PATIENT DATA DETAIL SHEET

PATIENT INFORMATION:

Name: ______________________________ Sex:
Address: ______________________________ Birth Date: ____________
2nd Addr: ______________________________ SSN: ____________
Email: ____________________ Primary Care Physician: ____________________

Phone (order by preference)	**Type**	**Who's Phone**		**Phone Owner's Name**
____________________	cell home work	self spouse parent other:	__________	____________________
____________________	cell home work	self spouse parent other:	__________	____________________
____________________	cell home work	self spouse parent other:	__________	____________________

RESPONSIBLE PARTY:

Relationship: __self __parent __guardian __other:__________ Sex:
Name: ______________________________ Birth Date: ____________
Address: ______________________________ SSN: ____________

CONTACTS: (Persons we may inform about your medical or financial information.)

Name: ____________________ Relationship to Patient: ____________ Phone: ____________
____________________ ____________ ____________

EMERGENCY CONTACTS:

Name: ____________________ Relationship to Patient: ____________ Phone: ____________
____________________ ____________ ____________

INSURANCE INFORMATION:

Primary: ____________________ Insured: ____________________ Birth Date: ____________
Secondary: ____________________ ____________________ ____________

CENSUS INFORMATION: (The federal government requires physician groups to collect certain information.
You are not requried to provide this and may DECLINE to answer.)

Ethnicity	**Race**		**Preferred Language**	
__Decline	__Decline		__Decline	
__Hispanic or Latino	__Asian	__Black or African American	__English	__Japanese
__Not Hispanic or Latino	__Hispanic	__American Native or Alaskan Native	__Chinese	__Korean
	__White	__Native Hawaiian or Other Pacific Islander	__French	__Russian
	__Other		__German	__Other

VISIT INFORMATION:

Describe how you were injured or where pain orginates: ______________________________
Date/Time of Injury or Date Pain Began: ___/___/___ , ___:___ AM / PM
Where did injury occur? __at home __at work __in an auto accident __other: ____________

Did another physician refer you here for this problem? __Y __N If yes, physician's name: ____________
Did you have x-rays or other tests for this problem? __Y __N If yes, where were they taken? ____________

Signature of patient / guardian: ______________________________ Date: ____________

Printed name of patient / guardian: ______________________________

Date: _________ **New Patient History** Revised: 2/12/15

Patient: _____________________ DOB:_____________ Gender: M[ ] F[ ] Race:____________

Active Specialist/Speciality: _________________/__________________ _________________/__________________
_________________/__________________ _________________/__________________

Review of Systems – Check if patient currently has any of the following.

Chills or Fever [ ]	Chest Pain(respiratory) [ ]	Stomach Pain [ ]	Abnormal Walking [ ]	Asthma [ ]
Night Sweats [ ]	Shortness of Breath [ ]	Loss of Appetite [ ]	Seizures [ ]	Food Allergies [ ]
Recent Weight Change [ ]	Heart/Chest Pain [ ]	Nausea / Vomiting [ ]	Skin Lesion/ Rash [ ]	Seasonal Allergies [ ]
Poor Appetite [ ]	Leg Swelling [ ]	Difficulty Urinating [ ]	Easy Bleeding [ ]	
Loss of Hearing [ ]	Abnormal Heartbeat [ ]	Blood in Urine [ ]	Easy Bruising [ ]	
Change of Vision [ ]		Urinary Incontinence [ ]		

Medical / Surgical History – Check if patient has any of the following.

AIDS/HIV [ ]	Blood Clots/ Phlebitis [ ]	Gout [ ]	Liver Trouble [ ]	Thyroid Trouble [ ]
Alcoholism [ ]	Cancer [ ] _________	Heart Disease [ ]	Mental Illness [ ]	Tuberculosis [ ]
Alzheimer's [ ]	COPD [ ]	Hepatitis [ ]	Osteoarthritis [ ]	Ulcers [ ]
Arthritis [ ]	Depression [ ]	High Cholesterol [ ]	Osteoporosis [ ]	Fractures [ ]
Asthma [ ]	Diabetes [ ]	Hypertension [ ]	Parkinson Disease [ ]	Other [ ]
Bleeding Disorders [ ]	Drug Abuse [ ]	Kidney Disease [ ]	Stroke [ ]	

Explain answers:

____
____

Surgeries - List all surgeries including approximate date.

________________________ ________________________
________________________ ________________________
________________________ ________________________
________________________ ________________________
________________________ ________________________
________________________ ________________________

FEMALES ONLY - Update the following.

