PATIENT INFORMATION SHEET
SURGICAL ONCOLOGY / GENERAL SURGERY

Please PRINT every section. If something is not applicable, please write "NA" rather than leaving blank

Patient Last Name:	First Name:	Middle:	Date of Birth:	Today's Date:
Ethnicity: Non-Hispanic/Latino Hispanic/Latino		Primary Language: English Other		Race:
Marital Status: Single Married Divorced Widowed Separated		Sex:	Social Security #	
Home Street Address:		City	State:	Zip:
Mailing Street Address (If Different Than Above):		City	State'	Zip:
Home Phone #:	Cell Phone:	**May we text you**?	Additional Contact Name and phone #	
Email Address: (**not** to be used for marketing or mass communications, but for possible individual correspondence):		**You want to access portal**? Yes No		
Employer:		Occupation		Work PH

Spouse's name (if applicable):	Spouse's Cell phone #:	Date of Birth	Employer:	Spouse Work Phone #:

Emergency Contact (not living with you):	Contact Phone	Relationship to Pt.:

INSURANCE INFORMATION

PRIMARY	SECONDARY
Primary Insurance Co.:	Secondar Insurance Co.:
Member ID#:	Member ID#:
Group #:	Group #:
Policy Holder Name:	Policy Holder Name:
Policy Holders Date of Birth:	Policy Holders Date of Birth:
Relationship to Patient Self Child Spouse	Relationship to Patient Self Child Spouse

REFERRAL INFORMATION

Your Primary Care Physician	Phone #	Preferred Pharmacy: Pharmacy Location (Street, City):
Referring Physician's Name:		Phone #: Specialty

Patient Consent and Authorization to

Obtain, Use, and Disclose of Health Information for Treatment, Payment, or Health Care Operations

NAME: ____ DATE _____________________

I understand that as part of my health care. Henry Kaufman, IV, MD and/or Jacob Landry, MD originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

Henry Kaufman, IV, MD and/or Jacob Landry, MD are authorized by me to obtain, use, or disclose my protected health information for the purpose of treatment, payment, or health care operations. HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual.

I have read and understand the Notice of Health Information Practices provided by this office. specifically authorize any current employee of Henry Kaufman, IV, MD and/or Jacob E Landry MD to obtain, use, and/or disclose my protected health information to another entity for these purposes. I consent to such obtaining and/or disclosure for these permitted uses, including via copy, fax, and/or electronic patient data transmission.

This authorization may include hospitals, physicians, nurses, other health care providers, worker's compensation employers, insurance companies and their representatives, rehabilitation workers, and any institution, agency and/or an individual representing me. Under the LA law regarding the disclosure of confidential information (LA R, S. 13:3734), the physician may release patient information without the patient's written authorization when the patient brings an action in tort or worker's compensation for personal injury.

I hereby request and authorize my Surgical Specialist of Lafayette and Southern Surgical & Medical Specialists physician and staff to disclose any medical information relating to diagnoses, care, treatment, test results, and prognosis concerning myself to the individuals listed below. (Spouse/relatives/children/friends with whom we can discuss your care) I understand information may be either obtained in person, in writing or by telephone. This consent is valid until revoked in writing:

Please state whom we can release Protected Healthcare Information to or write "NONE" if you do not want anyone to have access to your medical information:

Name ____ Relationship to patient _____________ Phone _______________

Name ____ Relationship to patient _____________ Phone _______________

Name ____ Relationship to patient _____________ Phone _______________

I wish to have the **following restrictions to the use** or disclosure of my health information: ____________________________
I understand that Henry Kaufman, IV, MD and/or Jacob Landry, MD are not required to agree to the restrictions requested.

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I also understand that by refusing to sign this consent/authorization or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Henry Kaufman, IV, MD and/or Jacob Landry, MD reserve the right to change this notice and practices and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations, Should Henry Kaufman, IV, MD and/or Jacob Landry, MD change this notice, they will send a copy of any revised notice to the address have provided (whether U. S. mail or, if agree, email),

I further understand that I retain the right to revoke this authorization, if done so in writing, except to the extent that action has been taken in reliance on this authorization. The revocation must include: 1) The patient's name, address, and patient number, 2) The effective date of this authorization, and the recipients of the protected health information according to this authorization, 3) The patient's desire to revoke this authorization, and 4) The date of the revocation, and the patient's signature.

