Dear New Patient:

Welcome to our clinic! We are pleased that you chose Louisiana Arthritis and Rheumatology for your healthcare needs. Thank you for completing this new patient paperwork. Please make sure to complete and sign all forms as this will help speed up the check-in process.

If you have received this packet, this means we have spoken and scheduled your new patient appointment. If for some unseen reason you need to cancel or reschedule this appointment, please call or leave a message with our office. This will allow us to schedule another patient for that appointment.

Please be here at least 30 minutes prior to your appointments to fill out our business office forms. Sometimes they are enclosed with the packets, depending upon the timing of your appointment.

Please contact your insurance company to verify that we are contracted providers for your plan. If you are unsure, you may contact us at any time to verify. Also, remember to bring your current insurance cards along with photo ID with you.

Payments for your first visit as follows:

1. PPO or HMO – any deductible that has not been paid as well as the co-pay or co-insurance etc. will be subject to fulfillment depending on your insurance benefits. If you have an HMO plan that requires a referral number, make sure that we have received your referral number at least 24 hours prior to your appointment. Payment arrangements must be made in advance.
2. Medicare with supplement- payment is based on your supplement type.
3. Medicare without supplement – your 20% co- insurance will be due at the time of service.
4. No insurance- patients will be required to pay $210.00 for your appointment, this amount is due at the time of service.

What to expect at your appointment:

1. Your medical history, medications, and symptoms will be reviewed and entered by a staff member prior to visiting with the doctor.

2. On-site labs and off-site -xrays may be ordered at the time of the visit to further assess your symptoms. You do not need to fast for labs and can take medications as scheduled.
3. Your labs and x- rays will be reviewed before any medication is prescribed by the doctor. You will be notified by a staff member when the medication is sent to the pharmacy if this is part of your treatment plan.
4. Certain medications prescribed may require lab monitoring between appointments to keep you safe on the medication prescribed to treat your symptoms.

We look forward to meeting you soon. Should you have questions, please call us at 318.219.7704

Sincerely,

New Patient Coordinator

LOUISIANA ARTHRITIS AND RHEUMATOLOGY PATIENT REGISTRATION

Patient's Full Name:_____
(Last) (First) (MI)

Date of Birth:_____ SSN:_____ □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated Language: □ English □ Other: _____

Race: □ American Indian □ Asian □ Black □ Caucasian □ Hispanic □ Latino □ Other:_____

Mailing Address:_____ Physical Address: _____

City:_____ State:_____ ZIP:_____

Home Phone:_____ **Work** Phone:_____ **Cell** Phone: _____

Email:_____ *Would you like to enroll for the patient portal? □ YES □ NO

Preferred Method of Contact: □ Cell □ Home □ Work □ Email □ Text

Appointment Reminder Method: □ TEXT □ CALL □ EMAIL

Employer:_____ **Address:**_____

Emergency Contact (Outside the home) :_____ Relationship: _____ Phone:_____

Primary Care Physician (PCP): _____ Phone #:_____

Preferred Pharmacy:_____ **Address:**_____

Responsible Party:_____Relationship:_____

Address:_____ City:_____ State:_____ ZIP:_____

Date of Birth:_____ **SSN:**_____ Male □ Female □

Employer:_____ Work Phone:_____

Referred By:_____ How did you find out about our clinic?_____

Is this visit related to an injury? Yes □ No □ Date of Injury:_____ **Place of Injury:**_____

Workers Comp Carrier:_____ **Adjuster:**_____ **Claim#:**_____

Is this visit subject to payment for a Liability Claim? Yes □ No □ Carrier: _____

Primary Insurance:_____ Address:_____

Member Name:_____Policy #:_____ Group #:_____

Member Date of Birth:_____ SSN:_____Employer:_____

Secondary Insurance:_____ Address:_____

Member Name:_____Policy #:_____ Group #:_____

Member Date of Birth:_____ SSN:_____Employer:_____

I authorize Louisiana Arthritis and Rheumatology to verify benefits and file my insurance.

SIGNATURE:_____ **DATE:**_____

LOUISIANA ARTHRITIS & RHEUMATOLOGY
Get the personal attention you deserve.

