PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST

Frank Bacque', M.D.
602 St. Landry Street
Lafayette, LA 70506

Thad Bourque, M.D.
1103 Kaliste Saloom Rd.
Ste. 200
Lafayette, LA 70508

Edgar P. Breaux, M.D.
Jason Breaux, M.D.
Henry Kaufman, M.D.
Jacob Landry, M.D.
457 Heymann Blvd.
Lafayette, LA 70503

Edward Breaux, M.D.
Jeannette Chassaignac, M.D.
Scott Neusetzer, M.D.
Jeremy Speeg, M.D.
1016 Coolidge Blvd.
Lafayette, LA 70503

Andre' Broussard, M.D.
2308 East Main St.
Ste. D
New Iberia, LA 70560

Martin "Zeke" Ducote, M.D.
Christopher Fontenot, M.D.
200 Beaullieu Dr.
Bldg. 7
Lafayette, LA 70508

Marcel LaHaye, M.D.
4940 Vidrine, Rd.
Ville Platte, LA 70586

William Roth, M.D.
Samuel Shuffler, M.D.
1000 W. Pinhook Rd.
Ste. 304
Lafayette, LA 70503

Jason Shumadine, MD
120 Rue Louis XIV
Lafayette, LA 70508

Jeffrey Thibodeaux, M.D.
200-A Energy Pkwy.
Lafayette, LA 70508

John Vallee, M.D.
Laura Owens, M.D.
1926 S. Union St.
Opelousas, LA 70570

Lafayette Diagnostic and Radiation Treatment Center
120 Rue Louis XIV, Lafayette, LA 70508

By physicians practicing with
Southern Surgical & Medical Specialists, including:
Southern Urology, LLC
Surgical Specialists of Lafayette, LLC

**** If you were *not* referred by a physician listed on this letterhead, you may skip this form and continue to the next****

Louisiana law requires that your physician disclose to you any financial interest he or she may have in another healthcare entity to which you may be referred, so that you may address any concerns you may have directly with your physician.

Your referring physician is a member, owner, or employee of Southern Urology or Surgical Specialists of Lafayette, also known as Southern Surgical and Medical Specialists (the "Group"). The physician members of the Group (listed at left) are also owners of Lafayette Diagnostic and Radiation Treatment Center, to which you have been referred for radiation therapy or diagnostic CT services.

By signing the below, you acknowledge your receipt of this Physician Disclosure of Financial Interest and understand that your referring doctor is an owner of this facility.

Print Patient Name:_____

Patient Signature (or legal representative):_____

Date:_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

As required by HIPAA, you have a right to request that communications concerning your personal health information be made through confidential channels. Periodically, we will need to contact you for appointment reminders, to give test results, or to speak with you regarding any insurance/billing concerns. Please assist us in providing the proper means to contact you, and if you are not available, the name(s) of those you give permission to speak to.

I hereby authorize Southern Urology LLC and Lafayette Diagnostic & Radiation Treatment Center to leave detailed messages regarding my personal health information via:

Home Telephone Number Yes No Phone #_____

Cell Phone Number Yes No Phone #_____

Written (mailed) Communication
To my home address on file Yes No
To another address only Yes No
Other address: _____
_____

I also hereby request and authorize my Southern Urology and/or Lafayette Diagnostic & Radiation Treatment Center physician to disclose any medical information relating to diagnoses, care, treatment, test results and prognosis concerning myself to the individuals listed below. (*This may include spouses, relatives, children, friends, etc*.). I understand information may be either obtained in person, in writing or by telephone. (*Write "None" in the space provided below if you do not want anyone to have access to your medical information.*). This consent is valid until revoked in writing.

Name	Relationship to Patient	Telephone (if different than the Home Number above)

_____ _____
Patient Name (Printed) Signature of Patient / Legal Guardian

_____ _____
Legal Guardian Name (If applicable) Date

LAFAYETTE DIAGNOSTIC & RADIATION TREATMENT CENTER

Southern Surgical & Medical Specialists / Southern Urology LLC
Jason T. Shumadine M.D.
120 Rue Louis XIV
Lafayette, Louisiana 70508
P: 337-769-7779
F: 337-769-7788

MEDICAL AUTHORIZATION RELEASE FORM

(To obtain you medical records from other providers)

DATE: _____

TO: _____
(Name of doctor / practice / medical facility you are requesting to release your medical records to us)

FAX: _____

I, _____(insert your name), HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS, OR COPIES OF SUCH, AND REQUEST THAT THEY BE TRANSFERRED TO:

JASON SHUMADINE, M.D.
120 RUE LOUIS XIV
LAFAYETTE, LA 70508
FAX# (337) 769-7788
PH# (337) 769-7779

SIGNATURE: _____

DATE OF BIRTH: _____

LAFAYETTE DIAGNOSTIC & RADIATION TREATMENT CENTER
Southern Surgical & Medical Specialists / Southern Urology LLC

Name:_____ Date:_____

PLEASE CHECK NEXT TO ANY OF THE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING.

