Anesthesiology & Pain Consultants, LLC

Welcome to our practice!

We are pleased you have chosen us to be part of your care.

Our goal is to provide excellent care for you and your family.

Enclosed is a packet of information for your review and completion. The following information is enclosed in your packet: A medication list, privacy form, information sheet and pain evaluation forms. Please take a few minutes to read the enclosed information and complete the forms. This will help to shorten the time of your visit with us.

If you should have any questions before your visit, please do not hesitate to contact us at your earliest convenience at (337) 988-5646.

Again, welcome to Anesthesiology & Pain Consultants. We look forward to providing excellent care for you.

NOTICE OF PRIVACY POLICIES FOR

Anesthesiology & Pain Consultants, LLC

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Rev.07/2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are required by law to provide you with this notice of our legal duties and the privacy practice that we maintain in our practice concerning your PHI. We are also required to notify any affected individuals following a breach of any unsecured protected health information. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgement of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

C. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe the different ways in which we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and list an example. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for, or we might disclose your PHI to a pharmacy when we order a prescription for. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information of our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Business Associates. Our practice may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain and/or transmit protected health information about you, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information.

5. Appointment Reminders. Our practice may use and disclose your PHI to contact you via phone or other means to remind you of an appointment.

6. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

7. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information.

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

   - maintaining vital records, such as births and deaths
   - reporting child abuse or neglect preventing or controlling disease, injury or disability
   - reporting to state and federal tumor registries
   - notifying a person regarding potential exposure to a communicable disease
   - notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - reporting reactions to drugs or problems with products or devices
   - notifying individuals if a product or device the may be using has been recalled
   - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); However, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
   - Providing proof of immunization to a school that is required by state or other law to have such proof with agreement to the disclosure by a parent or guardian of, or other person acting in loco parentis for an un-emancipated minor

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made a effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

   - regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - concerning a death we believe has resulted from criminal conduct
   - regarding criminal conduct at or offices
   - to identify / locate a suspect, material witness, fugitive or missing person
   - in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner of death. If necessary, we also may release information in order for funeral directors to perform their jobs. Also, we may disclose decedent's PHI to family members and others involved in care/payment for care of decedent prior to death, unless inconsistent with prior expressed preference.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waive of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (a) an adequate plan to protect the identifiers from improper use and disclosure; (b) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (c) adequate written assurances that the PHI will not be reused or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Fundraising Activities. We may contact you as part of our effort to raise funds for our Organization. You have a right to opt out of receiving fundraising communications and all fundraising communications will include information about how you may opt out of future communication.

9. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

10. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

11. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

12. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

13. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs. These programs provide benefits for work-related injuries or illness.

14. Individuals Involved in Your Care or Payment for Your Care. Our practice may disclose your PHI to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends of your condition. In addition, we may

disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. However, except in emergency situations, we will inform you of our intended action prior to making any such use or disclosure and will, at that time, offer you the opportunity to object.

E. OTHER USES OF YOUR PROTECTED HEALTH INFORMATION THAT REQUIRE YOUR AUTHORIZATION

With few exceptions, we must obtain your written authorization for uses and disclosures of your protected health information involving (1) certain marketing communications about a product or service and whether financial remuneration is involved, (2) a sale of protected health information resulting in remuneration not permitted under HIPAA, (3) disclosure of immunization information, authorization can be verbal or written; and (4) psychotherapy notes, except for certain treatment, payment and health care operations purposes, if the disclosure is required by law or for health oversight activities, or to avert a serious threat. If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

F. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Anesthesiology & Pain Consultants, 1103 Kaliste Saloom Road, Suite 304, Lafayette, LA 70508.** Your request must specify the method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure you had. Except as provided below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

   Effective September 23, 2013, we will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the Organization has been paid out-of-pocket in full. The Organization is not responsible for notifying subsequent healthcare providers of your request for restrictions on disclosures to health plans for those items and services, so you will need to notify other providers if you want them to abide by the same restriction. To request restrictions, you must make your request in writing to the **Anesthesiology & Pain Consultants, 1103 Kaliste Saloom Road, Suite 304, Lafayette, LA 70508.** In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

