DR. JOSEPH B. BOUCREE, JR., M.D.

PATIENT REGISTRATION FORM

LAST NAME: _____ **FIRST NAME:** _____ M.I. ____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SSN # _____-_____-_____ DOB: _____ MARITAL STATUS: _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ REFERRED BY: _____

EMERGENCY CONTACT NAME: _____PHONE:_____

IF YOU (THE PATIENT) **ARE NOT THE POLICY HOLDER** OF YOUR INSURANCE, PLEASE FILL OUT THE FOLLOWING INFORMATION SO WE MAY PROPERLY FILE YOUR CLAIM.

NAME OF INSURANCE: _____

POLICY HOLDER: _____

POLICY NUMBER:_____

DOB: _____ SSN# _____-_____-_____

RELATION TO PATIENT: _____ EMPLOYER: _____

IS AN ATTORNEY INVOLVED? ____YES ____ NO

NAME OF ATTORNEY: _____ PHONE #: _____

WHERE YOU INJURED ON THE JOB? _____YES _____NO

HAVE YOU REPORTED THIS TO YOUR EMPLOYER? _____YES _____ NO

COMPANY: _____ ARE YOU STILL EMPLOYED THERE? _____YES ____NO

I hereby authorize JOSEPH BOUCREE, MD (A.P.M.C.) to release to your company representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care.

I authorize and request your company to pay directly to the doctor the amount due me in my pending claim for Medical or Surgical treatment or services, by reasons of such treatment or services rendered to me. A photographic copy of this authorization shall be valid as the original.

DATE: _____ **SIGNATURE OF INSURED:** _____

I UNDERSTAND I AM FINACIALLY RESPONSIBLE FOR CHARGES AT ALL TIMES

Joseph B. Boucree, Jr. M.D.
Spine & Orthopaedic Surgery
Certification, Diplomate of the American Board of Orthopaedic Surgery
Fellow, American Academy of Orthopaedic Surgeons
www.spinecaredr.com
1570 Lindberg Dr.
Suite # 6
Slidell, La 70458
985-205-3456
985-288-0047(f)

CONSENT FOR TREATMENT

I voluntarily agree to receive medical treatment by Joseph B. Boucree Jr., MD and his medical staff.

I understand and agree that I will participate in my treatment plan and that I may discontinue treatment and/or withdraw my consent for treatment at any time.

Patient Name: _____

Patient Signature: _____

Date of Birth: _____

Date Signed: _____

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Financial Policy and Patient Responsibility

Patient's Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance, and co pays. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and /or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co pay at the time of service. There may be a $10 additional charge to bill for any co pay not paid at the time of service.
- To pay any Medicare deductible and co-insurance amounts not covered by their supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.
- A 60- day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.
- We require the worker compensation carrier's name and address prior to your visit. If the information is not provided, you are responsible for paying the full amount for all services on the day of service. Additionally, if your worker compensation claim is denied, you are responsible for all charges incurred.

Financial Policy Acknowledgement:

I have read and understood the above financial policy; I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, MasterCard, Visa, American Express, check or money order. I agree that if my account is referred to a collection agency or attorney I will be responsible for all cost of collection on my account including attorney's fees, and any interest or money due.

Patient Name (Please print): _____

Patient Signature: _____

Date of Birth: _____

Date: _____

Joseph B. Boucree, Jr. M.D.

Spine, Scoliosis & Orthopaedic Surgery

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of Joseph B. Boucree Jr., MD privacy notice.

I understand that a privacy officer has been appointed and that any questions regarding the privacy act may be directed to the HIPAA Privacy Officer.

I have read and understand the facility's privacy notice. I understand that I have the right to restrict how protected health information may be used. I also understand that the facility may refuse admission should the restrictions I place on my protected health information interfere with the ability to treat me; bill for services rendered or interfere with the operations of the facility.

_____ _____

Signature of patient Date

_____ _____

Signature of Facility Personnel Date

Joseph B. Boucree, Jr. M.D.

Spine, Scoliosis & Orthopaedic Surgery

HIPAA Authorization Form

Joseph B. Boucree Jr., MD has taken measures to protect all of our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurnace Privacy & Accountability Act) does allow us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital.

Please see the receptionist with any questions prior to signing this authorization form.

I, _____, am authorizing the person/people listed below to obtain medical information about myself. I understand Joseph B. Boucree Jr., MD is not responsible for the information provided as long as it is given to a person that I have listed below.