8508 Line Avenue, Suite C
Shreveport, LA 71106
318.219.7704

Patient History Form

Name:_____ **Birthdate:**__/__/__

Past Medical History (Condition and Date of Diagnosis)

Past Surgical History (Type and Date)

Present Medications (Include Dose and Directions)

Drug Allergies

Social History:

Do you smoke? □ Yes □ No If yes, how much?_____For how long?_____

If no, have you ever? □ Yes □ No If yes, how much?_____For how long?_____When did you stop?_____

Do you drink alcohol? □ Yes □ No If yes, how much?_____How often?_____

Family History: (Please list immediate family members major illnesses/diseases MOTHER, FATHER, CHILDREN, SIBLINGS)

LOUISIANA ARTHRITIS & RHEUMATOLOGY
Get the personal attention you deserve.

Name: _____ _____

Date: _____

Today's Visit

What brings you in today?_____

What is your pain level today? (0= no pain; 1- = worst pain) _____

Do you have morning stiffness? _____

If yes, for how long? (circle one) 15 minutes or less 30 minutes 45 minutes 60 minutes several hours

How long have you had your symptoms? _____

What is the status of your symptoms? □ Improving □ Stable □ Worsening

What makes your symptoms better?_____

What makes your symptoms worse?_____

Do you have any other symptoms that are related to your primary problem? _____

Have you seen other physicians for your current problem?_____If so, whom:_____

Previous studies to evaluate your current condition:

	Procedure	Date	Results
1			
2			
3			
4			
5			

Previous treatments for your current condition:

	Treatment	When	Did it help? How?
1			
2			
3			
4			
5			

Have you had a DEXA scan (bone density)? □ Yes □ No If yes, when:_____Where:_____

Do you take ⍰ calcium and/or □ Vitamin D? ☐ No

Have you had a flu shot? □ Yes □ No If yes, when:_____

Have you had a pneumonia vaccine? Yes □ No□ If yes, when:_____

Review of Systems (Do you have any issues with the following?):

□ Joint Pain	□ Lymphadenopathy	□ Cough	□ Burning with urination	□ Raynaud's
□ Joint Swelling	□ Ulcers of Mouth/Nose	□ Nausea	□ Blood in urine	□ Dry eyes
□ Joint Stiffness	□ Skin Rash	□ Vomiting	□ Numbness	□ Dry mouth
□ Back/Neck Pain	□ Rash with sun	□ Diarrhea	□ Headache	
□ Muscle Weakness	□ Hair Loss	□ Constipation	□ Psychosis	
□ Fever/Chills	□ Chest Pain	□ Heartburn	□ Confusion	
□ Weight Change	□ Shortness of Breath	□ Blood in Stool	□ Seizures	

Louisiana Arthritis and Rheumatology

8508 Line Avenue, Suite C
Shreveport, LA 71106

To Prospective Patients:

LOUISIANA ARTHRITIS RHEUMATOLOGY welcomes the opportunity to provide the highest quality medical assistance and treatment to you.

However, because prior patients' involvement in their personal liability claims and/or lawsuits against third parties caused great administrative costs and burdens to LOUISIANA ARTHRITIS AND RHEUMATOLOGY; LOUISIANA ARTHRITIS AND RHEUMATOLOGY **does not evaluate and treat** patients who are involved in any actual or potential litigation and/or liability claims.

In connection with any medical condition which may be evaluated by LOUISIANA ARTHRITIS AND RHEUMATOLOGY medial staff, LOUISIANA ARTHRITIS AND RHEUMATOLOGY respectfully requests you acknowledge the following in the space provided below:

"THERE IS NO PENDING OR PROSPECTIVE LIABILITY CLAIM AND/OR LAWSUIT ASSOCIATED WITH MY MEDICAL CONDITION(S) TO BE EVALUATED TODAY BY LOUISIANA ARTHRITIS AND RHEUMATOLOGY."

LOUISIANA ARTHRITIS AND RHEUMATOLOGY reserves the right to cancel the appointment of any person who chooses not to sign the below confirming such person is not involved in any actual or potential litigation and/or liability claim related to their medical condition.

****The term "litigation" means any injury that could potentially be covered by another third party, such as an auto accident, malpractice claim, workers compensation claim, or any other accident that could be the responsibility of another person or company.**

Thank you for your anticipated understanding of LOUISIANA ARTHRITIS AND RHEUMATOLOGY position.