3. Inspection and Copies. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information compiled in anticipation of or for use in civil, criminal or administrative proceedings, or certain information that is governed by the Clinical Laboratory Improvement Act. If the requested protected health information is maintained electronically and you request an electronic copy, we will provide access in an electronic format you request, if readily producible, or if not, in a readable electronic form and format we mutually agree upon. We may charge a reasonable cost-based fee consistent with HIPAA and Louisiana law. To inspect and copy medical information that may be used to make decisions about you, you must submit your rerquest in writing to **Anesthesiology & Pain Consultants, 1103 Kaliste Saloom Road, Suite 304, Lafayette, LA 70508.** Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information. To request an amendment, you must make your request in writing to the **Anesthesiology & Pain Consultants, 1103 Kaliste Saloom Road, Suite 304, Lafayette, LA 70508.**

5. Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information made during the six-year period preceding the date of your request. However, the following disclosures will not be accounted for: (i) disclosures made for the purpose of carrying out treatment, payment or health care operations unless HIPAA provides otherwise, (ii) disclosures made to you, (iii) disclosures of information maintained in our patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (iv) disclosures for national security or intelligence purposes, (v) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure,(vi) disclosures that occurred prior to April 14, 2003, (vii) disclosures made pursuant to an authorization signed by you, (viii) disclosures that are part of a limited data set, (ix) disclosures that are incidental to another permissible use or disclosure, or (x) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure for the period requested unless the period or right to receive the accounting is limited under HIPAA. To request this list or accounting of disclosures, you must submit your request in writing **Anesthesiology & Pain Consultants, 1103 Kaliste Saloom Road, Lafayette, LA 70508.** Your request must state a time period. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free of charge, but our practice may charge you for additional lists within the same 12-month period. We will notify you of the cost involved with additional requests, and you may choose to withdraw or modify your request at that time before any costs are incurred.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer – 337-988-5646. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

G. QUESTIONS OR CONCERNS:

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer at 337-988-5646.

Anesthesiology & Pain Consultants, LLC

PAYMENT POLICY

Important Changes - Please Read!

Thank you for choosing us to be part of your care. We appreciate your confidence in our care, and our goal is to provide you with excellent care and service after your procedure while minimizing any adverse financial problems.

It is our policy that all terms and conditions of your insurance plan are honored in compliance with state, federal and local laws, regulations and guidelines. Consequently, we are unable to waive deductibles, coinsurance amounts, copayment amounts or other amounts for which you are responsible to pay under the terms of your health plan. We will assist any way possible in the payment of any outstanding balance.

In the event your procedure is not covered by your health plan or you have no health insurance benefits, discounts or alternate payment arrangements are available through our office. We will do everything possible to inform you in advance of services ordered by your doctor that we know are not covered by your insurance plan. Our financial counselors will be happy to provide an estimate of your responsibility resulting from our services.

We encourage you to contact our office at (337) 706-1654 to speak with any of our courteous patient service representatives. Our office hours are Monday through Thursday 8:00 AM to 5:00 PM and Fridays 8:00 AM to 12:00 PM.

Attached to this notice are details of other important information concerning our mutual responsibilities concerning your bill. Please take a few minutes to review these important details.

If at any time you have any questions or concerns regarding your bill or the financial impact of your procedure, please feel free to contact us at your convenience at the number above.

Thank you for your consideration.

Anesthesiology & Pain Consultants, LLC

ASSIGNMENT OF BENEFITS AND RIGHTS STATEMENT

If you have health and accident insurance coverage, including worker's compensation benefits, automobile insurance or Medicare, your signature in the attached packet, that is to be filed in your chart, evidences your agreement to irrevocably assign and transfer all right, title and interest in any benefits payable under such programs to Anesthesiology and Pain Consultants. You agree to authorize and direct that any such payments be made directly to Anesthesiology and Pain Consultants. You further agree to irrevocably assign and transfer to Anesthesiology and Pain Consultants any and all of your rights to pursue administrative appeals of denials of claims for benefits and to assert legal claims or causes of action that my arise against your insurer or health plan for wrongful denial of claims for benefits. This transfer and assignment shall be for the sole purpose of granting Anesthesiology and Pain Consultants the independent right of recovery against your insurer or health plan, but shall not be construed as creating an obligation to exercise such rights.