Gone through menopause? Y[ ] N[ ]
Going through menopause? Y[ ] N[ ]
Is it possible you are pregnant? Y[ ] N[ ]
Have you had a hysterectomy? Y[ ] N[ ]

Medications - List all active medications. **Pharmacy:** _______________________________ **NONE [ ]**

__________________ __________________ __________________ __________________
__________________ __________________ __________________ __________________
__________________ __________________ __________________ __________________

Allergies (to medications): **NONE [ ]**

__________________ __________________ __________________ __________________
__________________ __________________ __________________ __________________

Family History – Check if patient's family members have the following (indicate mother, father, brother, sister).

AIDS/HIV [ ]	Blood Clots/ Phlebitis [ ]	Gout [ ]	Liver Trouble [ ]	Thyroid Trouble [ ]
Alcoholism [ ]	Cancer [ ] __________	Heart Disease [ ]	Mental Illness [ ]	Tuberculosis [ ]
Alzheimer's [ ]	COPD [ ]	Hepatitis [ ]	Osteoarthritis [ ]	Ulcers [ ]
Arthritis [ ]	Depression [ ]	High Cholesterol [ ]	Osteoporosis [ ]	Fractures [ ]
Asthma [ ]	Diabetes [ ]	Hypertension [ ]	Parkinson Disease [ ]	Other [ ]
Bleeding Disorders [ ]	Drug Abuse [ ]	Kidney Disease [ ]	Stroke [ ]	

Explain answers and add cause of death of parents, brothers and sisters.

____
____
____

Social History (Patient's)

Tobacco: Y[ ] N[ ] FORMERLY [ ] Packs / Day :_________________ Year Quit ______
Alcohol: Y[ ] N[ ] FORMERLY [ ] Frequency : Occasional [ ] Moderate [ ] Heavy [ ]
Illicit Drugs: Y[ ] N[ ] FORMERLY [ ]

Marital Status: S[ ] M[ ] D[ ] W [ ] **Children:** None [ ] # of sons [ ] # of daughters: [ ]
Work/School: Retired? Y [ ] N[ ] Disabled? Y [ ] N[ ]
Place of Employment Occupation: ______________________
OR School Name: _________________________________ Grade (Students Only): ______________

Peter D. Vizzi, M.D.

ORTHOPAEDIC SURGERY & SPORTS MEDICINE
A MEDICAL CORPORATION

1301 Camellia Blvd, Suite 102
Lafayette, Louisiana 70508

PHONE: 337-233-3201
FAX: 337-233-3207

Please print your name: ________________________________

Please read sections I, II, & III and sign in section IV.

I. **PLEASE PROVIDE RECEPTIONIST WITH A COPY OF YOUR INSURANCE CARD(S) ALONG WITH A COPY OF YOUR DRIVER'S LICENSE OR A PICTURE ID.** All charges are due at the time of service. If your insurance is a PPO, you will be responsible for your copay, % after deductible has been met, and/or full amount if deductible has not been met. If this is workers compensation, we will file your visits with your employer or compensation carrier as long as we have the necessary information. My signature in Section IV confirms my understanding.

II. **AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**. My signature in Section IV of this page authorizes Peter D. Vizzi MD AMC to release medical information necessary for claim reimbursement from Medicare, insurance companies, or other third parties to whom a claim may be submitted. I hereby assign payment of medical benefits to Peter D. Vizzi MD AMC. I understand that I am ultimately responsible for payment of all charges for medical services and if any claim to an insurance company or third party is rejected, modified or not paid within 90 days, it is my responsibility to pay all charges in full. A 1.5% per month rebilling charge is added after 90 days. I authorize Peter D. Vizzi MD AMC to release medical records and reports to the referring physician or any other physicians or health care providers that may be consulted or who need access to these records for my medical care. I also authorize any other physician, laboratory, hospital or to the provider to release all medical records and x-rays necessary for my care to Peter D. Vizzi MD AMC.

III. ACKNOWLEDGEMENT OF RECEIPT OF PETER D VIZZI MD AMC NOTICE OF PRIVACY PRACTICES. My signature in Section IV of this form acknowledges that I was provided the Notice of Privacy Practices for Peter D. Vizzi MD AMC.

IV. SIGNATURE FOR SECTIONS I, II, III. My signature below attests to my understanding and agreement to the information presented in sections I, II, and III.

____ ______________________
Signature Date

IF THIS IS A WORKERS COMPENSATION INJURY, PLEASE READ AND SIGN BELOW.

EMPLOYER NAME: ________________________________ **PHONE:** ______________________________

EMPLOYER CONTACT PERSON: ____

WORKERS COMP CONTACT PERSON: ____________________________ **PHONE:** ___________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS. I hereby authorize Peter D. Vizzi MD AMC to release medical records, x-rays, correspondence and any other information regarding my medical treatment requested by my Employer and/or Workers Compensation Carrier. This also authorizes verbal communication regarding my condition and/or treatment between my provider, employer and/or workers compensation carrier.

____ ______________________
Signature Date

Peter D. Vizzi, M.D.