ACKNOWLEDGED AND AGREED TO:

THIS _____ DAY OF _____ 2024

_____
Signature

_____
Printed Name

LOUISIANA ARTHRITIS AND RHEUMATOLOGY
CARE CONSENT

Thank you for choosing Louisiana Arthritis and Rheumatology as your healthcare provider. We are committed to providing the best medical care possible. The following Care Consent must be read, agreed to and signed prior to your treatment.

1. I consent to all medical care, including laboratory and diagnostic procedures, provided by the physician(s)/practice or it's contracted vendor(s) as ordered by my physician. I understand that diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

2. **CONTRACTED SERVICES** Laboratory services provided in our office are provided by independent contractors and are not employees or agents of the practice/physician(s) and will bill directly for these services.

3. **ASSIGNMENT OF BENEFITS** Each person signing this Consent assigns all rights, title, interest and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the practice and/or affiliated physicians and authorizes direct payment to the practice for such services and treatment. The undersigned all assigns all benefits under the Social Security Act otherwise payable to the patient for the services at the rate not to exceed the practice's regular charges. Payment to the practice by an insurance company, according to this authorization, shall discharge the insurance company of any and all obligations under a policy to the extent of such payment. I further authorize payment directly to any contractors rendering professional services. Each person signing this Consent is financially responsible for charges not collected by this assignment. The undersigned understands that any health insurance policies under which coverage exists are secondary payers to the extent any existing liability policies or any other sources of payment that may or will cover expenses incurred for services and treatment.

   I hereby appoint the practice, affiliated physicians, and any agent acting on their behalf of practice as my authorized representative to pursue any claims, penalties and administrative and/or legal remedies on my behalf for collection against any responsible payor or third party liability carrier of any and all benefits due me for the payment of charges associated with treatment.

   MEDICARE PATIENTS: If applicable: **STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, AND PATIENT.**
   I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

4. **RELEASE OF INFORMATION** To the extent necessary to determine liability for payment and to obtain reimbursement, the practice and the patient's physicians may disclose the patient's records to the Social Security Administration, Insurance or benefit payor, health care service plan, or workers compensation carrier which is, or may be, liable for all or any portion of the practice's or laboratory charges. The practice may disclose the patient's records to treating physicians, hospital personnel, other health care providers, medical researchers, audit committees, care evaluators and applicable state and federal agencies. The practice may dispose of medical records in accordance with the state health record retention laws.

5. **PERSONAL VALUABLES** The practice is not responsible for the loss of or damage to any money, jewelry, documents, garments, dentures, prosthetic devises or other articles of personal property. We ask that you leave valuables at home or with a relative/friend.

6. **FINANCIAL AGREEMENT** As a courtesy, we will bill your insurance company for the services provided to you. We rely on information provided by you to file your claims and we are not responsible for denials if you do not provide the correct insurance information. Some procedures require pre-certification or an authorization before services are performed and we expect you to be aware of these situations. Please assist us by insuring that pre-certification is obtained prior to services.

   Your insurance policy is a contract between you and your insurance company. If we do not have a contract with your insurance company and they have not paid the claim within 60 days, the balance of your account may be billed to you. If payment is not received within 60 days after the account has been billed to you, your account will be considered due in full and may be placed for collection (see "Past Due Accounts" below). Please be aware that some services provided may be "non-covered" services and/or not considered reasonable and necessary under your plan. It is your responsibility to understand your covered benefits.

   In consideration of the services to be rendered to the patient, each person signing this Care Consent authorizes credit investigation and individually obligates himself/herself to pay the patient's account in accordance with the regular rates and terms of the practice. If the account is referred to an attorney or collection agency, the same person agrees to pay actual attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

Usual and Customary Payment - We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. Our fees are not negotiable and we will not accept "reasonable and customary" payments as payment in full. You will be responsible for any remaining balance.

Missed Appointments - Unless canceled at least 24 hours in advance, our policy is to charge $50 for a missed follow up appointment, $100 for a new patient appointment. Please help us to serve you better by keeping appointments scheduled. This fee is not covered by insurance so it will be your responsibility. If you arrive more than 15 minutes late to your appointment, you may be asked to reschedule.

Returned Checks - A fee of $25 will be charged for all checks returned to us as unpaid by your bank.

