Thomas K. Bond, MD, MS
TotalCare Health & Wellness
1101 South College Rd.
Suite 201
Lafayette LA, 70503
Phone: (337) 264-7209
Fax: (337) 264-7214

Please print legibly, the following information becomes part of your confidential medical record.

Patient Name: _____ **Date**: _____
Address: _____ _____
City: _____ **State**: _____ **Zip Code**: _____
SSN: _____-_____-_____ **DOB**: _____/_____/_____ **Age**: _____
Male Female Marital Status: Single Married Divorced Widowed
Phone:(___)_____-_____ **Type**:_____ **Alternate Phone**:(___)_____-_____ **Type**:_____

E-mail address: _____ **Employer**: _____
Emergency Contact: _____**Relationship**: _____ **Phone**: (____)_____-_____

PRIMARY INSURANCE CARRIER: _____ MEMBER ID: _____

SUBSCRIBER NAME: _____ SUBSCRIBER D.O.B.: _____

SECONDARY INSURANCE CARRIER: _____ MEMBER ID: _____

SUBSCRIBER NAME: _____ SUBSCRIBER D.O.B.: _____

Confidential Channel Communication Request

As required by the health Information Portability and Accountability Act (HIPAA) of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels.

I hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supercedes any prior request for confidential channel communications I may have made.

1. *May we discuss our Personal Health Information with anyone else? (You must fill in the name and phone number if okay)*
   Name: _____ **Relationship**:_____ **Phone**:(____)_____-_____
   Name: _____ **Relationship**:_____ **Phone**:(____)_____-_____
   Name: _____ **Relationship**:_____ **Phone**:(____)_____-_____
   Name: _____ **Relationship**:_____ **Phone**:(____)_____-_____
   Name: _____ **Relationship**:_____ **Phone**:(____)_____-_____
2. *May we leave a detailed verbal message or send written correspondence to:*
   _____Personal Number _____Work Number _____Fax _____Home/Billing Address

Spouse /Parent/Guardian of Minor Information

Name: _____ **DOB**: _____
SSN #: _____-_____-_____ **Employer**: _____

_____ _____
Patient or Responsible Persons Signature **Date**

Patient Name: _____

If no one is listed we will leave a message with ***ONLY*** *a call back number.*

Social History: **Please circle your answer**

Tobacco:	None	Cigarettes	Cigars	Chew	Amount: _____Quit date: _____
Caffeine	None	Colas	Coffee	Tea	Amount: _____
Alcohol:	None	Yes	No		Amount: _____
Illicit Drugs:	None	Yes	No		Amount: _____

Surgical History:

Type of Surgery	Date of Surgery	Physician

Past Medical History/Family Medical History:

	Self	Father	Mother	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather	Brother	Sister
Asthma									
Autoimmune disease									
Cancer									
COPD									
Diabetes									
Heart Disease / Heart Problems									
Hepatitis									
High Cholesterol									
Hypertension									
Osteoporosis									
Seizure Disorder									
Stroke									
Thyroid Problems									
Other significant									

List all medications including dosage, frequency and medical problem: (use separate sheet or back for additional meds)

Medication	Dosage (mg)	Frequency	Medical Problem

Allergies

Name of Allergies	Type of Reaction

Do you have any allergies to iodine? [ ] No [ ] Yes
Do you have any allergies to latex? [ ] No [ ] Yes

Patient Name: _____ Date: _____

I hereby give consent to Thomas K. Bond, MD, MS, to provide whatever treatment he may deem necessary to the patient listed above.

I understand my responsibility for payment of services provide to me. I hereby assign insurance benefits, otherwise payable to me, to be paid directly Thomas K. Bond, MD, MS for Professional Physician's fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by the insurance policy.

In the matter of balances remaining unpaid, it is the policy of our office to refer such outstanding debts to either a collection agency or an attorney for further action. Accounts referred to either an attorney or collection agency are subject to a late fee of 35% of the unpaid amount.

I hereby authorize the release of my medical records Thomas K. Bond, MD, MS. I release you from all legal responsibility or liability that may arise from this authorization. You have my permission to fax my medical records whenever medically necessary.

