Southwest Mississippi Anesthesia, P.A., Inc. ®
455 E. Airport Drive
Baton Rouge, Louisiana 70806
Telephone: (225) 201-0950

First Choice Surgery Center of Baton Rouge, LLC
505 E. Airport Drive
Baton Rouge, Louisiana 70806
Telephone: (225) 201-0950

Arnold E. Feldman, M.D.
Medical Director

We would like to take this opportunity to welcome you to our office. Our goal is to provide patients with compassionate care while relieving chronic pain, restoring health, comfort and quality of life. Our state-of-the-art, full service facility is staffed with caring professionals ready to assist you in achieving your goal of eliminating pain from your daily life.

In order to serve you efficiently, please fill out the enclosed new patient packet. This will help us to get familiar with your personal situation ahead of time and also will reduce your wait time.

After becoming a patient and on all follow-up visits please bring ALL MEDICATIONS prescribed by our office to each appointment. This is important in order for us to treat each patient accurately and prescribe the correct dosage of medication as needed. If you do not bring your medications or current empty bottles your appointment will have to be rescheduled.

We would like to thank you in advance for returning this packet as soon as possible.

PATIENT REGISTRATION

Date:_____

PATIENT NAME:_____

PHYSICAL ADDRESS:_____

MAILING ADDRESS:_____

HOME#_____ **WORK#**_____ **CELL#**_____

EMAIL:_____ **SS#** _____

D.O.B.:_____ **SEX:** _____ **MARRIED**_____ **SINGLE**_____ **OTHER**_____

PLACE OF EMPLOYMENT: _____

TELEPHONE #_____**OCCUPATION**_____

ADDRESS:_____

SPOUSE NAME: _____

SPOUSE EMPLOYER: _____**TEL#**_____**OCCUPATION**_____

ADDRESS:_____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

HOME#_____**WORK#:**_____**CELL#:**_____

HOW DID YOU HEAR ABOUT US? **Friend** **Doctor** **TV** **Yellow Pages** **Sunshine Pages** **Radio** **Billboard** **Internet** **Brochure** **Newspaper** **Local Magazine (which)** _____

WHO REFERRED_____ **PRIMARY CARE?** _____

PROBLEM BEING SEEN FOR_____

IS THIS AN ACCIDENT OR ILLNESS_____**ACCIDENT DATE**_____

ATTY NAME_____**TEL#**_____

INJURED ON JOB? Y N REPORTED TO EMPLOYER? Y N

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS PROBLEM? YES NO

IF YES, DR.:_____**TEL#**_____

HAVE YOU HAD XRAY? Y N MRI? Y N CT? Y N
MEDS? Y N PT? Y N SURGERY? Y N

INSURANCE: (PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST)

PRIMARY INSURANCE

COMPANY: _____

ADDRESS: _____

SUBSCRIBER:_____

SUBSCRIBER'S SS#:_____-_____-_____

POLICY#:_____GROUP#:_____

SECONDARY INSURANCE

COMPANY: _____

ADDRESS: _____

SUBSCRIBER:_____

SUBSCRIBER'S SS#:_____-_____-_____

POLICY#:_____GROUP#:_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Southwest Mississippi Anesthesia, P.A., INC. (d/b/a "The Feldman Institute"), and/or First Choice Surgery Center of Baton Rouge, LLC and/or Dr. Arnold E. Feldman ("The Practice"), all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by my insurance plan, for whatever reason, and for all co-pays, deductibles and co-insurance amounts. Further, I understand that if and when charges are or become my personal responsibility, that such a balance account will constitute an "open account," for purposes of Louisiana law. If balances remain unpaid, The Practice may refer your account to a collection agency, which will result in up to an additional 40% of the unpaid balance in collection fees. I hereby authorize the providers to release all information necessary to secure the payment of benefits. I further authorize the use of this signature on all insurance submissions.

_____

PATIENT'S SIGNATURE DATE

Full Name: _____ M___F___ Date of Birth ____/___/____

Are you taking any Medications now? (This includes prescriptions, over-the-counter and/or herbal medications):

Medication Name:	Dosage:	How often:	Prescriber:	Length of time?

Are you allergic to any medications?

Medication Name	Type of Reaction (itching, nausea, or vomiting)

Any and all surgeries that you have had in the past: (Such as appendectomy, laminectomy, etc):

Surgeries:	Date:	Performing doctor:

What is your occupation? _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Separated ____

Highest level of education: (please circle one)
1 2 3 4 5 6 7 8 9 10 11 12 / Some College/ College Graduate/ GED/other: _____

Who referred you to us? _____

Have you had any of the following?

