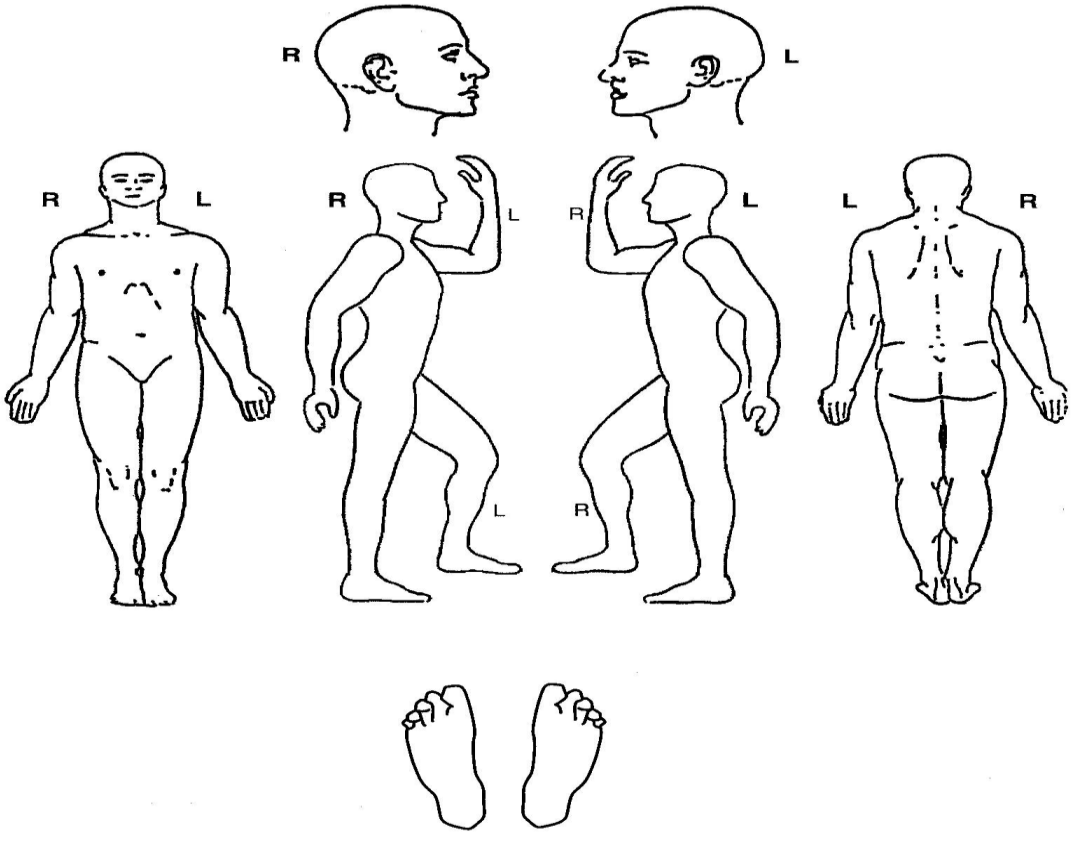
● List your other current doctors:_____

● To which doctors should we send our clinic notes? _____

● Have you seen anyone else for this problem (doctors, therapists, chiropractors)? Who?

_____

PLEASE **SHADE** IN, ON THE DRAWINGS BELOW, THE AREAS WHERE YOU FEEL PAIN.



PLEASE CIRCLE WHICH TREATMENTS YOU HAVE HAD FOR PAIN:

	DATE	HELPFUL	BY WHOM
EPIDURALS / NERVE BLOCKS / Other INJECTIONS (describe)		Yes / No	
Spine or Joint Surgery		Yes / No	
Therapy (Physical, Occupational, other)		Yes / No	
TENS / Neuromuscular Stimulator		Yes / No	
Chiropractor		Yes / No	
Biofeedback / Counseling		Yes / No	
Acupuncture		Yes / No	
Other:		Yes / No	

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD TO EVALUATE YOUR PAIN?

TEST	DATE DONE*	WHAT PART OF BODY *	WHAT FACILITY *	RESULTS IF KNOWN *
MRI				
CAT (CT) SCAN				
X-RAY				
EMG (TEST FOR NERVE DAMAGE)				
MYELOGRAM				
BONE SCAN				
LABORATORY (BLOOD TEST)				
BONE DENSITY				
EKG				
OTHER:				

***Please answer completely to the best of your knowledge.**

Are you **ALLERGIC** to medications, foods, or latex?_____

What medicine:	What happens? (ie rash, swollen throat, can't breathe etc):	What medicine:	What happens? (ie rash, swollen throat, can't breathe etc):

MEDICATIONS

What **medications** are you taking **now**?