Patient's Signature (Parent/Guardian if minor child):_____
Date: _____ **Witness Signature** _____

Thomas K. Bond, MD, MS
Authorization to Release Health Information

***ALL ASTERISKED ITEMS MUST BE COMPLETED.**

*Patient Name: _____ ***Date of Birth:** _____

***Patient Number:** _____ ***Social Security #** _____

***Address:** _____

***Entity to release the Health Information**
(Name of releasing entity)

_____
_____
_____
_____

***Provider receiving the Health Information:**
Thomas K. Bond, MD, MS
1101 South College Rd.
Suite 201
Lafayette LA 70503
337-264-7209 Phone
337-264-7214 Fax

Dates of service of Health Information that is covered by this authorization:
State date: _____ End date: _____ Start date: _____ End date: _____
*Health Information related to the patient to be release under this authorization:

_____ Complete health record
_____ Immunizations
_____ Laboratory tests
_____ Other (Please Specify): _diagnostic studies, op notes, consultant reports, history & physical
_____ Radiology Report
_____ Specific Physician
_____ Specific Medical Dept.

The following information will be release when included in the above unless you indicate otherwise:
_____ Do not release any AIDS or HIV test results
_____ Do not release any records of psychiatric care
_____ Do not release any records of alcohol/substance abuse treatment
_____ Other: _____
*Authorization expiration date or event:_____

You may revoke this authorization at any time, except to the extent that we have already relied upon it in making a use of disclosure. A written request to revoke an authorization any be sent to TotalCare Health & Wellness / Medical Records Department.
The patient has the right to refuse to sign this authorization. Dr. Thomas K. Bond cannot condition treatment, payment, enrollment or eligibility for benefits on the patient providing this signed authorization. When the patient's health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient or any of its agents and/or employees and may no longer be protected by 45 C.F.R. Parts 160 and 164.

A photocopy/facsimile of this authorization may serve as an original.
The party receiving the medical records is responsible for payment of the copying charges.
Records will be rendered after payment and signature are received

_____ _____
*Patient's Signature *Date

OR

*If patient is a minor or unable to sign for self:

By my signature below I certify that I am the _____ (relationship) of the above named patient.

_____ _____ _____
Signature of Patient Representative Printed Name Date

*Verification of identity of person in to whom records are being given, Indicate method of verification:
_____ personal knowledge _____ pictured ID _____ Other: Describe: _____

Thomas K. Bond, MD, MS
Authorization to Release Health Information

***ALL ASTERISKED ITEMS MUST BE COMPLETED.**

*Patient Name: _____ ***Date of Birth:** _____

***Patient Number:** _____ ***Social Security #** _____

***Address:** _____

***Entity to receive the Health Information**
(Name of receiving entity)

_____
_____
_____
_____

***Provider releasing the Health Information:**
Thomas K. Bond, MD, MS
1101 South College Rd.
Suite 201
Lafayette LA 70503
337-264-7209 Phone
337-264-7214 Fax

Dates of service of Health Information that is covered by this authorization:
State date: _____ End date: _____ Start date: _____ End date: _____
*Health Information related to the patient to be release under this authorization:

_____ Complete health record
_____ Immunizations
_____ Laboratory tests
_____ Other (Please Specify): _diagnostic studies, op notes, consultant reports, history & physical
_____ Radiology Report
_____ Specific Physician
_____ Specific Medical Dept.

The following information will be release when included in the above unless you indicate otherwise:
_____ Do not release any AIDS or HIV test results
_____ Do not release any records of psychiatric care
_____ Do not release any records of alcohol/substance abuse treatment
_____ Other: _____
*Purpose of Disclosure: Neurological Surgery Evaluation
*Authorization expiration date or event: _____

You may revoke this authorization at any time, except to the extent that we have already relied upon it in making a use of disclosure. A written request to revoke an authorization any be sent to TotalCare Health & Wellness / Medical Records Department.
The patient has the right to refuse to sign this authorization. Dr. Thomas K. Bond cannot condition treatment, payment, enrollment or eligibility for benefits on the patient providing this signed authorization. When the patient's health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient or any of its agents and/or employees and may no longer be protected by 45 C.F.R. Parts 160 and 164.

A photocopy/facsimile of this authorization may serve as an original.
The party receiving the medical records is responsible for payment of the copying charges.
Records will be rendered after payment and signature are received

_____ _____
*Patient's Signature *Date

OR

*If patient is a minor or unable to sign for self:

By my signature below I certify that I am the _____ (relationship) of the above named patient.