Date of birth must be provided so that our office can verify that we are speaking to the correct person

1. _____ DOB: _____
   Name/Relationship to patient

2. _____ DOB: _____
   Name/Relationship to patient

3. _____ DOB: _____
   Name/Relationship to patient

Patient Signature: _____ Date: _____

****

I, _____, **do not authorize** Joseph B. Boucree Jr. MD to release any of my protected medical information to anyone other than the entities that are disclosed in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

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PAST MEDICAL HISTORY FORM

PATIENT NAME _____ **DOB** _____ **DATE** _____
Height: _____ **Weight:** _____ **Smoker:** ____**YES** _____**NO** _____**Former Smoker**
If a smoker, how long have you been smoking and how many per day: _____
If a former smoker, when did you stop_____

MEDICATION ALLERGIES _____**No Known Allergies**
Allergy _____ Reaction _____
Allergy _____ Reaction _____
Allergy _____ Reaction _____
Allergy _____ Reaction _____

Current List of Medications (include dose, reason you take it, who prescribed it)

Medication	Dose	Quantity	Frequency	Use

Current List of over the Counter Medications (vitamins, food supplements, weight loss supplements)

_____
_____

Which of the following conditions are you currently being treated or have been treated for in the past?

___Heart Disease/murmur/angina
___High Cholesterol
___Low blood pressure
___High blood pressure
___Heartburn/reflux
___Anemia/blood or bleeding problems
___Swollen ankles/vein problems
___Diabetes
___Thyroid Problems
___COPD
___Asthma
___Lung problems
___Sinus Problems
___Kidney/bladder problems
___Cancer
___Seizures
___ Stroke
___Headaches/migraine
___Neurological problems
___Psychiatric care
___Liver problem/hepatitis
___Ulcers/colitis
___ Any type of metal implant

Please list any past surgical history (Please include date of surgery and surgeon who performed the surgery)

_____
_____
_____
_____
_____

PHARMACY NAME AND TELEPHONE NUMBER _____

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X-RAY CONSENT FORM

Patient: _____ DOB: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please choose one:

_____ I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose not to have any x-ray at this time and release my doctor of all liabilities.

Signature: _____ Date: _____

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exam.
With those factors in mind, I am advising my doctor that:

I am pregnant _____ yes _____ no _____ don't know
I could be pregnant _____ yes _____ no _____ don't know
My menstrual period is late _____ yes _____ no _____ don't know
I have an IUD _____ yes _____ no
I have had a tubal ligation _____ yes _____ no
I have had a hysterectomy _____ yes _____ no
I have irregular menstrual periods _____ yes _____ no
My last menstrual period began _____
I have begun menopause _____ yes _____ no

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: _____ Date: _____

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PHYSICIAN OWNERSHIP DISCLOSURE FORM

During the course of your physician/patient relationship with Joseph B. Boucree Jr., MD, Dr. Boucree may refer you to Southern Surgical Hospital ("*Hospital*"). The address of the Hospital is 1700 W. Lindberg Drive Slidell Louisiana 70458.

In connection with any referral to the Hospital, you are hereby advised that Joseph B. Boucree Jr., MD has an investment interest in the Hospital.

This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than Southern Surgical Hospital. You will not be treated differently by your physician or Southern Surgical Hospital_if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

If you have any questions concerning this notice, please feel free to contact our office.

By signing below you acknowledge that should you be referred to the Hospital, your signature below evidences your informed decision to decline the option to have your health care provided at another health care facility. Lastly, you further acknowledge by signing below that you signed Physician Ownership Disclosure Form prior to Dr. Boucree's referral of you to the Hospital

Date: _____, 20___

Signature of Patient: _____

Printed Name of Patient: _____

Joseph B. Boucree Jr., MD-Pain Management Agreement

You have agreed to receive opioid (narcotic) medications for the treatment of chronic pain. These medications are being prescribed to decrease your pain and/or increase your ability to function. Opioid medications are just a part of the medical care which may be needed to accomplish this. Other treatments including non-opioid medications, exercise and physical therapy, psychological counseling or other therapies or treatments may also be prescribed.

Please read this contract carefully. If you do not understand any of the information contained below, or require additional clarification on the policies of this office regarding the prescribing of opioid medications, please ask. You will be required to sign this contract before receiving any opioid medications.

I, _____, understand that adhering to the following is important in continuing to receive opioid medications prescribed by Dr. _____.

