LOUISIANA CARDIOVASCULAR & LIMB SALVAGE CENTER, A.P.M.C.

PATIENT INFORMATION

Please Print

Please bring with you:
Picture ID, Insurance cards, Current Medications or a Medication List

Patient Last Name: First MI

Address: City State Zip

Home Phone # Cell Phone #

Social Security # Date of Birth Gender Marital Status

Email Address Referred By:

Race:(circle one) White American Indian Asian Black or African American Other

Ethnicity: (Circle One) Hispanic or Latino Not Hispanic or Latino

Language _____

Employer's Name Phone #

Address City State Zip

Family Doctor Phone #

City State

Pharmacy Name Phone #

Address City State Zip

Emergency Contact Name Phone #

GUARANTOR INFORMATION (if different than above)

Last Name	First		
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Social Security #	Date of Birth	Gender	Relationship

You will be asked to provide insurance & identification cards so that we may gather the required information:

Primary Insurance _____ Subscriber Name

Secondary Insurance Subscriber Name

AUTHORIZATION TO PAY BENEFITS: I HEREBY ATHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO LOUISIANA CARDIOVASCULAR & LIMB SALVAGE CENTER, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO MY INSURANCE CARRIERS.

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE LOUISIANA CARDIOVASCULAR & LIMB SALVAGE CENTER, TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

LOUISIANA
CARDIOVASCULAR &
LIMB SALVAGE
CENTER, A.P.M.C.

Patient Name:_____Patient Date of Birth:_____

I understand that I am responsible for the payment of this account, subject to the terms noted below. I also agree to present my insurance card at each visit to Louisiana Cardiovascular and Limb Salvage Center, APMC (LCLSC) in order to allow for verification of insurance carrier information on file.

PRIVATE INSURANCE – As a courtesy to me, LCLSC will file my claims based on the information that I have provided. Should this information prove incorrect, I am responsible to pay the balance in full. I agree that my insurance benefits may be paid directly to LCLSC and payment of all deductibles and co-payments are required at the time of service. Any allowable amount not paid by my insurance carrier must be paid within 30 days of receipt of a statement, unless previous arrangements have been made with the Office Administrator (not the physician).

MEDICARE - LCLSC accepts Medicare assignment (Medicare approved charges). I understand that I am responsible for any deductible(s) or co-payment(s). If there is a Medicare supplement insurance policy, LCLSC will file my claims as a courtesy to me, and the benefits may be sent directly to LCLSC.

MEDICAID – I understand that LCLSC accepts Medicaid and that I must present a current Medicaid card at each visit. If Medicaid discontinues or denies these benefits, I agree to be responsible for payment of the account in full.

WORKER'S COMPENATION – I agree to allow LCLSC to verify my Worker's Compensation coverage with my employer or my employer's insurance carrier. The employer or insurance carrier may request medical information in order to process claims. Any requested information sent to my employer or the insurance carrier will also be provided to me. I agree to be responsible for payment of all charges which are not paid by my employer or its Worker's Compensation insurance carrier.

NO INSURANCE – If there is no insurance or other such coverage for the charges of this account, I agree to pay the full balance of all charges at the time of service, unless previous arrangements have been made with the Office Administrator (not the physician).

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered to me by LCLSC. If I fail to make any payment due as outlined above or as agreed upon, LCLSC may turn this account over to a collection agency and/or attorney for handling. If such action is taken on this account, I agree to pay the reasonable fees of said collection agency and/or attorney. I also acknowledge that it is my personal responsibility to make sure that all pre-certifications required by my insurance provider are completed according to my contract with them. I certify that the information on this form is true and correct to the best of my knowledge and that I will notify you of any changes in my status or the above information.

_____ _____

Patient/Responsible Party Signature Date

PLEASE PRINT

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

Please check symptoms/conditions you currently have or have had in the past that may indicate cardiac or heart disease.

____ Family history of cardiac or heart disease
____ Heart Disease
____ Heart Attack
____ Heart Surgery
____ Heart Stents
____ Chest Pain
____ High Blood Pressure
____ Low Blood Pressure
____ Irregular Heart Beat
____ Rapid Heart Beat
____ Pacemaker
____ Dizziness or Lightheadedness
____ Fainting/Near Fainting
____ Blurred vision
____ Vertigo
____ Passing Out
____ Shortness of Breath
____ Decrease in Exercise Capacity

Please check symptoms/conditions you currently have or have had in the past that may indicate leg or arm Peripheral Vascular Disease (PAD/PVD).