Include prescriptions, vitamins, herbal supplements, & over the counter medications.

Medication & Dose	How do you take it?	Why Prescribed?	**Doctor** who prescribed it

Pharmacy name and location: _____**Phone #:**(___)_____

Are you on any of the following over the counter medications? (*Circle*) Aspirin, Angelica, Cloves, Danshen, Dong Quai, Feverfew, Garlic, Ginger, Gingko Biloba, Ginseng, Glucosamine, Green Tea, Horse Chestnut, Red Clover, St. John's Wort, Turmeric, Vitamin E.

Are you taking any **BLOOD THINNERS**? *Circle all that apply* **(Aggrenox, Persantine–Dipyridamole; Coumadin, Jantoven-Warfarin; Plavix-Clopidogrel; Ticlid-Ticlopidine, Pletal-Cilostazol, Effient-Prasugrel, Brilinta-Ticagrelor, Xarelto-Rivaroxaban, Trental (Pentoxifylline), Pradaxa (Dibigatran, Etexilate). Why?**_____

LIST medications tried in the past for pain or headaches that **did not** work:

_____

MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD OR PRESENTLY HAVE:

- ☐ Pacemaker
- ☐ Diabetes
  - Diet Controlled? Y/N
  - Do you take insulin? Y/N
  - Oral Medications? Y/N
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Irregular Heart Beat (explain type_____)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Easy Bleeding
- ☐ Claustrophobic
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Cancer Type:_____
  - Has it spread? Y / N
  - Where? _____
- ☐ Sleep Apnea
- ☐ Ulcers/Gastric Reflux
- ☐ Kidney Problems (Describe:_____)
- ☐ Lung Problems (COPD, Emphysema, Asthma)
- ☐ Current /Recent Infection
- ☐ Other Medical Problems or Diseases:_____ _____
- ☐ Seizures

Are you pregnant or plan to become pregnant? Y / N

Do you have any metal implants, orthodontic braces, metal piercings, or tattoos? Y / N

If yes, explain:_____

HEADACHE QUESTIONS

PLEASE FILL OUT IF YOU HAVE HEADACHES.

1._____ Is this the worst headache of your life?

2._____ How frequently do you have headaches; has the severity or frequency increased?

3._____ Was this a sudden headache that woke you from sleep?

4._____ Where are your headaches located?

5._____ Have you or a loved one noticed disorientation, memory problems, etc? Explain_____

6._____ What time of day do your headaches start?

7._____ Does it start with exertion (i.e. bowel movement, straining, exercise)?

8._____ From the beginning of the headache, how long does it take to reach maximum intensity (minutes, hours, etc.)?

9._____ How long do your headaches last?

10._____ Do you notice any symptoms before the headache begins ("aura")? Please explain "aura"._____

11._____ How would you characterize the headache pain? Is it burning, shooting, sharp, dull, pounding or other?

12._____ Does anything help the headache?

13._____ List of medications you are (if not yet listed) presently taking or have taken for headaches: _____

14._____ List other therapies for your headaches: _____

16._____ Do you have family members who experience headaches:_____

17._____ Are the headaches a sudden onset after the age of 50?

15._____ Do you experience any of the symptoms listed below during your headache?

	(Please Circle)			(Please Circle)	
Neck Stiffness	Yes	No	Tingling	Yes	No
Dizziness	Yes	No	Sensitivity to Light	Yes	No
Vomiting	Yes	No	Sensitivity to Noise	Yes	No
Numbness	Yes	No	Need to Walk or Move Around	Yes	No
Confusion	Yes	No	Disorientation	Yes	No

AMBULATORY SURGERY CENTER

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

Patient's have:

1. The right to quality care and treatment given with respect, consideration and dignity.
2. The right to appropriate privacy.
3. The right to the privacy of information regarding patient's diagnosis, treatment options, communication, and the potential outcomes of the treatment as well as access to information contained in his/her medical record.
4. The right to participate in decisions concerning care and treatment.
5. The right to know if the physician performing his/her procedure may have financial interest or ownership in this ASC.
6. The right to be informed of patient responsibilities, conduct, and ASC rules affecting the patient's treatment.
7. The right to knowledge of services provided at this facility.
8. The right to discharge instructions, including information about after hours' care.
9. The right to detailed information regarding service fees and all charges.
10. The right to refuse participation in experimental research.
11. The right to receive the policy on advance directives, and living wills in the facility and to be given information upon request.
12. The right to receive information on this ASC's non participation in advanced directives.
13. The right to knowledge of the medical staff credentialing process, upon request.
14. The right to know the names of those treating the patient.
15. The right to truthful marketing or advertising utilized by the facility.
16. The right to be informed if the physician does not carry malpractice insurance.
17. The right to address a grievance.
18. The right to refuse a treatment, as permitted by law. One can refuse treatment and still receive alternate care.
19. The right to be fully informed regarding one's condition.
20. The right to understand and sign an Informed Consent form before receiving care.
21. The right to appropriate assessment and management of pain.
22. The right to continuity of care. If overnight care is required, staff will arrange for transportation of a patient to the transfer hospital.
23. The right to respectful, safe care and treatment free from seclusion, restraints, abuse and harassment.
24. The right to have a family member notified of his/her admission as well as notification of his/her personal physician, if requested by the patient.
25. The right to leave the facility against the advice of his/her physician.
26. The right to express spiritual and cultural beliefs.
27. You have the right to exercise the above without being subjected to discrimination or reprisal.