This office will file on your behalf insurance claims for all services performed by our physicians upon receipt of necessary insurance information. This is a service that we provide, but please remember that you may be ultimately responsible for payment if your insurer or health plan does not pay in full.

Anesthesiology & Pain Consultants, LLC

ADDITIONAL DETAILS CONCERNING YOUR BILL

Payment is due upon receipt of your bill. If you are unable to meet your financial obligations, please contact our office as soon as possible to avoid collections activity that may negatively impact your credit history.

Depending upon your insurance carrier or health plan, the amount you may owe may include copayment amounts, coinsurance amounts, your deductible or the entire amount of your bill.

We will submit your claim (bill) to your insurance company based upon the information you provide us. It is important that this information is up to date, accurate and current to avoid delays which may result in you owing the full amount of your bill. Delays in payment from your insurance company beyond the time frame allowed by law will be billed to you.

In the event your insurer does not cover part or your entire bill based upon your health plan, you will be billed for this amount. This amount will be reported as your responsibility on your insurance carrier's Explanation of Benefits (EOB). It is important for you to review your EOB once received in the mail and to call our office with any errors.

Balances remaining unpaid will incur a rebilling charge or interest each month. Nonpayment of amounts due will negatively impact your credit rating.

Most importantly, as part of our goal to provide excellent service to you, we strive for fairness in the conduct of our business practices. If at any time you believe you have been treated unfairly or that you have not received excellent service, we encourage you to call the telephone number below and report your issue. We will work to resolve any issue you may have.

Report Service Problems: (337) 988-5646 "Ask for the Supervisor"

Anesthesiology & Pain Consultants, LLC

FINANCIAL DISCLOSURE STATEMENT

In an effort to provide the highest quality and the most cost effective treatments for our patients some or all of the physicians in our group have ownership in Park Place Surgical Hospital, Lafayette Surgical Specialty Hospital and APC Pharmaceuticals.

You have choices to where your surgery, procedure or therapy is performed. If you have any questions regarding this, you can discuss them with your physician at any time.

Anesthesiology & Pain Consultants, LLC

NOTICE TO PATIENTS:

In order to provide more effective and efficient care to you, we would like to inform you of our policies regarding clinic hours, missed appointments, and medication refills.

CLINIC HOURS

The pain clinic is open Monday through Thursday from 8:00 a.m. until 5:00 p.m. and on Fridays until 12:00 noon. Should an emergency arise, you should go to the nearest emergency room. Refills are not considered a medical emergency and will not be handled over the weekend or holidays.

MEDICATION REFILLS

Medically indicated refill requests will be honored the same day only if the request is made before 12:00 noon on regular business days Monday through Thursday. If you call after 12:00 noon Monday through Thursday, your request will be addressed the following clinic day. Refill requests will not be accepted after 5:00 p.m. on clinic days nor on weekend or holidays. *We will not accept refill requests on Fridays.* Refills are not considered a medical emergency and will not be handled over the weekend or holidays.

You should anticipate your medication refill needs and have your pharmacist call before you run out of your prescription. In addition, you should only have one physician managing your pain medications and utilize only one pharmacy for dispensing those medications.

MISSED APPOINTMENTS

If you find you will be unable to keep your appointments, please call the office to reschedule or cancel. This will make the appointment time available for someone else.

Because missed appointments have become an increasing problem, we reserve the right to bill patients for the missed office visit if you do not call to cancel or reschedule. We regret the need to do this but feel it is in the best interest of our practice. If you have any questions regarding these policies, please call our office at 337-988-5646.

Anesthesiology & Pain Consultants, LLC

NO-SHOW AND LATE CANCELLATION POLICY

Thank you for choosing us to be part of your care. We appreciate your confidence in our care, and our goal is to provide you with excellent care and service before and after your visit.