_____ _____ _____
Signature of Patient Representative Printed Name Date

*Verification of identity of person in to whom records are being given, Indicate method of verification:
_____ personal knowledge _____ pictured ID _____ Other: Describe: _____

YOUR RIGHTS AS A PATIENT

Although your health record is the physical property of this office, the information belongs to you. You have the right to:

- *Inspect and obtain a copy of your health record* – Your health record contains medical records, billing records, and other records that your physician and staff use for making decisions about you. There are some records that, under Federal law, may ***not*** be inspected or copied by you. Please contact our Privacy Officer for more information.

- *Request a restriction on certain uses and disclosures of your information* – You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations or that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is *not required* to agree to a requested restriction if your physician believes it is in your best interest to permit use and disclosure of your protected health information. You may request a restriction form by contacting our Privacy Officer.

- *Obtain a paper copy of privacy practices upon request* – Contact our Privacy Officer.

- *Request to have your physician amend your health record* - You may request amendment of your protected health information for as long as we maintain this information; however, we may deny such a request. If we deny your request, you may file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of that rebuttal. Contact our Privacy Officer with questions about amending your medical record.

- *Obtain an accounting of disclosures of your protected health information* – This applies to any disclosure other than treatment, payment, or healthcare operations as described in the Notice of Privacy Practices, and excluding disclosure we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003, subject to certain exceptions, restrictions, and limitations.

- *Request confidential communications of your health information by alternative means or at alternative locations* – We will accommodate reasonable requests and will not question your request. We may, however, request payment for accommodating this request.

- *Revoke your authorization to use or disclose health information except to the extent that action has already been taken.*

This office has made me aware of my rights as a patient. I hereby acknowledge my full and complete understanding of these rights.

_____ _____

Patient's Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgment of notice and consent authorizes Thomas K. Bond, MD, MS. to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notices of Privacy Practices

Thomas K. Bond, MD, MS. has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent**.**

Amendments

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to:

TotalCare Health & Wellness
1101 South College Rd, Suite 201
Lafayette, LA 70503
(337) 264-7209

Acknowledgement and Consent

I have received a copy of Thomas K. Bond, MD, MS, Notice of Privacy Practices. I understand that he is allowed to use and disclose health information about me for the purposes of treatment, payment, and healthcare operations consistent with the Notice of Privacy Practices.

Signature of patient	**Printed name of patient**
Signature of personal representative	**Printed name of representative**
Relationship to patient	**Date signed**

TotalCare
Health & Wellness Medical Center
For your health. For your life.

Narcotic Medication Use Agreement

I, _____, understand that I have been/may be diagnosed with a condition in which my functional capacity is limited on a daily basis due to pain. Because of this, I am being / have been prescribed narcotic medication(s) (also known as, "pain medication"). I understand and agree that the intent of this prescription medication is to increase my ability to become more physically and functionally active, though it is unlikely to eliminate the pain completely.

I understand the **purpose of this agreement** is to prevent misunderstandings and miscommunication about the above-mentioned intent, mechanism of action, potential risks & benefits, side effect profile, and legal aspects of these controlled substances (narcotics). I understand this agreement is to assist both my physician and myself to comply with all state and federal laws regarding controlled pharmaceuticals.

I recognize that this Agreement is absolutely essential to the trust and confidence necessary in the doctor-patient relationship which allows my physician to treat me with narcotics. I further recognize that should I break this trust by altering or deviating from the rules and statements of this Agreement in any way, my physician will reserve the right to discharge me from his practice, no longer providing care or writing prescriptions for me.

I understand that *my doctor has no obligation whatsoever to provide these medications to me*, and that he reserves the right to discontinue the medication at any time based on his clinical judgment.

I understand that it is my responsibility to safeguard and secure my prescriptions and medications, including keeping them away from children and/or pets. Any lost or stolen medications will not be refilled unless a copy of the submitted police report is given to my physician.

I understand and agree with the fact that narcotic prescriptions will only be written for me in the physician's office during an office visit, and will never be provided by telephone, after regular business hours, on a weekend, or holiday.

I understand and agree that as part of this agreement, my physician may require random in-office urine-drug screen in order to assess my compliance with the prescribed regimen. This testing, if asked of me, will be mandatory and at my expense. Failure to comply with this test may result in dismissal from the practice.