ORTHOPEDIC SURGERY & SPORTS MEDICINE
A MEDICAL CORPORATION

1301 Camellia Blvd, Suite 102
Lafayette, Louisiana 70508

PHONE: 337-233-3201
FAX: 337-233-3207

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW

Welcome to our office. In order for us to be able to deliver the quality care to which you are accustomed, we have established the financial policies which are listed below:

1. As health care providers, our relationship is with you, not your insurance company or a third party such as an attorney or liability insurance. All charges are your responsibility from the date the services are rendered.
2. By Federal Law and Health Care Contract obligations, this office is required to collect co-payment, co-insurance and deductible for each encounter. Penalty for not following this requirement could result in the termination and cancellation of medical coverage for the patient.
3. We ask that you present your insurance card at the time of your first visit. It is your responsibility to provide us with the correct information to bill your insurance. We ask you to inform us of any insurance changes as they occur.
4. If you have a change of address, telephone numbers, or employer, please notify the receptionist so we may update your information.
5. We will collect your deductible, co-payment, co-insurance or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also collect your account balance. We accept cash, checks, Visa, Discover, American Express and MasterCard.
6. When an appointment is not cancelled in advance and the patient “no-shows”, we reserve the right to charge a $50 fee. This is considered a non-covered service by insurance and will be the responsibility of the patient. We will assume after 3 “no-shows” for the current problem, that you have severed our relationship and no longer wish for Dr. Vizzi to be your physician.
7. If your insurance denies our charge, or does not pay us in a timely manner, it will become your responsibility to pay the charges in full.
8. We will assess a 1.5% monthly interest charge on unpaid balances of 90 days old. Your account may also be referred to a collection agency, attorney and/or reported to the credit bureau. If any account is placed in the hands of an attorney and/or collection agency for collection after default, the undersigned agrees to pay all cost of the collection including a reasonable attorney and/or collection agency fee in addition to the balance of the account.
9. Returned checks will be subject to a $25.00 NSF fee.
10. **IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE,** we will require payment at the time of service. If you would like to file a claim to your insurance company, you may request a claim form to do this.
11. **MEDICARE PATIENTS:** We are participating providers with Medicare and will bill Medicare for all of your covered charges. If you have supplemental insurance, we will also bill for them for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
12. **PATIENTS INVOLVED IN A MOTOR VEHICLE ACCIDENT (MVA):** If you are involved in a MVA, you are responsible for payment of all charges at time of service. You must also provide your auto insurance information so we may inform them of your visit. We will not file claims to your health insurer if you were involved in a MVA.
13. **SELF-PAY PATIENTS:** Patients who choose not to use their insurance or those with no insurance will be expected to pay at time of service.

Disclosure of Financial Interest: In accordance with La. R.S. 37:1744 and 42 CFR 489.20, please be advised that Dr. Vizzi has an ownership interest in Park Place Surgical Hospital. If you have any questions about receiving care at Park Place Surgical Hospital, or you have objections to receiving treatment at Park Place Surgical Hospital, please let a nurse or Dr. Vizzi know before any physician orders are issued in connection with your treatment at another facility.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I have read and fully understand the financial policy of the practice Peter D Vizzi MD AMC and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature	Patient Name (please print)	Date

Peter D. Vizzi, M.D.

ORTHOPAEDIC SURGERY & SPORTS MEDICINE
A MEDICAL CORPORATION

1301 Camellia Blvd, Suite 102
Lafayette, Louisiana 70508

PHONE: 337-233-3201
FAX: 337-233-3207

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods.

It may be necessary to communicate with you about your healthcare/billing. We will, at times, leave brief messages on your answering machines or voicemail or with someone at your contact number, including home, work or mobile.

We may use or disclose identifiable health information about you without your written authorization for treatment, payment and healthcare operations. Subject to certain requirements, we may also give out health information without your authorization for: communication with family/close personal friends or any other person you identify regarding medical treatment or payment related to your care; public health activities and in cases of emergency including abuse, neglect or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; with regard to decedents to coroners, medical examiners and funeral directors; organ procurement organizations; research purposes; averting a serious threat to health or safety; specialized government functions including to correctional institutions; workers' compensation; and when otherwise required by law. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information. You can later revoke that authorization to stop any future uses and disclosures.

We will not use or disclose any protected health information (PHI) for things like marketing or fundraising.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post a new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

INDIVIDUAL RIGHTS: In most cases, you have the right to look at or get a copy of health information about you that we will use to make decisions about your care. If you request copies, we will charge you only normal copy fees. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorize it. If you believe that the information is incorrect or if important information is missing you have the right to request, in writing, that we correct the existing information or add the missing information. This does not obligate us to alter the record. You have the right to request restrictions on certain uses and disclosures of protected health information. This does not obligate us to agree to the requested restriction. You have the right to request to receive communications of protected health information from us by alternative means or at alternative locations. You have a right to obtain a paper copy of this notice. You have the right to request a restriction of certain protected health information from disclosure to health plans where you pay out of pocket, in full, for care. You have a right to receive notifications whenever a breach of your unsecured PHI occurs within 60 days following the discovery

COMPLAINTS: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

OUR LEGAL DUTY: We are required by law to maintain the privacy of PHI and to provide this notice about our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the notice currently in effect.

