John L Ledbetter, M.D.
Vince R. Forte, M.D.
J. Hardy Gordon, M.D.
Ronald L. Ellis, M.D.

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** _____-_____-_____

**Referring Physician:** _____ **Primary Care Physician:** _____

**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_____ Adjustor _____ Claim #_____

**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.***

***I hereby authorize and direct Drs. Ledbetter, Forte, Gordon and Ellis 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*** _____

LOUISIANA PAIN CARE

John L Ledbetter, M.D.
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Board Certified
Pain Medicine
Anesthesiology

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.

**NAME: _____ DATE: _____**

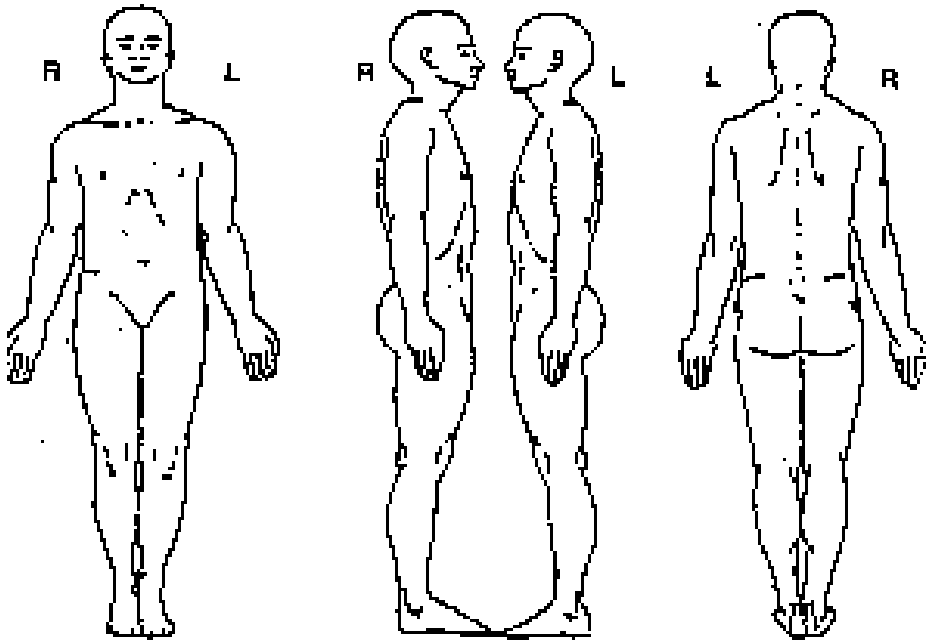
**AGE: _____ HEIGHT: _____ SEX: _____RACE: _____**

**REFERRING PHYSICIAN: _____ Phone #: _____**
**Please list any other physicians you have seen for your pain: _____**

**Please circle any diagnostic study you have had in the past to evaluate your pain (Circle all that apply)**
MRI----Bone Scan----Cervical X-ray----Thoracic X-ray----Lumbar X-ray----CT Scan----EMG/NCV----Myelogram

Is your pain the result of an accident? NO _____ YES _____ If yes, date of accident_____
Brief explanation of accident_____

**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

0-------1-------2-------3-------4-------5-------6--------7------8-------9--------10

10=extreme

210 LAYTON AVENUE SUITE 20, MONROE, LOUISIANA 71201

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

*Fellowship Trained Physicians Committed to Pain Solutions*

LOUISIANA PAIN CARE

Board Certified
Pain Medicine
Anesthesiology

John L Ledbetter, M.D.
Vince R. Forte, M.D.
J. Hardy Gordon, M.D
Ron Ellis, M.D.

**NAME: _____ DATE: _____**

**CHIEF COMPLAINT:**

_____
_____
_____
_____
_____

**MEDICATION ALLERGIES: Are you allergic to Betadine or Iodine? YES _____ NO_____**
**Please list all allergies:**

_____
_____

**MEDICATIONS: Please list all medications you are currently taking**

| MEDICATION | REASON TAKEN | HOW OFTEN | DOCTOR |
|---|---|---|---|
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210 LAYTON AVENUE SUITE 20, MONROE, LOUISIANA 71201

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Place a √ mark in each box of symptons you are experiencing **TODAY**

# Review of Systems

**Constitutional**
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight gain
- ☐ Weight loss

**Cardiovascular**
- ☐ Chest pain(tightness)
- ☐ Blood clots
- ☐ Heart murmur
- ☐ Irregular heartbeat
- ☐ Leg/Feet swelling
- ☐ Fainting spells
- ☐ Poor circulation
- ☐ High blood pressure

**Integumentary**
- ☐ Contact allergy
- ☐ Itchy skin
- ☐ Rash
- ☐ Skin infections
- ☐ Skin lesion
- ☐ Hair loss

**Metabolic/Endocrine**
- ☐ Cold intolerant
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Heat intolerant
- ☐ Diabetes

