William S. Johnson, III, MD
Linda G. Thompson, MD
502 Rue de Sante, Suite 106
LaPlace, LA 70068
(985) 653-5570

Account # _____ F/C _____

Resp. Party # _____ DR _____ LOC _____

I. PATIENT INFORMATION

Patient _____ Title: Mr/Mrs./Other: _____ Suffix: Jr./Sr./Other _____

Mailing Address _____ _____ _____ _____
City State Zip

Hm. Ph. _____ Wk. Ph. _____ Ext _____

Cell Ph. _____ Date of Birth _____ Sex: M F

Social Security # _____ Marital Status: Married Single Widowed Divorce (circle one)

Employer _____ Student: Full Part-time (circle one)

Referred by _____ Employment Status:

Date of Injury _____ Is the injury work related? _____

II. RESPONSIBLE PARTY INFORMATION

Responsible Party _____ Title: Mr./Mrs./Other _____ Suffix: Jr./Sr./Other _____

Mailing Address _____ _____ _____ _____

Hm. Ph. _____ Wk. Ph. _____ Ext _____ Date of Birth _____ Sex: M or F

Social Security # _____ Employment Status: Full-time Part-time Retired Self Employed Not Employed Unknown Military Active

Employer _____

III. INSURANCE INFORMATION

PRIMARY

Insurance Company _____

Address _____

_____ _____ _____
City State Zip

Patient's Relationship to Insured: Self Child Mate Other

Group # _____ Policy # _____

CoPay: Primary Care _____ Specialist _____

Insured's Name _____
Last First Middle

SECONDARY/SUPPLEMENTAL

Insurance Company _____

Address _____

_____ _____ _____
City State Zip

Patient's Relationship to Insured: Self Child Mate Other

Group # _____ Policy # _____

CoPay: Primary Care _____ Specialist _____

Insured's Name _____
Last First Middle

IV. INSURED INFORMATION

INSURANCE POLICY HOLDER

Address _____

_____ _____ _____
City State Zip

Ph. _____ Wk. Ph. _____ Ext _____

Address _____

_____ _____ _____ Hm.
City State Zip

Hm. Ph. _____ Wk. Ph. _____ Ext _____

River Region Orthopedics
502 Rue de Sante, Suite 106
Laplace, LA 70068
985-653-5570

This document contains the financial policies of our office. Please read it carefully before signing because you are agreeing to all of these provisions.

Payment: Your insurance co-payment is due on the day of your appointment. You may pay by cash, check, or credit card (Visa or MasterCard).

If you have no insurance, a $500 deposit is due at your first visit. You may pay by cash or credit card. Subsequent charges will be deducted from this deposit and any remaining deposit will be refunded to you.

Insurance: If your insurance company requires a referral from your primary care physician, you are responsible for obtaining this referral. Failure to obtain a referral may result in lower payment or no payment from your insurance company and you will be responsible for the charges.

We will bill your insurance company and you authorize payment directly to us. Once your insurance company determines the amount you owe us, based on your policy, this amount is due. We do send statements, but your balance is due even if you have not received a statement.

If your insurance company requests additional information from you and you fail to provide it in a timely manner, your insurance company will not pay us. You will be responsible for all charges.

Re-billing Fee: A re-billing fee of $5 will be imposed on each account that is over 30 days past due. We determine your account is past due by taking the balance you owed 30 days ago and subtracting any payments you made to the account during that time.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. (Currently this is 33 1/3% of the account balance.)

Returned Checks: There is a fee, currently $25, for any check returned by the bank.

Treatment of Minors: Any patient under the age of 18 must be accompanied by a parent or guardian. The person authorizing treatment for a minor will be responsible for the charges on the account. If a divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

I authorize insurance payments directly to River Region Orthopedics.

Signature: _____ **Date:** _____

Patient's Name (print): _____

Consent for the Use or Disclosure of Protected Health Information

River Region Orthopedics
502 Rue de Sante, Suite 106
LaPlace, LA 70068

As required by the Health Insurance Portability and Accountability Act of 1996 River Region Orthopedics may use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Privacy Practices by describing the requested restrictions on a Restriction Request Form. You may revoke this consent at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

CONSENT SECTION

I,_____(print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read River Region Orthopedics' Notice of Privacy Practices and to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing a Restriction Request Form. I further understand that River Region Orthopedics is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to 502 Rue de Sante, Suite 106, LaPlace, LA 70068. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

_____ _____

Signature Date

REVOCATION SECTION

I hereby revoke this consent.

_____ _____

Signature Date