

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

Race: _____ Ethnicity: _____ Primary Language: _____

Preferred Pharmacy: _____ Phone: _____

Phone: (____) _____ - _____ Type: _____ Other: (____) _____ - _____ Type: _____

E-mail address: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____ - _____

Spouse /Parent/Guardian of Minor Information

Name: _____ DOB: _____

SSN #: _____ - _____ - _____ Employer: _____

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

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

Patient or Responsible Persons Signature

Date

Patient Name: _____

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

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

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.

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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 acknowledgment 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