I will accept this and all other "pain medications" only from TotalCare providers, and will not seek or accept any medications for pain from anyone other than the TotalCare providers. . I further understand that to do so would constitute a felony in the state of Louisiana (diversion of prescription medication). I understand the definition of "pain medications" to be prescription medication, borrowed medication from friends/family, and any and all illicit or "street" drugs.

I agree to take the medication only as prescribed. I will not imbibe alcohol, or take any other sedative without the approval of my TotalCare physician.

I understand that should my pain not be appropriately controlled with this medication and/or there are concerns for my safety and/or well-being, as per the physician's best clinical judgment, my care may be transferred to a Board-Certified Pain Management Physician. If this occurs, my TotalCare physician will no longer see me for medical management of my pain, and thus, will not write prescriptions for narcotic pain meds.

I agree to be sincere and honest in relaying all aspects of my painful condition to the physician and other healthcare team members of TotalCare. I will behave honestly and professionally in all dealings.

I agree to fill my prescriptions at the following pharmacy. If I change pharmacies, I will contact TotalCare to alert them of this change. I understand that a copy of this Agreement will be sent to my pharmacy.

Pharmacy Name: _____.
Pharmacy Address: _____.
Telephone: _____. Fax: _____.

I understand that by signing this Agreement, I must abide by all of its contents, and failure to do so will result in the termination of my participation as a patient here at TotalCare, termination of further pain medication prescriptions, and possible criminal charges if warranted.

Patient Signature: _____. Date _____.

Physician Signature: _____. Date: _____.

Dear Patient -

We want you to know a few key things about your bloodwork.

- TotalCare is NOT responsible for any billing of lab work
- TotalCare draws labs at the office for courtesy and convenience of our patients
- You are responsible for knowing your benefits for out of pocket cost when it comes to lab work bills
- Our staff cannot provide you with an estimation of cost, because Clinical Pathology Labs (CPL) has their own contracted rate with your insurance company
- Lab work bills are processed differently than your out-of-pocket cost at our office, and is not included in your out-of-pocket that you pay to our office
- You will not pay TotalCare for your labs, rather you will get a separate bill from Clinical Pathology Labs
- Any questions concerning your lab work needs to be directed to Clinical Pathology Labs
- All lab work that is ordered is needed to continue to treat you as a patient – lab work is not optional

Thank you and have a wonderful day!

Brooke Miller
TotalCare Patient Billing Manager

Patient Signature: _____ Patient Full Name (Printed):_____

By signing this document, you acknowledge that you have fully read and understand our lab work procedures.

NOTICE OF PHYSICIAN'S FINANCIAL INTEREST

A referring physician must disclose the existence and nature of any financial interest, as defined by law, in any other health care provider to which a patient is being referred for health items or services in advance of any such referral according to La. Admin. Code 46:XLV:§§ 4203, 4211-19. (I/We) support these laws in order to help patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of these laws, you are being advised that (I/we) have a financial interest in a management services company named OHVMSO 14, LLC, which provides certain administrative support services to the entity named below providing laboratory services. Further the treatments, goods, or services (I/we) have prescribed are available elsewhere on a competitive basis.

NAME OF DIAGNOSTIC, TREATMENT OR DISPENSING FACILITY:

Crescent City Surgical Centre

TREATMENT, GOODS, OR SERVICES:

Laboratory Services

Please provide your acknowledgement that you have read and understood these disclosures by dating and signing this form in the spaces provided below. (I/We) will keep the signed original in your patient file; you will receive a copy upon request.

ACKNOWLEDGEMENT: (I/We) have read this "Notice of Physician's Financial Interest" form, and (I/we) understand by signing this form that the physician has disclosed his/her direct financial interest in an entity providing administrative support services to the laboratory services entity he/she has prescribed or referred.

_____

Signature of Patient or Guardian

_____

Printed Name of Patient or Guardian

_____

Date

DOCTOR CONNECT

TotalCare
Health & Wellness Medical Center

Our clinic is now using DoctorConnect to better serve you and connect with our patients. Please provide us with your cell phone number, email address, etc., so we may keep direct communications as open as possible.

If you are have lab results, we will require your social security number to remain compliant with identity verification and HIPPA regulations.

Thanks in advance for your cooperation!

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Cell Phone Number: _____

Email: _____