It is our policy that all appointments must be cancelled or rescheduled 24 hours prior to the scheduled appointment. You can cancel or reschedule your appointment by contacting your physician's scheduler at (337) 988-5646.

Our scheduling lines are open 24 hours a day, 7 days a week. In the event that you receive the scheduler's voicemail, please leave the cancellation on the voicemail and the scheduler will contact you as soon as possible to reschedule. If calling after office hours, when the voicemail answers, dial your correct scheduler's extension to leave a message.

Failure to contact the appropriate scheduling personnel 24 hours prior to a scheduled visit to cancel or reschedule your appointment will result in you being billed a $50.00 no-show fee. This fee must be paid in full prior to rescheduling any future appointments.

Please feel free to contact our customer service specialist at (337) 988-5646 ext. 258 with any questions regarding this policy.

Thank you for your consideration.

Anesthesiology & Pain Consultants Inc.

Wheelchair and Sedation Policy

I acknowledge that at some point in my treatment that I may be required to undergo sedation or to otherwise undergo treatment or procedures that would impair my mental status and might affect my coordination.

I acknowledge the advisability of submitting to transport from the clinic facility to my vehicle by wheelchair.

I understand the risk of noncompliance, and agree as part of my pain contract to comply with any request by the clinic for me to be transported by wheelchair.

I also agree to make arrangements to have a driver at such times so that I will not operate my vehicle in these instances. I understand the risk of noncompliance, and agree as part of my pain contract to comply with any request by the clinic for me to make arrangements for a driver.

I agree to assume all risk of damage in the event of noncompliance. I acknowledge that at no time this clinic will waive these policies or agree to such noncompliance, and that any noncompliance is against medical advice.

Witness _____ Patient _____

1103 Kaliste Saloom Road, Ste. 304
Lafayette, LA 70508
Phone: (337) 988-5646 Fax (337) 769-9994

Anesthesiology & Pain Consultants, LLC

Authorization to Obtain or Disclose Protected Health Information

I, _____, (DOB: _____) hereby authorize Anesthesiology & Pain Consultants, Inc. to obtain, use or disclose the following protected health information:

1. Health information regarding my therapy at treating facility;
2. Payment/billing information regarding my charges for services rendered by treating facility;
3. Information to complete an excuse/release to work/school form
4. Other (please specify): _____
   for purposes of _____

The protected health information may be disclosed to (please name):

_____ My spouse: _____
_____ Any entity involved in my treatment care _____
_____ My school/employer: _____
_____ Other: _____

NOTE: An authorization is not required for use with any provider who has an indirect or direct treatment relationship with the patient (i.e. treating physicians, consulting physicians, worker's comp., auto insurance companies responsible for payment, etc.)

This protected health information is being used or disclosed only for payment, treatment, and/or operations. This authorization shall be in force and in effect until (check one) [ ] revoked or changed by me, in writing, at such time as the new authorization will become effective immediately, [ ] date: _____, or [ ] event: _____.

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to Anesthesiology & Pain Consultants, Inc., Attn.: HIPAA Compliance Officer, 1103 Kaliste Saloom Road, Suite 304, Lafayette, LA 70508.

I understand that a revocation is not effective to the extent that Anesthesiology & Pain Consultants, Inc. has relied on the use or disclosure of the protected health information. 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. I understand that the ASC will not condition my treatment on whether I provide authorization for the requested used or disclosure.

I understand I have the right to:

- Inspect or copy my 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.)
- Refuse to sign this authorization.

I attest that I have received a copy of the company's privacy practices.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

OPPORTUNITY TO OBJECT

I, _____, hereby object to the release of my protected health information to:

_____

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

A copy of this authorization will be provided to the patient and/or personal representative upon request.