CONSTITUTIONAL
- □ Appetite Change
- □ Chills
- □ Fever
- □ Fatigue
- □ Weakness
- □ Weight Change
- □ Weight Loss

EYES
- □ Blind
- □ Blurred Vision
- □ Double Vision
- □ Eye Pain
- □ Worsening Eyesight

ALLERGIES
- □ Animal
- □ Drug
- □ Enviromental
- □ Food
- □ Seasonal

NEUROLOGICAL
- □ Balance Problems
- □ Disoriented
- □ Dizzy
- □ Headache
- □ Leg/Arm weakness
- □ Memory Loss
- □ Numbness or Tingling
- □ Speech Problems
- □ Tremors

ENDOCRINE
- □ Sugar Diabetes
- □Thirsty
- □ Thyroid Problems
- □ Tired/Sluggish
- □ Too hot/cold

GASTROINTESTINAL
- □ Abdominal Pain
- □ Abdominal cramps
- □ Reflux
- □ Bloody Stools
- □ Constipation
- □ Diarrhea
- □ Nausea/ Vomiting
- □ Hemorrhoids
- □ Indigestion

CARDIOVASCULAR
- □ Chest Pain
- □ Shortness of breath on exertion
- □ Edema
- □ Irregular Heart Beat

SKIN/INTEGUMENTARY
- □ Acne
- □ Boils
- □ Moles
- □ Itching
- □ Rash

MUSCULOSKELETAL
- □ Back Pain
- □ Joint Pain
- □ Muscle Cramps
- □ Muscle Weakness

ENT
- □ Ear Infections
- □ Sinus Trouble
- □ Sore Throat
- □ Deafness

GENITOURINARY
- □ Bedwetting
- □ Blood in urine
- □ Burning on urination
- □ Erection Problems
- □ Bladder stones
- □ Leaking urine

RESPIRATORY
- □ Asthma Attack
- □ Cough
- □ Shortness of breath
- □ Wheezing

HEMAT/LYMPATIC
- □ Swollen Glands
- □ Blood Clotting Problems
- □ Bleeding Problems
- □ Bruising

PSYCHOLOGICAL
- □ Do you feel anxious?
- □ Do you feel depressed?

Pharmacy: _____Location & Phone #: _____

Are you allergic to Iodine? : _____ Are you diabetic? _____ Do you have a cancer policy? _____

Who is your Primary Care Physician? _____

Do you have a pacemaker, stent, or any other metal devices? _____

LAFAYETTE DIAGNOSTIC & RADIATION TREATMENT CENTER

Southern Surgical & Medical Specialists / Southern Urology LLC

PATIENT HISTORY UPDATE FORM

PATIENT NAME: _____

ACCT # (*office*): _____

DATE OF BIRTH: _____

CONSULT DATE: _____

MEDICAL HISTORY:

Which of the following conditions are you currently being treated or have been treated for in the past (please check):

□Coronary Artery Disease
□Sleep Apnea
□Glaucoma
□High cholesterol
□Asthma
□Seizures
□Gout
□High blood pressure
□Low blood pressure
□Stroke
□COPD
□Lung problems/cough
□Atrial Fibrillation
□Headaches / Migraines
□Arthritis
□Acid Reflux (GERD)
□Anxiety
□Neurological problems
□Irritable bowel disease
□Tonsillitis
□Depression
□Ulcers/Colitis
□Congestive Heart Failure
□Ear problems
□Hypothyroidism
□Hyperthyroidism
□Diabetes

Please describe any current or past medical treatment not listed above:

_____
_____
_____
_____

PAST SURGICAL HISTROY:

□Amputation
□Knee replacement
□CABG
□Colonoscopy
□Hysterectomy
□Pacemaker
□Thryoidectomy (thyroid)
□Appendectomy (appendix)
□Tubal ligation
□Catarectomy (cataracts)
□Heart surgery stent
□Lumpectomy
□Plastic surgery
□Tonsillectomy (tonsils)
□Back surgery
□Bone marrow transplant
□Cholecystectomy (gallbladder)
□Herniorraphy (hernia)
□Mastectomy
□Prostatectomy (prostate)
□Vasectomy

Please list all prior surgeries not listed above:

_____
_____
_____
_____
_____
_____

continue to next page

LAFAYETTE DIAGNOSTIC & RADIATION TREATMENT CENTER
Southern Surgical & Medical Specialists / Southern Urology LLC

PATIENT NAME: _____
ACCT # (*office*): _____
DATE OF BIRTH: _____
CONSULT DATE: _____

ALLERGIES:

Please list any allergies you have below:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____
_____