**HEENT**
- ☐ Blurred vision
- ☐ Double vision
- ☐ Difficult swallowing
- ☐ Facial pain
- ☐ Frequent headache
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Vision loss
- ☐ Nasal congestion
- ☐ Ear drainage
- ☐ Nose bleeds
- ☐ Sinus problems

**Gastrointestinal**
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Black tarry stool
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Hemorrhoids
- ☐ Vomiting blood
- ☐ Loss of bowell control

**Neurological**
- ☐ Difficulty walking
- ☐ Dizziness
- ☐ Poor coordination
- ☐ Memory loss
- ☐ Muscle weakness
- ☐ Seizures
- ☐ Tremors

**Psychiatric**
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Nervousness

**Hematologic**
- ☐ Bleeding
- ☐ Bruising

**Respiratory**
- ☐ Asthma
- ☐ Chest pain(respiratory)
- ☐ Cough
- ☐ Short of breath
- ☐ Recent infections
- ☐ Known TB exposure
- ☐ Wheezing
- ☐ Sleep Apnea

**Genitourinary**
- ☐ Frequent urination
- ☐ Urge incontinence
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Jaundice
- ☐ Blood in urine
- ☐ Vaginal pain
- ☐ Irregular menstral cycle
- ☐ Loss of bladder control

**Musculoskeletal**
- ☐ Arthritis
- ☐ Swollen joints
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Shoulder pain
- ☐ Chronic back pain
- ☐ Morning stiffness
- ☐ Muscle spasms
- ☐ Neck pain

**Immunological**
- ☐ Enviromental allergies
- ☐ Food allergies
- ☐ Seasonal allergies

Other Problems:

# Louisiana Pain Care, LLC

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. § 164.520

### Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("PHI"). PHI consists of individually identifiable health information, which may include demographic information we collect from you or create or receive by another health care provider, a health plan, your employer, or a health care clearinghouse, and that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

We must provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to PHI and make new privacy policies effective for all PHI that we maintain. We will post a copy of our current Notice of Privacy Practices in the waiting room, and keep a copy of the revised Notice at the registration desk, and provide you with a copy upon your request, and if we maintain a website, we will post our Notice of Privacy Practices on our website.

### Examples of Uses and Disclosures of Your PHI relating to Treatment, Payment & Operations

HIPAA privacy regulations give us the right to use and disclose your PHI without your consent to carry out (i) treatment, (ii) payment, and (iii) health care operations. Here are some examples of how we intend to use of your PHI in regard to your treatment, payment, and health care operations.

Treatment. In connection with treatment, we will, for example, use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We will disclose your PHI to other providers who may be treating you. Additionally, we may disclose your PHI to another provider who has been requested to be involved in your care.

Payment. We will use your PHI to obtain payment for our services, including sending claims to your insurer or to a federal program, such as Medicare, that pays for your treatment and sending you a bill for any amounts due which your insurer does not pay. We may also employ Business Associates, such as a billing company or collection agency to help us bill and collect. The PHI will

include items such as description of your condition(s), our treatment, your diagnosis, supplies and drugs we used, etc.

Health Care Operations. We will use your PHI to support our business activities, such as allowing our auditors, consultants, or attorneys access to your PHI to audit our claims to determine if we billed you accurately for the services we provided to you, or to evaluate our staff to see if they properly cared for you, or to send information about you to third party Business Associates so they may perform some of our business operations.

**Description of Other Required or Permitted Uses and Disclosures of Your PHI**

Appointment Reminders. We will call you to remind you of an appointment. We may call your residence, office, or any other number we have on file. We will leave a message if you are not in, and we will state the name of our clinic, the date and time of the appointment, and the address at which the appointment is to be kept. We may also mail you a notice of your appointment to any address we have on file.

As Required by Law. We will use and disclose your PHI when required to by federal, state, or local law. For example, we may receive a subpoena for which we are required by law to provide copies of your medical file.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your PHI to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Workers Compensation. We will use and disclose your PHI for workers compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. If you are an inmate, we will use and disclose your PHI to a correctional institution or law enforcement official only if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Other Services and/or Fundraising. We may use your PHI to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your PHI to contact you in an effort to raise funds for our operations, however, you have the right to opt out of receiving any fundraising communications by sending a letter to our Privacy Officer in writing at the address at which you are treated.

**Uses and Disclosures to which You have an Opportunity to Object**

Others Involved in Your Care. We may provide relevant portions of your PHI to a family member, a relative, a close friend, or any other person you identify as being involved in your medical care or payment for care. If you bring someone with you into a treatment room, you are hereby notified that you will have identified that person to us as being involved in your care or payment for your care, by voluntarily bringing them in the room. If you do not object to us discussing your PHI in front of them, we may discuss your PHI in their presence because you did not object. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it after the emergency, and give you the opportunity to object to future disclosures to family and friends.