NAME: ____ DATE ______________________

I wish to be contacted in the following manner (check all that apply)

As required by HIPPA, 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're not available, the name(s) of those you give permission to speak to: ____

Cell Phone/Beeper # ___________________

____ OK to leave message with detailed information

____ Leave message with call back number only

Written communication

_____ OK to mail to my home address

_____ OK to fax to this number_______________

Home Phone # ________________________

____ Ok to leave message with detailed information

____ Leave message with call back number only

Work Phone # _______________________

______ OK to leave message with detailed information

______ Leave message with call back number only

Patient Acknowledgement of Financial Policy & Assignment of Benefits

By signing below, I certify that have read this Financial Policy and understand its terms and conditions. I authorize the release of any medical information necessary to process my Insurance claims, and request that payment of insurance benefits be made directly to Southern Urology who we are partners with. The office visit co-pay is due at the time of the visit and covers only the office visit. Any procedures performed will be considered surgery by my insurance, so deductible and coinsurance will apply. I understand that I am responsible for my own bill in the event that my insurance company does not pay or pay within a timely fashion.

I have read the above information and understand that I am responsible for payment for services receive. I fully understand and accept the terms of this authorization.

I fully understand and accept the terms of this consent.

I hereby acknowledge that I have been given the opportunity to read and review our Notice of Information Practices that provides a more complete description of information uses and disclosures, located on our web site at **http://SouthernSurgicalLafayette.com** and in the lobby of our office. I understand that a copy of this notice will be made available to me if requested.

This authorization shall be valid and not expire until it is revoked in writing by the patient or on the death of the patient. A photocopy of the authorization may serve as an original.

Signature of Patient / Responsible Person: ____

Print Name ____ Relationship to patient: _________________________

NAME: ______________________________ DATE ______________

WELCOME TO OUR CLINIC PATIENT PORTAL

In our ongoing efforts to improve the quality of care provided by Dr. Henry Kaufman, IV and Dr. Jacob Landry, we are pleased to announce the availability of our Patient Portal to better serve you. The Patient Portal is a secure, web-based system that allows you to review certain aspects of your medical record. The portal also allows you to securely communicate with us between visits for NON-EMERGENT issues and questions. You can even download and securely transmit a summary of your medical record to other web-based applications and providers of care. Over time, we will be phasing in various features and functions that will be available through the Patient Portal.

OPT IN: **Portal Acceptance**

I have read and understand the above and authorize Surgical Specialist of Lafayette / Southern Urology, LLC to activate my patient portal account using the email address listed below, I understand that it is my responsibility to safeguard the email address and my Patient Portal passwords in order to maintain the security and privacy of my personal health information. I also understand that Surgical Specialist of Lafayette / Southern Urology, LLC will use the Patient Portal as a means of communicating with me when appropriate. I further understand that the Patient Portal is <u>not to be used for urgent medical needs. nor does it replace the need for me to keep my regular appointments with my doctor:</u>

Patient Signature: ______________________________ Date of Birth:______________

Email address to use in conjunction with my account: ______________________________

**The activation email will have more specific information about the Patient Portal Announcement, the Patient Portal Online Access Instructions, and the Patient Portal Guidelines and Usage Instructions.

NOTIFY US IMMEDIATELY IF YOU CHANGE YOUR EMAIL ADDRESS AT ANY TIME

OPT OUT:Portal Decline

I have read and understand the above announcement and choose to decline the use of the Patient Portal at this time

Patient Signature:______________________________ Date of Birth: ______________

We are sorry that you currently choose to decline but please let us know if we can answer any specific questions or concerns you may have. If you'd also like to look at more specific information about Patient Portal Announcement, the Patient Portal Online Access Instructions, and the Patient Portal Guidelines and Usage Instructions on your own time, we would gladly make copies available to you.

SOUTHERN SURGICAL & MEDICAL SPECIALISTS

PATIENT NOTIFICATION OF OUR FINANCIAL POLICY

Henry Kaufman, IV, M.D., and Jacob Landry, M.D. are committed to providing the highest quality of healthcare available while maintaining a financial policy that is fair to our patients. First and foremost, it is important for you to understand that, regardless of your insurance status, you are ultimately responsible for payment of your account.