If you have any questions, requests, or complaints, please contact
Meredith Robicheaux, Office Manager, at the contact information on the top of this notice.

Revised 06/07/2013

PETER D. VIZZI, M.D.
Orthopaedic Surgery
& Sports Medicine
A Medical Corporation

1301 Camellia Blvd, Suite 102
Lafayette, Louisiana 70508

PHONE: 337-233-3201
FAX: 337-233-3207

Thank you for choosing our office for you orthopedic needs.
Please be at our office 20 minutes before your appointment to enable us to put your chart together and have you seen by Dr. Vizzi at your scheduled appointment time.

Please bring the following:

1. The attached forms completed.

2. Insurance cards with a form of payment. ***You are expected to pay copays, coinsurance and/or deductible amounts at the time of service***. We accept cash, check, Visa or Mastercard.

3. Picture ID. If the patient is a minor, a parent must accompany the patient with a pictured ID.

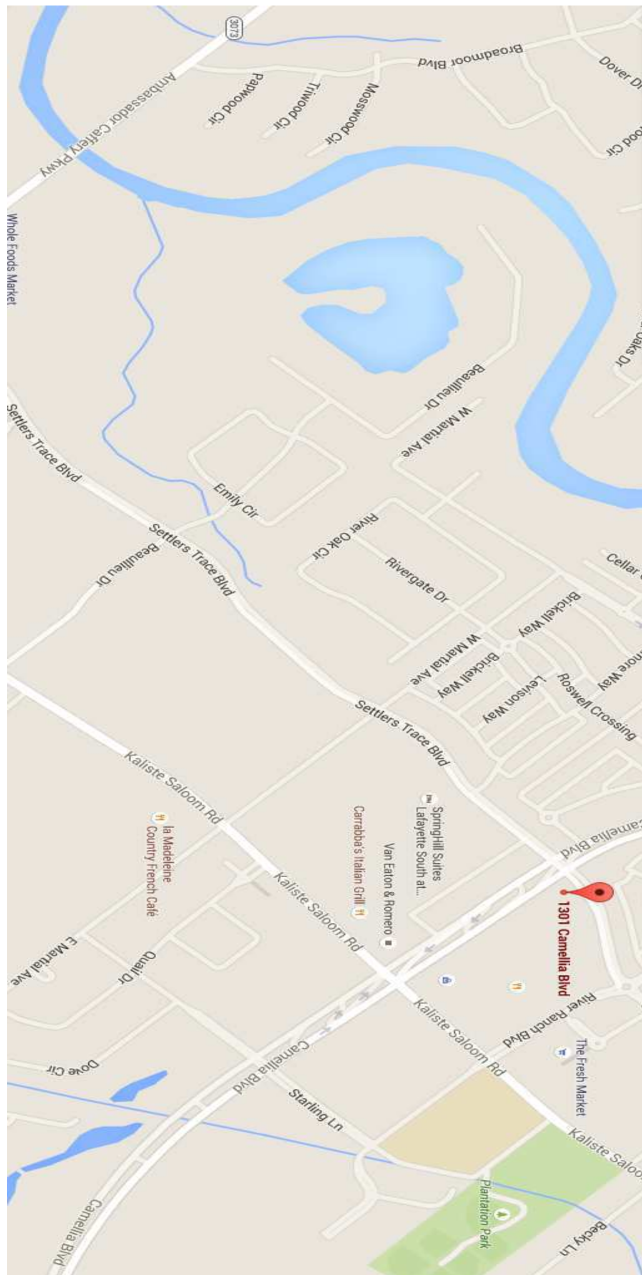
4. If you have seen any other physicians for this problem/injury, please bring all records pertaining to this problem/injury.

5. If you have had x-rays, diagnostic testing such as an MRI, Bone Scan, CT Scan, etc. for this problem/injury, please make sure you pick up the actual study (CD or film) along with the report from the facility where they was performed.

6. Please bring a list of medications you are currently taking.

7. If this is a motor vehicle accident, please remember ***YOU ARE RESPONSIBLE FOR PAYING FOR YOUR VISIT***. Please bring your motor vehicle insurance information or attorney information (name, address, phone number, and claim number) for our records in the event surgery or diagnostic testing is needed.

MAP TO OUR OFFICE:



If you have any questions, please call us at 337-233-3201.
Thank you in advance for your cooperation. We look forward to seeing you.