TREATMENT		WAS IT HELPFUL?
1. Acupuncture	YES or NO	YES or NO
2. Analgesics (Tylenol, Aspirin, etc...)	YES or NO	YES or NO
3. Bed Rest	YES or NO	YES or NO
4. Biofeedback	YES or NO	YES or NO
5. Chiropractic	YES or NO	YES or NO
6. Decreased Activity	YES or NO	YES or NO
7. Massage	YES or NO	YES or NO
8. Nerve blocks	YES or NO	YES or NO
9. Occupational Therapy	YES or NO	YES or NO
10. Physical Therapy	YES or NO	YES or NO
11. Psychologist	YES or NO	YES or NO
12. Surgery	YES or NO	YES or NO
13. Tens Unit	YES or NO	YES or NO

other:

_____

_____

_____

NEW PATIENT PAIN QUESTIONNAIRE

What is your chief complaint?

_____

Do you have any other area(s) of your body where you experience pain?

1) _____
2) _____
3) _____

Do you have radiating pain? YES NO If yes, where does it radiate to?

_____

Describe your pain. (Ex. Aching, burning, sharp, shooting pain)

_____
_____

How long have you experienced this pain?

_____

Is the pain constant? YES NO

What aggravates your pain the most?

_____

Is there anything that relieves it? YES NO

If yes, what?

_____

How has your pain affected your life?

_____

If your pain is due to an injury/accident please explain.

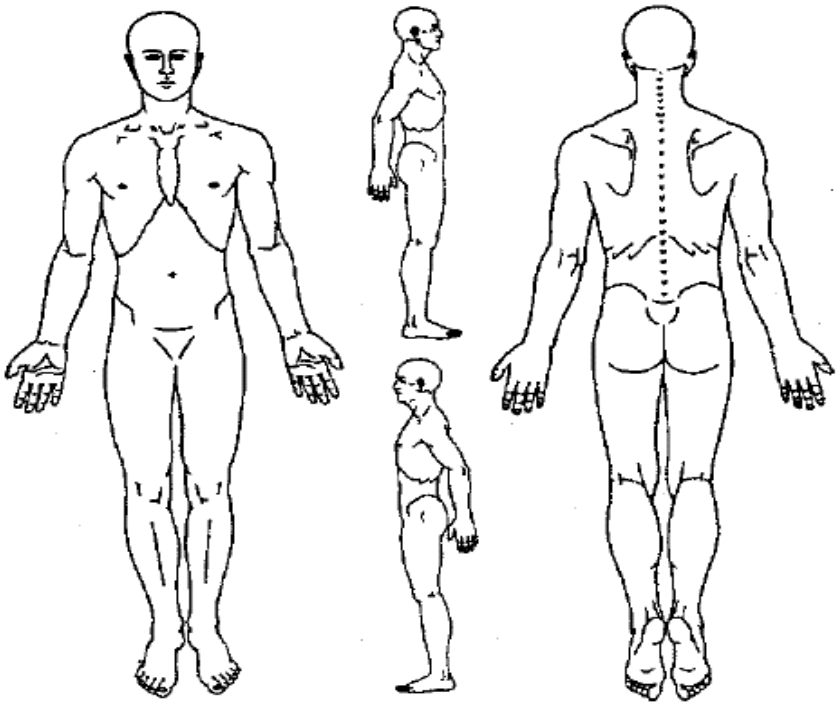
_____
_____
_____

PATIENT EVALUATION

Name: _____DOB_____ Date: _____

BP: R_____/L_____ P:_____ ___ R:_____SaO2:_____Temp:_____Wt:_____

Please use these symbols to describe your pain on the body:
● = Dull/Ache O = Sharp X = Burning + = Running



Please rate your pain from 1 -10, 10 being the worst, to indicate the intensity of your pain:

Without medications: 1 2 3 4 5 6 7 8 9 10

***With medications*:** 1 2 3 4 5 6 7 8 9 10

Have you been seen by any other clinical specialist/physician since your last visit?
_____

Have you received any new medications from any other source (hospital or doctor)?
_____

Did you bring your medications with you? (Circle One) YES NO

Please let us know how you are/or have been feeling to help us better treat you today:
_____
_____
_____

THE FELDMAN INSTITUTE [SM]
FIRST CHOICE SURGERY CENTER, LLC
SOUTHWEST MISSISSIPPI ANESTHESIA, P.A., INC.
DR. ARNOLD E. FELDMAN

Arnold E. Feldman, M.D.
Medical Director

TREATMENT AGREEMENT

Listed below are specific guidelines that you, as a patient of The Feldman Institute [SM], must agree to in order to receive treatment and/or be issued prescriptions through The Feldman Institute [SM]. **Failure to comply with these guidelines will result in termination of treatment and your prescription will be revoked.**