PAYMENT IS EXPECTED ON THE DATE OF YOUR VISIT. we accept cash, checks, and major credit cards. we accept Medicare assignment and are participating providers for many managed care plans. We are obligated to follow their guidelines related to billing, collections and allowable pricing on "covered" services. However, each policy is written differently and it is the patient's responsibility 10 be aware of what their own policy does and does not cover.

Some other key points to know:

- On the date of your office visit, you are responsible to pay:
  1. Any unpaid deductible and
  2. Your percent of the insurance allowed amount (co-insurance) or your set fee per visit (co-pay).
  3. If you have a minor surgery in our office, you will need to pay an additional fee on the date if your surgery, which will be applied toward your portion of the surgery charges. Since this is only a down-payment, once the claim is processed by your insurance company, you may receive and additional bill for the balance.
  4. Should you need major surgery; we request that you pay your estimated portion of surgery at the office visit when services are scheduled. Since this is only an estimate, once the procedure is performed you may receive an additional bilk for the balance.
- If insured, we ask that you present your insurance card at each visit. It is your responsibility to ensure that the card (and your coverage) is current and correct. For us to file your insurance, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance and payment in full will be required.
- Please let us know whenever any demographic information (address, phone numbers, etc.) has changed.
- If we are "participating providers" with your insurance company, we will collect co-pays, deductibles, co-insurance and other out-of-pocket expenses your insurance company does not cover at the time of service.
- Your office visit co-pay is due at the time of the visit and in many cases covers only the office visit charge. Any procedure performed such as a minor surgery, will be considered surgery by your insurance company and deductibles and coinsurance percent apply.
- For our private pay patients, we offer a 25% "prompt pay" discount from our charge schedule when paying in full.
- For private pay patients and those with insurance plans with whom we do not participate, your payment is due at the time of service. If we do not participate with your insurance plan, we can file your claims and refund you any portion your insurance plan covers.
- If the assignment of benefits is rejected or if your insurance fails to pay on a claim according to our contractual terms within 60 days after it has been filed (unless there is a valid reason for denial), it will be your responsibility to pay the charges in full.
- We send statements and bills to patients on unpaid amounts owed. At the discretion of our billing department, we may agree to an installment payment plan. However, lacking any agreed-upon payment arrangement with you (or failing to make payment on such agreed-upon amount) we may turn your account over to an outside collection agency. <u>If at any time you cannot pay your bill, please contact our billing office to discuss possible payment arrangements,</u>
- Certain diagnostic tests may be performed that require an "outside" physician's professional services (example: a pathologist's interpretation/report on a biopsy sample). Be aware that you may receive a separate bill from a physician or lab for services not performed by Southern Urology. Please inquire with our physician or nurse should you have questions about whether of your particular tests are sent to outside providers.
- For commercial insurance patients, a deposit may be required for any outpatient or inpatient hospital procedures to cover your deductible, unless we can verify that your deductible and major medical out of pocket has been met.

- Non-Medical Charges: Special medical forms and record copying is charged at a variable rate depending on number of pages. This is based on a $25 base fee plus $1.00 per page.
- $25 is charged on all NSF checks.
- You may be referred to certain services (diagnostic CT, radiation oncology, certain lab testing) at Lafayette Diagnostic & Radiation Treatment Center. This facility is part of the Southern Urology, wholly owned and part of our Group Practice. Bills for these tests will come from Southern Urology, but show as a separate practice location. • Several Southern Surgical & Medical Specialists physicians are also partnering and/or have a financial interest in other local healthcare organizations. At some point during your care with Southern Surgical & Medical Specialists you may be referred to and receive services by one of these entities. The following table provides a list of those organizations by physician.

Table of Ownership Interest in other Healthcare Organizations by our physician members:

Jacob E Landry MD	Park Place Surgical Hospital
Henry Kaufman, M.D.	Park Place Surgical Hospital

Southern Urology, who we are partnered with, currently has a contract to participate with the health plans listed below. Please be aware, however, that some insurance companies add "sub-networks" (PPO, POS, Medicare Advantage, etc.) that may not be part of our agreement, this list is meant to be for general reference.