Anesthesiology & Pain Consultants, LLC

Please fill out the following information for our records:

Name: _____

Address: _____

_____

Date of Birth: _____ Social Security No.: _____

Home Phone Number: _____

Alternate Phone Number: _____

Alternate Phone Number: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Email Address: _____

Insurance: _____

Anesthesiology & Pain Consultants, LLC

PATIENT STICKER HERE

Referring M.D.: _____

REVIEW OF SYSTEMS

Patients Complete ALL 3 pages and *BRING TO YOUR FIRST APPOINTMENT*
Please indicate by marking the box if you have experienced any of the following:

Eyes: ☐ Double vision ☐ Vision loss ☐ Blurry vision ☐ Eye drainage

Ear, Nose, Throat: ☐ Ear ache ☐ Ear drainage ☐ Difficulty hearing ☐ Ringing in ears ☐ Dizziness
☐ Nasal congestion ☐ Nasal drainage ☐ Sore throat ☐ Hoarseness ☐ Difficulty swallowing

Cardiovascular: ☐ Chest pain ☐ Irregular heart beat ☐ Swelling in legs or feet ☐ Shortness of Breath on exertion
☐ Sleeping on pillows to help breathing ☐ Pain in legs when walking ☐ Sleeping in Recliner

Respiratory: ☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Productive cough

Musculoskeletal: ☐ Back pain ☐ Neck pain ☐ Joint pain ☐ Swelling ☐ Muscle Pain

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Blood in stool ☐ Diarrhea ☐ Stomach pain

Genitourinary: ☐ Pain when urinating (peeing) ☐ Frequency in urination (peeing)
☐ Blood in urine (pee) ☐ Waking to urinate (pee)

Skin: ☐ Unusual redness ☐ Rash ☐ Birth marks ☐ Moles ☐ Scars ☐ Wounds

Neuro: ☐ Memory loss ☐ Loss of balance
☐ Muscle weakness (where?) _____
☐ Tingling (where?) _____
☐ Numbness (where?) _____

Psychiatric: ☐ Depression ☐ Anxiety ☐ Angry ☐ Crying Spells ☐ Difficulty with Concentration ☐ Substance Abuse

Hematologic/Lymphatic: ☐ Bruising (where?) _____
☐ Bleeding from gums ☐ Ulcers in mouth ☐ Recurrent infections

Endocrine: ☐ Heat intolerance ☐ Cold intolerance ☐ Weight loss ☐ Weight gain ☐ Increasing thirst

SOCIAL: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Pt. Occupation: _____ Spouse Occupation: _____

Are you ☐ Right handed ☐ Left handed

Children: How Many? _____ Ages? _____ Living at Home? _____

Alcohol Use: ☐ No ☐ Yes Smoker: ☐ No ☐ Yes How long? _____ Packs per day? _____

Dr. Initials_____ Date: _____

Anesthesiology & Pain Consultants, LLC

PATIENT STICKER HERE

Past Pain Doctors and Location: 1) _____ 2) _____ 3) _____

List all medications you are currently taking with dose and frequency: 1)

2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____

8) _____ 9) _____ 10) _____

Your allergies & describe reaction:

1) _____ 2) _____ 3) _____ 4) _____

List all Past Surgeries & Dates

_____

_____

_____

_____

List All Past Injuries

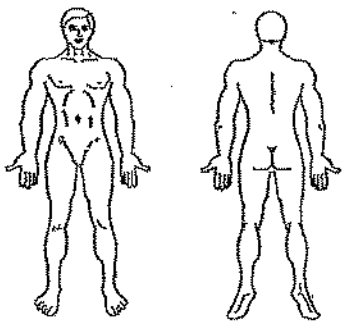
_____

_____

_____

_____

Why are you here today?



Location: _____

Quality: ☐ Burning ☐ Numbness ☐ Pins & Needles ☐ Shooting or shock like

☐ Stabbing ☐ Throbbing ☐ Sharp ☐ Pressure ☐ Pulling ☐ Dull ☐ Radiating

☐ Other: _____

Severity: (Functional Scale to be handed to patient at window) · VAS _____

Duration: Pain started _____

Timing: ☐ Constant ☐ Comes and goes ☐ Night ☐ Morning

Context: ☐ Work Injury ☐ Surgery ☐ Other: _____

☐ Medical Illness ☐ Accident at home ☐ Motor vehicle Accident ☐ Other Preexisting Conditions