---

1. I understand that I will
    a. Take medications **only** as they are prescribed by this physician. This includes the prescribed dose and frequency.
    b. Not increase or change medications without the approval of this physician.
    c. Not request or attempt to get opioid or other medications from any other physician unless specifically directed by this physician.
    d. Tell this physician of all the medications that I am taking.
    e. Only obtain my medications from one pharmacy. If I need to change or obtain medications from a different pharmacy, I will tell this physician immediately.
    f. Safeguard and protect my prescriptions and medications. I understand that these **will not** be replaced if they are lost, left behind, or destroyed. If my medication is stolen I will complete a police report understanding that only one stolen prescription **may** be replaced in a year.
    g. Agree to participate in psychiatric or psychological treatment or counseling, if needed.
    h. Adhere to the following if I have an addiction problem.
        i. I will not use illegal or street drugs, alcohol, or other medications that were obtained illegally or that were intended for use by someone other than me.
        ii. I will follow the advice of this physician and enter an addiction program such as:
            1. 12-step program and secure a sponsor.
            2. Individual counseling.
            3. Inpatient or outpatient treatment.
            4. Other: _____
2. I understand that in the event of an emergency, this physician should be contacted and the problem will be discussed with the emergency room or other treating physician. No more than three days of medications may be prescribed by the emergency room or other physician without this doctor's approval.
3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.
4. I understand that this physician may stop prescribing opioid medications or change the treatment plan if:
    a. I trade, sell or misuse the medication.
    b. The clinic finds that I have broken any part of this agreement.
    c. I do not go for a blood or urine test when asked.
    d. My blood or urine test shows the presence of medications the staff is not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for.
    e. I get opioid medications from sources other than this physician.
    f. Any member of the professional staff of this clinic feels it is in my best interests that opioid medications are stopped.
    g. I display any aggressive behavior toward my physician or any of the clinic staff.
    h. I consistently miss appointments.

_____ Patient Signature Date

_____ Physician Signature Date

JOSEPH B. BOUCREE JR., MD

HIPPA NOTICE OF PRIVACY PRACTICES

Summary

The record of the medical care you receive at Joseph B. Boucree Jr., MD- your medical information-has always been treated as personal and private. However, this medical information is now also governed by federal privacy laws that we are required to communicate to you.

There are circumstances under which we, as the provider of your health care, are permitted to use and disclose your medical information:

In order to provide you with medical treatment and coordinate your care, physicians, nurses, medical students and other personnel within the institution may share your medical information with one another. We may communicate it to individuals outside the institution who are involved in you medical care. We may disclose medical information about you to your insurance company for the purpose of reimbursement. We may review you medical information to make sure that your care has met our standards, and we may use it to educate our own staff and students. The medical information of our patients may also be collected, tabulated and analyzed to help us improve overall clinic and hospital services. We may share these statistical data with other healthcare institutions in order to better evaluate our own performance. As the patient, you are entitled to request a restriction on the medical information we use or disclose about you for treatment, payment, or the improvement of clinic and hospital operations.

Appointment reminders, and communications to you about other treatments or services, entail the disclosure of you medical information. You may request that we communicate confidentially with you. If you are a patient in the hospital, certain limited information about you will be entered in the hospital directory for the benefit of your visitors. Your religious affiliation may be revealed to a priest or rabbi. We may disclose your medical information to a family member or friend who is involved in your care, but you may request a limit to the information we share with them. Under certain circumstances your medical information may be used for research purposes. All research projects are carefully monitored. The philanthropic division of our organization may use your contact information to include you in its fundraising efforts.

Entities to which we may disclose your medical information are funeral directors, the coroner or medical examiner, Workers' Compensation programs, public health officials, state and federal agencies charged with oversight of the health care system, correctional institutions, military authorities, and national security and intelligence agencies. In serious situations we may release medical information about you to law enforcement agencies. We may disclose medical information in the defense of a malpractice claim, or in response to a court or administrative order.

Except under special circumstances, you are entitled to view and/or copy your medical record. You have the right to amend your medical information if you have reason to believe it is incorrect or incomplete. You are entitled to receive a list of those entities or individuals to whom we may have disclosed your medical information. You are entitled to receive a paper copy of the full Notice of Privacy Practices. Finally, if you feel your privacy rights have been infringed, you may file a complaint, without fear of penalty, with our institution or with the Federal Government