Medicare	Multi Ian
Aetna	NPPN
Beech Street / Best Health	Office of Group Benefits
Blue Cross Blue Shield of Louisiana	PHCS
CIGNA	PPO Plus
Coventry / First Health	Tricare / Humana (PPO only
Gilsbar 360	United Healthcare
Great West Healthcare (Under CIGNA)	Verity
Humana	

Southern Surgical & Medical Specialists is the Doing Business As ("DBA") name for Southern Urology, LLC, and we participate with insurance companies under this original entity name. Southern Urology currently has contracts to participate with many major health plans. We can confirm whether we participate with your health plan when you make your appointment, or any time thereafter. Please be aware, however, that some insurance companies add "subnetworks" (PPO, POS, Medicare Advantage, etc.) that may not be part of our agreement.

There are other plans with whom we "credentialed providers", which may cover services without having a contractual agreement in place (several Medicare Advantage plans, for example). You may contact your urologist's office to inquire whether we will accept a non-contracted insurance, and we certainly encourage you to contact your health plan to determine how (or if) they will cover your visit.

Henry J. Kaufman, IV, M.D
Jacob E Landry, MD.
457 Heymann Blvd.
Lafayette, LA 70503

Kaufman Landry
oncologic and general surgical specialists

In Partnership with Southern Urology, LLC

Phone: 337-237-5457
Fax: 337-237-4939 Nurse
337-237-4940 Referral

Date: ____________ Acct #: _____________

Name: ____ Age: ___________ DOB: ______________

Referring Physician: ________________________________ Primary Care Physician: _______________________________

Other Physicians: ___________________________________ ____

___________________________________ ____

Reason for Today's Visit: ____

HPI (Office Use): ____

____

____

____

____

____

____

MEDICATION ALLERGIES OR INTOLERANCES: ____

Do you or any family members have allergies or problems with latex or anesthesia? ____

MEDICATIONS: include over-the-counter, supplements, vitamins, birth control/hormones, etc.

Are you currently on a blood thinner? (Coumadin, Warfarin, Plavix, Aspirin, Eliquis, etc.) YES NO

PAST MEDICAL HISTORY: (Diabetes, emphysema, asthma, depression, anxiety, etc)

Have you had your annual mammogram? YES where:______________________ NO - If due to Mastectomy (R) (L)
Have you had a colonoscopy? YES NO When & Where ____

PAST SURGICAL HISTORY:

Kaufman Landry
oncologic and general surgical specialists

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Lafayette, LA 70503

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Phone: 337-237-5457
Fax: 337-237-4939 Nurse
337-237-4940 Referral

Date: _________ Name: ____ Acct #: _______________

REVIEW OF SYMPTOMS:

General
___Weight Change
___Night Sweats
___Fever
___ Diabetes
___Pain
___Enlarged Glands or Lymph nodes
___Pacemaker/Defibrillator
___Hearing Aids
___Prosthetic Devices
___Cold/Heat Intolerance

Heart/Circulation
___Blood Pressure Problem
___Heart Attacks
___Heart Rhythm Problems (A fib)
___Palpations
___Heart Murmur
___Varicose Veins
___Anemia
___Blood Clots/DVT/PE
___Chest/Jaw/Arm Pain
___Stroke
___Pacemaker
___High Cholesterol
___ Coronary Artery Disease
___ History of Stents
___Other: _____________

Lungs
___Shortness of breath
___Cough/Sputum/Phlegm
___Difficulty Sleeping Flat
___Use Oxygen
___Asthma

___Other:____________

Neurological
___Seizures
___Hearing Problems
___Dizziness
___Other _________

Mobility
___Difficulty Walking
___Wheelchair/Crutches
___Exercise
___Osteoporosis
___Joint Stiffness or Swelling
___Arthritis
___Back Pain
___Other: _____________

Diet
___Vomiting
___Change in Appetite
___Difficulty Swallowing
___Ulcers
___Indigestion
___Frequent Burping, Hiccups, Gas
___Bloating
___Nausea

Bowels
___Date of last Colonoscopy_______
___Incontinence
___Abdominal Pain
___Constipation
___Diarrhea
___Bleeding
___Dark/Black Stool
___Hemorrhoids
___Use Laxatives
___Other: ____________

Bladder
___Infection
___Testicular Swelling or Mass
___Hernia
___Frequent Urination
___Pain/Burning
___Incomplete Emptying
___Incontinence
___Other: ___________________