SOCIAL HISTORY

Smoking History:

□ Current every day smoker — If yes, how many packs per day? _____
□ Current some day smoker — If no, how many pack did you smoke per day? _____
□ Former smoker — How many years have you been/did you smoke? _____
□ Never — How many years have you quit smoking? _____

Alcohol Consumption:

□Active (Everyday) — How many days a week do/did you consume alcohol? _____
□Occasional (Somedays) — How many drinks a day do/did you consume alcohol? _____
□Former Drinker — How many years have you quit consuming alcohol? _____
□Never

Caffeine:

Do you currently drink any caffeinated beverages? □Yes □No
If yes, what types of caffeinated beverages do you drink? _____
How many caffeinated beverages do you drink daily? _____

Activity Level:

□Occasional Exercise □Light Exercise □Regular Exercise □Extensive Exercise

LAFAYETTE DIAGNOSTIC & RADIATION TREATMENT CENTER
Southern Surgical & Medical Specialists / Southern Urology LLC

PATIENT NAME: _____

ACCT # (*office*): _____

DATE OF BIRTH: _____

CONSULT DATE: _____

FAMILY HISTORY

	Living	Age (or age at death)	List serious illnesses
Father	□Yes □No	_____	_____
Mother	□Yes □No	_____	_____
Maternal Grandmother	□Yes □No	_____	_____
Paternal Grandmother	□Yes □No	_____	_____
Maternal Grandfather	□Yes □No	_____	_____
Paternal Grandfather	□Yes □No	_____	_____
Sister	□Yes □No	_____	_____
Sister	□Yes □No	_____	_____
Sister	□Yes □No	_____	_____
Brother	□Yes □No	_____	_____
Brother	□Yes □No	_____	_____
Brother	□Yes □No	_____	_____

Please list any other relatives with his/her serious medical conditions:

_____
_____
_____
_____
_____

Any information the patient would like to let us know:

_____
_____
_____
_____
_____

Patient/Legal Guardian Signature _____ **Date:**_____

LAFAYETTE DIAGNOSTIC & RADIATION TREATMENT CENTER
MEDICATION LIST
Southern Surgical & Medical Specialists / Southern Urology LLC

NAME:_____ ACCT:_____ DOB:_____ DATE:_____

Please list your medications below:

MEDICATION	DOSE	HOW OFTEN DO YOU TAKE THIS MEDICINE	REASON FOR TAKING MEDICATION	DATE STARTED MEDICATION	PRESCRIBER

SIGNATURE:_____DATE: _____

NOTICE OF PRIVACY PRACTICES
SOUTHERN SURGICAL & MEDICAL SPECIALISTS
(Includes Southern Urology, LLC, Surgical Specialists of Lafayette, LLC, and Lafayette Diagnostic & Radiation Treatment Center)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA), requires all health records and other Protected Health Information ("PHI") used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice in its currently in effect was updated on 03/26/13 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the Company Contact information listed at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: Without specific written authorization, we are permitted to use and disclose your healthcare records for the purpose of TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, and OTHER REASONS REQUIRED BY LAW:

TREATMENT: This means providing, coordinating, or managing health care and related services by one or more healthcare providers/physicians. For example, if your specialist asks your primary care doctor to share PHI related to any physical exams or diagnostic procedures done.

PAYMENT: This means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be billing your insurance company or Medicare for services rendered.

HEALTH CARE OPERATIONS: This is the business aspect of running our practice, such as conduction quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be a periodic quality review/assessment of our documentation protocol, etc.

PUBLIC HEALTH, ABUSE or NEGLECT, HEALTH OVERSIGHT, and OTHER REASONS REQUIRED BY LAW: We will use and disclose your PHI when we are required to do so by federal, state or local laws. We may disclose your PHI to public health authorities that are authorized by law to collect information, or to a health oversight agency for activities included but not limited to: response to a court order or administrative order; if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute-- but only if we made an effort to inform you of the request or obtain an order protecting the information the party has requested. We may release your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death or if you are an organ donor. We may release your PHI to the tumor registry. We may use and disclose PHI when necessary to reduce or prevent a serious threat to your health and safety, of another individual or to the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PHI if you are a member of the U.S. or foreign military (including veterans) when required for appropriate intelligence or national security activities authorized by law. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We 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 for the institution to provide health care services to you, for the safety and security of the institution, and to protect your health and safety or that of other individuals or the public. We may release your PHI for worker's compensation and similar programs.

In addition, your confidential information may be used to remind you of an appointment (electronically, by mail, letters, voicemail messages, or postcards) or provide you with information about treatment options or other health related services including release of information to friends or family members that are *directly* involved in your care or assist in taking care of you.

PATIENT RIGHTS

AUTHORIZATION: Any uses or disclosures of your PHI *not* addressed above may only be made with your authorization. You may revoke such authorization in writing and we are required to honor and abide that written request, except to the extent that we have already taken actions relying on your authorization.