**Uses and Disclosures that Require Your Signed Authorization**

There are certain uses and disclosures of your PHI that require your written authorization. For example, most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require your signed authorization. Also, any use or disclosure of your PHI not described in this Notice requires your signed authorization.

**Your Right to Revoke Your Authorization**

If you sign an authorization allowing us to use or disclose your PHI outside of the uses and disclosures made in this Notice, you may revoke that authorization by advising us in writing with a letter addressed to Privacy Officer, at the address where we treat you. Your revocation will become effective as soon as we are reasonably able to enter it into our records, which is typically within 5 business days after we receive the letter. Your revocation will not affect our prior reliance on your authorization prior to the effective date of revocation.

**Your Right to Restrict Certain PHI to a Health Plan**

You have the right to require us to restrict any disclosure of your PHI to a health plan regarding an item or service for which you (or someone on your behalf - other than a health plan) paid out-of-pocket to us the entire amount due for the health care item or service which we provided and billed to you. You must make such a request in writing to us, with a letter addressed to Privacy Officer at the address where you receive your treatment. If you make such a request, we are required to honor it.

**Notification in Case of Breach of Unsecured PHI**

In the event of an unauthorized or improper use or disclosure of your PHI (i.e., a “breach”), you have the right to receive, and we will notify you of the circumstances surrounding, the breach, what we have done to investigate and mitigate it, and how to best protect yourself in our opinion.

**Patient Rights Related to PHI**

In addition to your other rights provided herein, you have the right to:

Request an Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our Privacy Officer, stating what information is incomplete or inaccurate and the reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason that we believe supports the request. We may also deny your request if the information was not created by us, or the person who created it is no longer available to make the amendment.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to the Privacy Officer addressed to the address at which you receive care. We are not required to agree to your request. If we do agree, we will comply with your request except for emergency treatment.

Inspect and Copy. You have the right to inspect and copy the PHI we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer at address at which you receive treatment. We will have 30 days to respond to your request for information that we maintain at our facility. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay. HITECH expands this right, giving individuals the right to access their own e-health record in an electronic format if we maintain your records in an electronic format, and to direct us to send the e-health records directly to a third party. We may only charge for labor costs under electronic transfers of e-health records.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests; however, we will not accommodate a request that we perceive is an attempt to avoid receiving notice of a bill for the payment of our services.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us or directly to the Secretary of the United States Department of Health and Human Services: U.S. Department of Health & Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201, Phone: (202) 619-0257, Toll Free: (877) 696-6775. To file a complaint with us, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer at the address at which you were treated. No patient will be retaliated against for making a complaint.

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

**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).**

## Contact Person

You may contact our Privacy Officer at the following phone number for any questions:
Phone number: 318-323-6405

## Effective Date

The effective date of this revised Notice of Privacy Practices is March 26, 2013.

## 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**

**AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION**

1. I, _____, hereby authorize _____ to disclose the following protected health information to:

Louisiana Pain Care
210 Layton Avenue
Monroe, LA 71201
(318) 323-6405
(318) 807-0239 (fax)

2. The specific information subject to this authorization is:

_____
_____
_____

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

_____
_____

4. This authorization shall be in force and effect until _____ at which time this authorization to disclose this protected health 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 consent a claim under the policy.

6. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure 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.

_____ _____
Name of Patient or Representative Date

_____ _____
Signature of Patient or Representative Description of Representative's authority

# LOUISIANA PAIN CARE

## AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

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

2. The specific information subject to this authorization is:
   _____
   _____
   _____

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

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 re-disclosure 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 the 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 Representative's authority



**Date:** _____

**Patient's Name** _____

**Patient's Date of Birth** _____

**I understand that during the course of my treatment I will incur charges from both Louisiana Pain Care, LLC ("LPC") and ArkLaMiss Surgery Center, LLC ("ASC"). I also understand that on occasion there may be overpayments ("credit balances") made by my insurance company or me to LPC or ASC. I hereby agree that if I owe money to either LPC or ASC at a time when either LPC or ASC owes me for credit balances, LPC may pay ASC the credit balance otherwise owed to me if I owe ASC any money, and ASC may pay LPC the credit balance otherwise owed to me if I owe LPC any money.**

**Patient's Signature**

_____

**210 Layton Avenue, Suite 20** **Monroe, LA 71201** **Phone (318) 323-6405**


# NOTICE TO ALL LOUISIANA PAIN CARE PATIENTS

As our practice has grown, it's been increasingly difficult to schedule appointments in our office. One way we can address this is to increase the available appointment "slots" by minimizing patient "no-shows." We have thereby instituted a $30 fee for any missed appointment that occurs without a 24 hour prior notice.

We appreciate your understanding in this attempt to better serve all our patients.

I have read the above policy and understand my financial obligation to Louisiana Pain Care. Should I not be able to make a scheduled appointment, I will give at least 24 hours prior notice or be assessed a fee of $30.00.

Patient Signature Date

Print Name DOB Date