Your responsibilities:

1. Provide complete and accurate health insurance information.
2. Comply with the requirements of your health plan by understanding your benefits, obtaining proper authorization for services, submitting referrals, or completing forms required by your insurance company to resolve claims issues.
3. If your insurance plan requires you to obtain services from a participating provider, you must contact your insurance carrier to verify our physician(s)/practice is a participating provider for your network. Obtaining treatment from a non-network provider may cause denials and/or larger patient responsibility.
4. Respond promptly to requests you may receive from your health plan.
5. Pay co-payments, deductibles, coinsurance amounts and balances due at the time of your visit.

7. **HEALTH CARE SERVICE PLANS** Each person signing this consent is individually obligated to pay the full cost of all services rendered to the patient by the practice/physician if the patient belongs to a plan which does not contract with this office.

   This practice has no contract, express or implied, with ***Health Plus or any Bayou Health Medicaid Plans***.

8. **CONSENT TO CONTACT** You agree, in order for us to service your account or collect any amounts you may owe, we may contact you by telephone at any number that you have provided to us or may provide in the future, including cellular telephone numbers, which could result in charges to you. We may also contact you by sending you phone messages, text messages or emails using e-mail addresses that you have provided to us nor or in the future. Methods of contact may include using pre-recorded or artificial voicemail messages and the use of an automatic dialing device, as applicable. Your consent to contact you by these methods shall transfer to any of our affiliates, partners, agents or others calling at our request or on our behalf.

9. **PRIVACY POLICY**: I acknowledge receipt of the Notice of Privacy Practices. The Health Insurance Portability Act of 1996 (HIPAA) grants you the right to designate one or more individuals to act on your behalf regarding the protection of health information that pertains to you. This person shall be given all of the privileges that would belong to you regarding your health information. Your designation can be revoked at any time by signing a revocation and delivering it to practice. However, any revocation will not apply to the extent that persons authorized to use or disclose the health information have already acted in reliance on your previous designation.

Designated Personal Representative: ☐ None _____

Relationship: _____

AKNOWLEDGEMENT

My signature below acknowledges that I have been given the opportunity to satisfy myself by asking questions about this Care Consent form and the Conditions herein. I acknowledge receipt of Notices of Privacy Practices referenced herein. I voluntarily give my consent to care and I accept the Conditions herein. A photocopy of this authorization shall be considered as effective and valid as the original. I consent to and agree to assume responsibility for the Financial Agreement Assignment of Benefits and Health Care Service Plan as stated herein. I have the right to revoke this consent, in writing, at any time, except to the extent that the practice/physician has taken action in reliance on this consent.

Signature:_____ Date: _____

Print Name: _____

□ Patient □ Parent/Legal Guardian □ Other (Specify):_____

Witness:_____

LOUISIANA ARTHRITIS & RHEUMATOLOGY
Get the personal attention you deserve.

RELEASE TO:

8508 Line Avenue, Suite C
Shreveport, LA 71106
318.219.7704 PHONE
318.219.7752 FAX

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Requested From: _____ _____

_____ _____

Patient Name: _____ D.O.B. _____

Patient Address: _____City/State/Zip _____

Protected health information to disclose for treatment dates _____**to** _____

☐ Medical Records (last two years) ☐ X-Ray ☐ Lab Reports ☐ Entire Chart

☐ MRI Film/Report ☐ EMG Report ☐ Other _____

The above information is disclosed for the following purposes:

☐ Medical Care ☐ Legal ☐ Personal ☐ Insurance ☐ Other _____

_____ I specifically consent that the released information may contain alcohol and drug abuse, psychiatric, HIV, or genetic information.
(initials)

This authorization shall be in force and effect for two years at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Louisiana Arthritis and Rheumatology at 8508 Line Avenue, Suite C, Shreveport, LA 71106**. I understand that the revocation is not effective to the extent that Louisiana Arthritis and Rheumatology has relied on the use or disclosure of the protected health information. I further understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. There are associated fees for providing copies of medical records see LSA-R.S.40.1299.96A(2)(b).

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal or state law. I also understand I have the right to refuse to sign this authorization.

_____ _____ _____

(Signature of Patient) (Printed Name) (Date)

If signed by legal representative, relationship to patient: _____