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to your physician to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies, electronic media storage, and staff time.

RESTRICTIONS: The following uses and disclosures will be made only with your authorization: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for fundraising or marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this NPP.

ADDITIONAL RESTRICTIONS: You have the right to request additional restrictions on our use or disclosure of your health information. This must be made in writing, and must identify: (i) the information to be restricted; (ii) the type of restriction being requested (i.e. on the use of information, the disclosure of information, or both); and (iii) to whom the limits should apply. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

RESTRICTING DISCLOSURE TO YOUR INSURANCE COMPANY: We must comply with your restriction request if you have paid for your services out-of-pocket, in full, and you are requesting that we not disclose your PHI related solely to those services to your health plan. This request must be made in writing prior to or on the date of the service to allow our office to provide you with the information on your out of pocket cost, collect necessary fees for service, obtain a signature of this request, and avoid filing to your insurance.

DISCLOSURES OF ACCOUNTING: You have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes other than treatment, payment, healthcare operations and other reasons required by law herein, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your request must be in writing and specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Website, you are entitled to receive this Notice in written form.

BREACH: We are required to notify you if there is a breach and/or unauthorized use of your PHI.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information, you may contact the person below. You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your rights to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACTS:

Company's Contact:
Mark Eldredge
120 Rue Louis XIV
Lafayette, LA 70508
PHONE: 337-769-7779
FAX: 337-769-7788

Government Contact:
U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201
Toll Free 877-696-6775

Revised on 04/26/2013

LAFAYETTE DIAGNOSTIC & RADIATION TREATMENT CENTER

Southern Surgical & Medical Specialists/ Southern Urology LLC
Jason T. Shumadine M.D.
120 Rue Louis XIV
Lafayette, Louisiana 70508
P: 337-769-7779
F: 337-769-7788

PRIVACY NOTICE ACKNOWLEDGMENT FORM

I hereby acknowledge that I have been given the opportunity to read and review our Notice of Privacy Practices, located on our web site and in the lobby of our office. I understand that a copy of this Notice will be made available to me, for my personal use, if requested.

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient/Representative **Signature** Date of Signature

_____
Representative's Relation to Patient, If Applicable

Documentation of Good Faith Effort

(To be completed by our staff if a signature is not obtained by patient or representative)

A good faith effort has been made to obtain a written acknowledgement of the Notice of Privacy Practices made available to the patient, provided in the lobby of our office. An Acknowledgement has not been obtained because:

☐ Patient refused to sign the Acknowledgement despite having opportunity to read and review.

☐ Other: Patient was unable to sign the acknowledgement because:_____
_____

_____ _____
Employee Signature Date

AUA SCORE SHEET

***** For PROSTATE CANCER patients only*****
(All other patients may discard this page)

NAME:_____ **Date:**_____

Prostate cancer patients complete this section:

Please circle the number in the appropriate box to answer each question.	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always
1. Incomplete emptying: Over the past month, how often have you had the sensation of not emptying your bladder completely?	0	1	2	3	4	5
2. Frequency: Over the past month, how often have you had to urinate again in less than 2 hours?	0	1	2	3	4	5
3. **Intermittency:** Over the past month, how often have you stopped and started when urinating?	0	1	2	3	4	5
4**. Urgency**: Over the past month, how often have you found it difficult to postpone urinating?	0	1	2	3	4	5
5. **Weak stream**: Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. **Straining:** Over the past month, how often have you had to push or strain to begin urinating?	0	1	2	3	4	5
7. **Nocturia**: Over the past month, how often did you most typically get up to urinate from the time you went to bed until the time you wake up in the morning?	0	1	2	3	4	5

Clinic Staff to complete this summary;

Column Sub Total						

Total Score:

***** For all FEMALE PATEINTS only*****
(Male patients may discard this page)

Reproductive History: Menstrual Cycle

NAME:_____ **ACCT #:**_____ **DOB:**_____**DATE:** _____

Age at first period: _____

Menopausal (Circle): **YES / NO** **If yes, age at menopause:** _____

Menopause Reason (Circle): **Chemotherapy** **Natural** **Removal of Ovaries**
Removal of Uterus **Hysterectomy**
Other : _____ **Date:** _____

Are you sexually active (Circle): **Never** **Not Currently** **Yes**

First day of last menstrual cycle: _____

Are you currently trying to conceive: **Yes** **No** **Other:**_____

Pregnancies

Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies.

BIRTH DATE	WEEKS AT DELIVERY	SEX	TYPE OF DELIVERY	ANESTHESIA	COMPLICATION

Any other information you would like our office to be aware of:

_____

_____

_____

Patient/Legal Guardian Signature _____ **DATE:**_____