1. Dr. Feldman **must** be informed of any additional medications that are currently being prescribed for you, regardless of the nature of the prescription.
2. You may only use one pharmacy for medication prescribed by Dr. Feldman, which must be listed in your file. If you decide to switch pharmacies during your treatment, you must inform the office before you do so.
   List pharmacy of your choice: _____
3. Patient agrees **not** to receive pain medication from any other physician. **Refusal to comply with this will result in discharge from The Feldman Institute [SM].**
4. Lost or stolen medication will **NOT** be replaced under any circumstances.
5. All medication prescribed by Dr. Feldman **must** be brought to each appointment. If you are out of medication, please bring the empty bottles. **Appointments will be rescheduled if you do not bring your medication with you.**
6. Prescriptions will **NOT** be called in unless otherwise noted in the chart by clinical staff. They must be prescribed during regular office appointments. Due to the increase in volume of patients, please remember to make you return appointment before you leave. It will be difficult to schedule appointments on short notice.
7. Any requests for early refills will be denied and patient will be subject to discharge. If there is a need to increase quantity of medication, this must be discussed during an appointment.
8. Patient agrees to random urine screening. Any patient who refuses testing will not receive treatment and be discharged. **Patients who screen positive for drugs other than ones prescribed will be discharged from The Feldman Institute [SM] immediately.**
9. Patients who are more than 45 minutes late will have to reschedule their appointment.
10. Patient agrees to comply with all other parts of treatment programs if prescribed by Dr. Feldman (i.e. physical therapy, behavioral pain management, seminar attendance, etc.)
11. **Any breach of trust in this agreement will result in cessation of prescriptions and discharge from The Feldman Institute [SM].**

I, the undersigned, agree to the above terms of this agreement.

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

The Feldman INSTITUTE
For the Treatment of Acute and Chronic Painful Disorders

First Choice SURGERY CENTER

First Choice Surgery Center, LLC

Authorization to Release or Obtain Health Information

Name:_____ Request Date:_____

Mailing Address: _____ Date of Birth:_____

_____Social Security#:_____

I AUTHORIZE: Dr. Arnold E. Feldman, and/or The Feldman Institute [SM], and/or First Choice Surgery Center of Baton Rouge, LLC, located at 505 E. Airport Drive and 455 E. Airport Drive, respectively, Baton Rouge, Louisiana 70806, as a physician or practice, under whose care I am under or under whose care I am seeking, to:

□ **RELEASE information TO** **OR** □ **TO OBTAIN information FROM**

Name:_____

Mailing Address:_____

City, State, Zip Code:_____

Relationship:_____ Telephone Number:_____

The **Purpose of this Authorization** is indicated in the box(es) below.
□ Medical Care □ Personal □ Legal Investigation or Action □ Changing Physicians □ Research related treatment □ Changing Physicians □ Research related treatment □ Getting health information for disclosure to a third party □ Other (Specify):_____

I authorize the release of the following protected health information:
□ Entire Record □ Medical History, Exams, Reports □ Surgical Reports □ Treatment or tests
□ Prescriptions □ Immunizations □ MR/DD Records □ Hospital Records □ Lab Reports □ Diagnostic Reports (X-Ray, CT, etc..) □Other:_____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:
□ Alcoholism □ Drug Abuse □ Mental Health □ Genetics □ Vocational Rehab □ HIV (AIDS)
□ Sexually Transmitted Diseases □ Psychotherapy Notes □ Other:_____

This authorization shall expire on _____(date) beginning_____ending_____.
I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both this form and the Notice of Privacy Practices of the provider(s).

_____ _____
Signature of Individual or Authorized Representative Date

_____ _____
Signature of Witness (*If signed with an "X" or mark)* Date

THE FELDMAN INSTITUTE SM
FIRST CHOICE SURGERY CENTER, LLC
SOUTHWEST MISSISSIPPI ANESTHESIA, P.A., INC.
DR. ARNOLD E. FELDMAN

PHOTO CONSENT

I, _____, give the above referenced healthcare providers permission to take my photograph for the purpose of completing my medical chart.

I HEREBY AUTHORIZE AND REQUEST YOU TO DISCUSS AND/OR RELEASE MY MEDICAL INFORMATION

TO: _____

RELATIONSHIP:_____

TELEPHONE NUMBER(S):_____

PATIENT'S NAME:_____

DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER:_____

_____ _____
PATIENT'S SIGNATURE **WITNESS**

_____ _____
DATE **DATE**

THE FELDMAN INSTITUTE SM
FIRST CHOICE SURGERY CENTER, LLC
SOUTHWEST MISSISSIPPI ANESTHESIA, P.A., INC.
DR. ARNOLD E. FELDMAN

Notice of Privacy Practices Acknowledgement

I, _____ acknowledge that I have received a copy of the above referenced healthcare providers' Privacy Notice.

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

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

_____ _____
Signature of Patient Date

_____ _____
Signature of Facility Personnel Date

First Choice Surgery Center, LLC

NOTICE OF PRIVACY PRACTICES:

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:
- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Feldman Institute (225) 201-0950 x 225, Care of Kara Kantrow, Privacy/Compliance Officer.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and

items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or

administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI 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: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

This information is contained in and available, together with other helpful information about our practice, at www.TheFeldmanInstitute.com

***Privacy/Compliance Officer is on staff and available to answer any questions you may have about this information.**