Cause: ☐ Falling ☐ Lifting ☐ Pushing ☐ Being struck by an object ☐ Other: _____

What makes pain worse? _____

Better? _____

Current work status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Disabled (Give Date) _____ ☐ Retired (Give Date) _____

Has pain affected any of the following: ☐ Concentration ☐ Sleep ☐ Appetite ☐ Relationships ☐ Emotions

What types of activities do you do on a daily or weekly basis? _____

Identify medications you have tried for your pain in the past: *(Please Circle)*

☐ Tylenol (acetaminophen)

☐ Aspirin, Ibuprofen (Advil, Nuprine, Motrin), Dolobid, Naprosyn, Feldene, Lodine, Toradol, Voltaren, Cataflam, Ansaid, Oruvail, Clinoril, Relafen, Indocin, Prednisone, Medrol Dose Pack, Mobic, Arthrotec, Celebrex, Vioxx, Bextra

☐ Elavil (Amitriptyline), Sinequan (Doxepin), Pamelor (Nortriptyline)

☐ Diazepam, Valium, Xanax, Alprazolam, Ativan (Lorazepam), Effexor, Celexa, Topamax

☐ Lortab, Lorcet, Vicodin, Codeine, Tylenol #3, Tylox, Percocet, Percodan, Darvocet, Darvon, Demerol, Morphine

☐ Other: _____

☐ Lyrica, Neurontin, Tegretol (Carbamazepine), Dilantin, Mexilitene, Zanaflex, Skelaxin

☐ Please Indicate approximately the total number of pain pills you take per day: _____

Dr. Initials _____ Date: _____

Anesthesiology & Pain Consultants, LLC

PATIENT STICKER HERE

HISTORY / LIST OF MEDICAL PROBLEMS

Do you have or have you ever experienced any of the following?

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Irregular heart beat
- ☐ Heart valve disease
- ☐ Blockage of blood vessels
- ☐ Chest pain
- ☐ Heart failure
- ☐ Pacemaker
- ☐ Blood clots
- ☐ Heart defect at birth

- ☐ Tobacco use
- ☐ Lung infections
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Blood clots in lungs

- ☐ Fluid/salt imbalance
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Recurrent Urinary Tract Infections

- ☐ High blood sugar
- ☐ Low blood sugar
- ☐ Diabetes
- ☐ Overweight
- ☐ Thyroid disorders

- ☐ Hearing loss
- ☐ Vision changes
- ☐ Neuropathy
- ☐ Stroke/TIA
- ☐ Paralysis
- ☐ Seizures
- ☐ Substance abuse
- ☐ Alcohol dependency
- ☐ Drug abuse of which drugs?

_____

- ☐ Arthritis (Type) _____
- ☐ Osteoporosis
- ☐ Abnormal curvature of the spine
- ☐ Muscle Disease

- ☐ Reflux disease (heartburn)
- ☐ Ulcers of the stomach
- ☐ Hiatal hernia
- ☐ Intestinal obstruction
- ☐ Inflammatory bowel disease
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Jaundice

- ☐ Anemia
- ☐ Blood clotting abnormality
- ☐ Blood transfusions
- ☐ Reactions to blood transfusions

- ☐ Tuberculosis
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ AIDS

- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Dr. Initials _____ Date: _____

I have received, read and understand the following documents. I have been given the opportunity to ask any questions about these documents. Please sign by each document below.

1. Payment Policy Procedures:

_____ _____
Signature Date

2. Assignment of Benefits & Right Statement:

_____ _____
Signature Date

3. Notice of Privacy Policies:

_____ _____
Signature Date

4. Financial Disclosure Statement:

_____ _____
Signature Date

5. No-Show and Late Cancellation Policy:

_____ _____
Signature Date

PLEASE LIST ALL MEDICATIONS CURRENTLY TAKING

MEDICATION	DOSE	HOW MANY A DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

BRING THIS PAPER (FILLED OUT) AND YOUR MEDICATION IN ITS ORIGINAL PRESCRIPTION BOTTLE TO YOUR APPOINTMENT