Reproduction (ALL WOMEN)
Age Period Started_________________
# of Pregnancies___________________
# of Children_____________________
Age at birth of 1st child _______________
Date of last period_________________
Age at menopause__________________
Date of last Mammogram _____________
______Hormone Supplements
______Irregular periods
______Prior Abnormal Pap Smear

Liver
___Hepatitis
___Other

Kidney
___Stones
___Infection
___Other: ___________

Endo
____ Hypothyroidism
____ Hyperthyroidism

Skin
___Lumps/Bumps
___Rashes
___Bruises
___Jaundice
___Itches
___Scars
___Wounds
___Burn
___Moles

Have you had any of the following:
___Blood Transfusion
___Hepatitis
___Tuberculosis
___HIV
___Exposure to Toxic Chemicals
___Exposure to Asbestos

FAMILY HISTORY:

Have you or any family members had any of the following medical problems? If yes then please list who:

Cancer (Breast, melanoma, colon, ovary or other): ____

Bleeding Problems: _____ Blood Clots: _______ Heart Disease: ______ Diabetes_______ Other: ___________________________

SOCIAL HISTORY:

Where do you live? ______________________________________ Occupation: ______________________________________

Do you currently smoke: **NO YES** If yes, # of packs/day _____ Patient received document on tobacco cessation intervention.

Have you smoked in the past? **NO YES** If yes, # of years: ________, Quit how long _________, Most # of packs/day _________

History of substance abuse: **NO YES** Do you drink alcoholic beverages? **NO YES**

How many alcoholic drinks have you had in the past week? ____ How many alcoholic drinks have you had in the last month?__

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Phone: 337-237-5457
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Date: ____________ Name: ____ Acct #: ____________

MEDICAL EXAM – This page is completed by Physician

VITALS: TEMP __________ HT__________ WT________ BMI________

GEN: ____

HEENT: ____

NECK: ____

AXILLA: ____

CHEST: ____

CV: ____

ABD: ____

INGUINAL: ____

EXT: ____

SKIN: ____

OTHER: ____

A)____

P)____

Documentation of education information given to patient.

DATA REVIEW

RADIOGRAPHS
_____ Mammogram
_____ CT/MRI/PET
_____ __________

LABS
_____ CBC/CMP/PT/PTT
_____ CEA/CA19-9/AFp/BHCG
_____ ____________________

REPORTS
_____ Previous medical records
_____ Oncology Note
_____ EGD/COLONOSCOPY
_____ Breast Biopsy

COUNSELING
_____Constipation Counseling
_____Bowel Regimen
_____Smoking Cessation
_____Weight Loss Counseling
_____Diet/Nutrition Counseling
_____Wound Care Instructions
_____Infection Precaution
_____Self-Breast Exam Instructions
_____End of Life Discussion
_____Risks, Benefits, Indications alternative to the therapeutic plan discussed
_____Pathophysiology of disease process discussed in detail
_____Pictures Drawn
_____Breast Cancer Rx & Recon
_____Care coordination with other treating physicians' _____________
____
____

Pre-OP Addendum
Changes: ______________________
____

No changes to H&P _____________

___________________________________ Date: ____________ Time: ____
Signature

Authorization to Transfer Medical Records

Authorization

I hereby authorize Henry J. Kaufman IV MD / Jacob E. Landry MD to release any and all medical records, including but not limited to hospitalization for diagnosis and/or treatment of psychiatric and/or mental condition, alcoholism, drug abuse and/or HIV test results, AIDS, or AIDS related conditions.

Release to: Physician Name:_________________________________
Practice: ____
Address:____
City: ___________________ State: _____ ZIP: _________

Uses

The purpose of the release of this information is:
Continuity of Medical Care
Other (Specify) ____

Restrictions

The recipient should not further disclose medical information unless a valid authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

Duration

This authorization will expire 90 days from today or at an earlier date, at my election (To cancel this authorization prior to the above limit, notification must be sent to the Medical Record Department in writing and bear the patient's or legal representative's signature).

Patient Information (Please print)

Patient's Name:____ Date of Birth:______________

Social Security #:__________________________ Date(s) of Treatment: ________________________________

Signatures

Patient's Signature:____ Date:_________________

Legal Representative's Signature:________________________________ Date:_________________

Witness Signature:____ Date:_________________