____ Numbness or tingling of the arms, legs, or feet
____ Cold or "cool to the touch" of the arms, legs, or feet
____ Thick skin/thickening of the skin or dark skin of the legs around/above the ankles
____ Stroke
____ TIA
____ Wounds/Sores that will not heal
____ Peripheral Artery Disease (PAD/PVD)
____ Varicose Veins or Spider Veins
____ Venous Insufficiency
____ Blue Discoloration of the toes
____ Kidney Disease
____ Dialysis
____ Decrease in exercise capacity
____ Abdominal pain or swelling
____ Abdominal pain after eating
____ Leg pain when walking
____ Leg pain while sitting/laying down
____ Leg weakness
____ Swelling of the legs/ankles
____ Swelling of the arms

Acknowledgement of Receipt of Notice Of Privacy Practices and Consent to Disclosures

Louisiana Cardiovascular & Limb Salvage Center
Louisiana Cardiovascular & Nephrology Center of Excellence

A copy of the Notice of Privacy Practices of Louisiana Cardiovascular & Limb Salvage Center and Louisiana Cardiovascular, Limb, Foot and Wound Center of Excellence (collectively, "LCLSC") has been made available to me. This notice states in detail how my protected health information may be used and disclosed as permitted under federal and state law. I understand that I should read it carefully and that I may direct any questions, concerns or complaints regarding the privacy practices of LCLSC to the Privacy Officer, whose contact information is below. I am aware that the Notice may be changed at any time. I may obtain a revised copy of LCLSC's Notice by requesting one at any of my office visits.

I give my consent to LCLSC to use and/or disclose my protected health information for the purposes of treatment, payment, and health care operations as allowed by HIPAA.

Contact the Privacy Officer: 901 Wilson Street ; Lafayette, LA 70503; Phone: (337) 456-6523; Fax: (337) 456-6521;

Print Patient Name:_____

Date of Birth:_____

Patient Signature:_____

Date:_____

As the patient's personal representative, I acknowledge receipt of the Notice on his or her behalf.

Signature:_____Printed Name_____

Relationship to Patient:_____ Date_____
LCLSC employee Witness_____ Date_____

LOUISIANA
CARDIOVASCULAR &
LIMB SALVAGE
CENTER, A.P.M.C.

PAIN MANAGEMENT CONTRACT

I understand that treatment by Physicians at Louisiana Cardiovascular & Limb Salvage Center may include an attempt to manage my pain, and that some of the medications needed may carry a risk of causing an addiction. Because of this, special care must be taken in their use.

As a result, I agree to the following:

1. That narcotics/opioids prescribed will be taken exactly as directed, with adjustments made only if and as instructed by the physician.
2. Narcotics/controlled substances will not be refilled via a telephone call. Patients will have to come in and see the physician in order to get the refill. This will allow the physician to re-evaluate the need for continued therapy with the narcotic/controlled medicine.
3. If a prescription for narcotic/controlled substance or medicine is lost or Stolen, before the refill is due, depending on the circumstances no refill will be authorized without a valid police report.
4. A refill will be authorized at the end of the month the prescription runs out and there will be no authorization for early refills for any reason.
5. There are no early refills for replacement of lost prescriptions, as federal law prohibits the writing of a certain number of pills at a time, and doctors and pharmacists are held accountable.
6. Attempts at altering prescriptions, selling medications, or obtaining narcotics from sources other than our physicians will end treatment immediately.
7. When there are no alternatives other than to manage my pain with long- term use of narcotics, I agree that regular attempts to reduce dosage and/or develop alternative approaches to functional comfort will be part of the plan, and I will cooperate with them.

I have read, understood, and agree to these terms and statements.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

LOUISIANA
CARDIOVASCULAR &
LIMB SALVAGE
CENTER, A.P.M.C. 337-456-6523
901 Wilson St., Lafayette LA 70503

Written Consent for Medical Information Disclosure

I,_____, request and authorize Louisiana Cardiovascular & Limb Salvage Center to use and disclose my protected health information, including my appointment information or in the event of an emergency, to the following individuals.

1 Name_____Phone_____

2 Name_____Phone_____

3 Name_____Phone_____

4 Name_____Phone_____

I understand that LCLSC will not use or disclose my protected health information, including appointment information, to anyone not on this list, unless otherwise allowed by state and federal law.

I understand that I have the right to revise this list from time to time and that this consent will remain in effect until altered by me, or my authorized representative.

I understand that I have the right to request that LCLSC restrict the use and disclosure of my protected health information if I present the request in writing. LCLSC does not have to agree with the restriction

_____ _____

Printed Name of Patient Signature Date

_____ _____ _____

Printed Name of Witness Signature Date

_____ _____

Office Representative Signature Date