PATIENT #:_____

JOHN R. BUDDEN, M.D. APMC
2625 North Drive
Abbeville, LA 70510
johnrbuddenmd.com

PATIENT REGISTRATION (Please Print)

DATE: _____

PATIENT'S NAME: _____
(Last) (First) (Middle)

ADDRESS:_____ **City/State**_____ **Zip Code**_____

PATIENT'S BIRTHDATE:_____ **AGE:**_____ **SEX (check one):** **Male** ☐ **Female** ☐

HOME PHONE #:_____ **CELL PHONE #:**_____

WORK PHONE #:_____ **EMERGENCY #:** _____

MARITAL STATUS (check one): **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐

NAME OF HUSBAND/ WIFE:_____ **FAMILY DOCTOR:**_____

RESPONSIBLE PARTY NAME: _____
(Person Paying Bill or Insured Person) (Last) (First) (Middle)

ADDRESS:_____ **City/State**_____ **ZipCode**_____

HOME PHONE:_____ **EMPLOYER #:**_____

EMPLOYER:_____ **OCCUPATION:**_____

RELATIONSHIP TO INSURED PARTY: (check one): **Self** ☐ **Husband** ☐ **Wife** ☐ **Child** ☐ **Other** ☐

(Completion of ALL the above is necessary for our office records)

INSURANCE CO. NAME:_____

INSURANCE CO. ADDRESS:_____

City/State_____ **Zip Code**_____

POLICY #:_____ **GROUP #:**_____

SUBSCRIBER'S NAME:_____

SECOND INSURANCE CO. (if applicable):_____

SECOND INSURANCE CO. ADDRESS:_____

City/State_____ **Zip Code**_____

POLICY #:_____ **GROUP#:**_____

TREATMENT AND FINANCIAL AGREEMENT: I hereby apply for treatment by John R. Budden, M.D. and his assistants. Such treatment may include: x-rays, injections and other office procedures as deemed necessary. I accept full responsibility for any charges incurred for services rendered to me.

INSURANCE ASSIGNMENT: This will authorize the filing of any insurance in force and the direct payment to John R. Budden, M.D. APMC, any amounts due from my claim under the above stated policy (policies). I understand that I am financially responsible for all charges not covered by my insurance policy. Release of any of my medical information, which may be necessary for the completion of insurance forms, is hereby authorized.

I understand that I will be responsible for all service charges, finance charges, court costs, collection agency fees and reasonable attorney's fees involved should this account be turned over for collection. I understand that I will be charged finance charges (18% APY), on any unpaid balance 90 days from the date of service. Failure to reschedule an appointment prior to your appointment time or failure to show up to your scheduled appointment will result in a $30.00 no show charge. This will be billed directly to you and will be your responsibility to pay prior to another visit being scheduled.

_____ _____

(Date) **(Witness)** **(Signed)** **(Insurance Subscriber if other than Spouse)**

Patient History Form

PATIENT'S NAME: _____ DATE:_____

REASON FOR TODAY'S VISIT: _____
(What part of your body are you here to see us for and why. BE SPECIFIC)

_____

_____

_____

DATE SYMPTOMS FIRST BEGAN: _____

TREATMENT RECEIVED (Include Physicians Name):_____

_____

X-RAYS TAKEN (check one): YES ☐ NO ☐ WHERE: _____

DO YOU SMOKE? _____ DO YOU DRINK ALCOHOL? _____ IF SO, HOW MANY IN A DAY? _____

HAVE YOU HAD THE FLU VACCINE? YES ☐ NO ☐ IF YES, WHEN WAS YOUR LAST VACCINE? _____

HAVE YOU HAD THE PNEUMONIA VACCINE? YES ☐ NO ☐ IF YES, WHEN WAS YOUR LAST VACCINE? _____

DO YOU HAVE AN ADVANCE DIRECTIVE (ADVANCED CARE PLAN)? YES ☐ NO ☐
IF YES, DATE: _____ IF NO, ARE YOU INTERESTED IN INFORMATION? YES ☐ NO ☐
IF YES, _____PROVIDED PATIENT WITH INFORMATION ON ADVANCE DIRECTIVES ON _____