Patient Responsibilities

1. The patient is responsible for providing accurate/complete information related to his/her health; reporting perceived risks in his/her care, and for reporting unexpected changes in his/her health.
2. The patient and family are responsible for asking questions when they do not understand, what a staff member has told them about the patient's care or expectations of what they are to do.
3. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
4. The patient is responsible for notifying the ASC office when unable to keep a scheduled appointment.
5. The patient is responsible for providing his/her healthcare insurance information, and assuring the financial obligations of his/her care are fulfilled as promptly as possible.
6. The patient is responsible for the consequences if he/she refuses treatment or fails to follow the practitioner's instructions.
7. The patient is responsible for being respectful and considerate of other patients and organizational personnel.

These rights and responsibilities outline the basic concepts of service here at the Ambulatory Surgery Center. If you believe, at any time, our staff has not met one or more of the statements during your care here, please ask to speak to the Medical Director or Nurse Manager. We will make every attempt to understand your complaint/concern. We will correct the issue you have if it is within our control, and you will receive a written response.

Kristen Cole, RN, DON Day Surgery, Inc. 151 Frontage Road-A Gray, LA 70359-6301 985.580.1200	Jennifer Stevens Haines P.O. Box 3767 Baton Rouge, LA 70821-0629 Phone: 225.342.2205 Fax: 225.342.0157	Web site for the Office of the Medicare Beneficiary Ombudsman: visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) or use www.cms.hhs.gov/center/ombudsman

Headache & PAIN CENTER amc
answertopain.com
Expert Pain Relief Since 1994

Patient's Demographic Information

Today's Date: _____

Patient's Name: _____

Spouse's Name: _____

Mailing Address: _____
Street City State Zip

Sex: _____ Date of Birth: _____ Age: _____ S.S. #: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Patient's Employer: _____ Phone #: _____

Self Employed: Yes / No Occupation: _____

Primary Insurance: _____ Secondary Insurance: _____

Guarantor's Name: _____ S.S. #: _____
(if different from patient)

Guarantor's Employer: _____ Phone #: _____

Was this condition due to an accident? Yes/No Date of Accident_____

Do you currently have any open claims? (If yes, please give detailed information): Yes / No

_____

Workers' Compensation? Yes / No Through Whom: _____

Attorney or Liability Insurance? Yes / No Through Whom: _____

This form was read and completed by whom? _____

Signature of Patient / Guardian: _____

Revised: 10/01/20 MT

HEADACHE & PAIN CENTER, AMC

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Patient Name:_____

Address:_____

Date of Birth:_____Social Security #:_____

I hereby authorize:

Facility/Provider Name:_____

Address:_____

Phone/Fax #:_____

To release copies of my health information, specifically:

_____ Any & all records
_____ Only the following test _____
_____ Only the following dates of treatment_____
_____ Other specific information

To:

Facility/Provider Name: HEADACHE & PAIN CENTER, AMC
Address: 123 Frontage Road-A, Gray, LA 70359-6301
Phone/Fax #: Phone: 985-580-1200 Fax: 985-580-1218

Purpose of Disclosure:_____

THE PATIENT MUST READ AND INITIAL THE FOLLOWING STATEMENTS:

- **I understand that my healthcare and payment for my healthcare will not be affected if I do no sign this form.**
- **I understand that I may see and copy the information described on this form if I ask for it, and that the Headache & Pain Center, AMC will give me a copy of this form after I sign it.**
- **I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.**
- **I understand that I may revoke this authorization at any time by notifying the Headache & Pain Center, AMC in writing, but if I do revoke it, the revocation will not have any affect on any actions the Headache & Pain Center, AMC took before it received the revocation.**

_____ _____
Signature of Patient **Date**

_____
Printed Name of Patient