HEIGHT: _____ WEIGHT: _____ B.P.:_____

PAST SURGICAL HISTORY: (LIST PROCEDURE AND DATE): _____

_____

PAST HOSPITALIZATION: (LIST REASON AND DATE): _____

_____

CHRONIC MEDICAL PROBLEMS: _____

_____

ARE YOU TAKING ANY MEDICATION? YES ☐ NO ☐ IF YES, PLEASE SEE PATIENT MEDICATION FORM ATTACHED

Family History of

Y	N	Family Member
☐	☐ Alzheimer's Dz	_____
☐	☐ CAD	_____
☐	☐ Diabetes	_____
☐	☐ High Cholestrol	_____
☐	☐ Thyroid Dz	_____

Family History of

Y	N	Family Member
☐	☐ Cancer	_____ORIGIN_____
☐	☐ Depression	_____
☐	☐ Glaucoma	_____
☐	☐ HTN	_____
☐	☐ Other	_____

ALLERGIC TO ANY KNOWN MEDICATIONS: _____

_____

Patient Medication Sheet

Patient Name: _____

Medical Record Number:_____

Date					
Medication **Dosage** **Frequency**					
1) _____ daily bid tid qid nightly prn weekly					
2) _____ daily bid tid qid nightly prn weekly					
3) _____ daily bid tid qid nightly prn weekly					
4) _____ daily bid tid qid nightly prn weekly					
5) _____ daily bid tid qid nightly prn weekly					
6) _____ daily bid tid qid nightly prn weekly					
7) _____ daily bid tid qid nightly prn weekly					
8) _____ daily bid tid qid nightly prn weekly					
9) _____ daily bid tid qid nightly prn weekly					
10) _____ daily bid tid qid nightly prn weekly					
11) _____ daily bid tid qid nightly prn weekly					
12) _____ daily bid tid qid nightly prn weekly					
13) _____ daily bid tid qid nightly prn weekly					

bid= twice a day tid=three times a day qid=four times a day prn=as needed

Date	Short Term Medication	Date	Short Term Medication	Date	Short Term Medication

Patient Signature_____ **Date:** _____

John R. Budden, M.D. APMC
Orthopedic Surgery

2625 North Drive
Abbeville, LA 70510
337-422-6500

P.O. Box 1537
Abbeville, LA 70511
johnrbuddenmd.com

PATIENT INSURANCE ACKNOWLEDGEMENT FORM

DATE: _____

By signing this statement, I am acknowledging that I want Dr. John Budden's office to file my current injury/condition: _____, on my Personal Insurance: _____. I acknowledge that this is not due to any type of work-related injury/condition or liability.

I also understand that once I sign this statement, I agree that Dr. John Budden's office will not file any Workers Compensation Claim or Liability Claim should I decide that this injury/condition become work related or a liability at a later date.

Patient Name: (please print) _____

Patient's Signature: _____

Witness: _____

Notice of Privacy Practices

John R. Budden, M.D.
2625 North Drive, Abbeville, LA 70510
Phone: (337) 422-6500 Fax: (337) 422-6502

This notice describes how your health information may be used and disclosed and how you can access this information. Please read it carefully.

At Dr. John Budden's office, we have always kept our health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor who we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may call your and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become property of the new owner.

Except as described above, this practice will not use or disclose your health information without prior written consent.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. Upon written request, we will release your records to you. The records can be picked up in our office at the above address.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Nicole Champagne at (337) 422-6500.

This notice goes into effect as of January 19, 2016.

Acknowledgement

I have received this copy of Dr. Budden's Notice of Privacy Practices.

Date: _____

Signed: _____

Print Name: _____

If signing as a parent or guardian, please note the name of the patient _____.

John. R Budden, M.D.

A Professional Medical Corporation

Orthopedic Surgery
2625 North Dr.
Abbeville, LA 70510

Telephone: (337) 422-6500
Fax: (337) 422-6502

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

As required by HIPPA, you have the 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 are not available, the name(s) of those you give permission to speak with.

I hereby authorize John R. Budden, M.D. to leave detailed messages regarding my personal health information via:

Home Telephone Number ☐Yes ☐No Phone #_____
Cell Phone Number ☐Yes ☐No Phone #_____

I hereby request and authorize John R. Budden, M.D. to disclose any medical information relating to diagnoses, care, treatment, test results and prognosis concerning myself to the individuals listed below. (*This may include spouses, relatives, children, friends, etc.)* I understand information may be either obtained in person, writing or by telephone. (*Write "None" in the space provided below if you do not want anyone to have access to your medical information*). This consent is valid until revoked in writing.

Name	Relationship to Patient	Telephone (if different than the Home Number above)

_____ _____
Patient Name (Printed) Signature of Patient/Legal Guardian

_____ _____
Legal Guardian Name (If applicable) Date