CANE RIVER SURGERY CENTER

William A. Ball, Jr., M.D., F.A.C.S.
General Surgery
Board Certified by American Board of Surgery

New Patient Information Record

PATIENT INFORMATION

Patient's Name/Last:	First:	Middle:	SSN:	
Residence Address:	City:	State:	Zip:	
Mailing Address*: (Check here if same as above)* ☐				
Home Telephone Number:	Cell Telephone #	Email Address:		
Date of Birth/Month: Day: Year:	☐ Male ☐ Female	Race:		
Employer's Name:	Work Telephone#	Ext.		
Marital Status: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED				
RESPONSIBLE PARTY *(Check here if same as above)* ☐				
Name/Last: First: Middle:	Responsible Party's SSN:	Date of Birth:		
Mailing Address:	City:	State:	Zip	
Home Telephone Number:	Relationship to Patient:			
Employer's Name:	Work Telephone #	Ext.		
Responsible Party's Spouse's Name (if applicable):	SSN:			
In Case of an Emergency, who may we notify (other than someone living with you)	Relationship to Patient:			
Name:	Telephone Number:			
Address:	City:	State:	Zip	
Who referred you to our office?	Telephone Number:			

WILLIAM A. BALL, JR., M.D., F.A.C.S. AND CANE RIVER SURGERY CENTER

Patient Name: What is your reason for your visit today?

Date :

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

❑ Skin care advice	❑ Facial veins	❑ Scar revision
❑ Skin care products	❑ Facial redness	❑ Breast size
❑ Facial Injectables/ Fillers	❑ Brown spots/age spots/freckle	❑ Abdominal area
❑ Facial fine lines/wrinkles	❑ Drooping brow	❑ Hips
❑ Thin lips	❑ Drooping eyelids	❑ Legs
❑ Length of Eyelashes	❑ Nose size or shape	❑ Facial Contouring
❑ Fullness of Eyelashes	❑ Facial fullness/drooping	❑ Body Contouring
❑ Darkness of Eyelashes	❑ Mole removal	❑ Unwanted Hair
❑ Chemical peel	❑ Neck wrinkles	
❑ Blotchy skin	❑ Make up	

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the length, thickness, darkness of my eyelashes

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

❑ My physician	*Full name:*
❑ My insurance company provider	*Name:*
❑ The yellow pages	*Specify Ad:*
❑ A friend or family member	*Name:*
❑ Internet	
❑ The Physician/Practice website	
❑ Seminar	*Date/location:*
❑ Other	

❑ Approval to contact you.	*Best phone number to reach you:*
❑ Approval to send you information on products and services (including special offers)	*Email address:*

❑ *I'm not interested in any additional services provided at this time*

↓ For Staff Use Only ↓

Physician / provider:

Follow-up	*Date*	*Completed by (name)*
❑ Initial Inquiry/Information Given		
❑ Contact in future – give date		
❑ Products		
❑ Free consultation		
❑ Procedure scheduled		
❑ Procedure completed		

Authorization

All the personnel of Cane River Surgery Center take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

The authorization form, when completed and signed, allow our staff members to speak only with the individual or individuals you designate in the event that you are not able to receive our phone calls or have an adult family member that helps coordinate your medical care. YOU SHOULD NOT DESIGNATE A PHYSICIAN.

If you feel, for example, comfortable allowing us to talk with another person regarding an appointment, then you should check that box too. Please check all boxes that apply to your needs. If there is an additional person you wish to authorize, please complete the next section as you did the first.

I authorize the employees of Cane River Surgery Center to speak with the following person(s):

NAME: _____

PHONE: _____

_____APPOINTMENTS

_____ACCOUNTS/BILLS

_____LAB RESULTS

_____TEST RESULTS

_____MEDICAL CARE

NAME: _____

PHONE: _____

_____APPOINTMENTS

_____ACCOUNTS/BILLS

_____LAB RESULTS

_____TEST RESULTS

_____MEDICAL CARE

I AUTHORIZE THE EMPLOYEES OF CANE RIVER SURGERY CENTER TO REVIEW ALL MEDICATIONS AND MEDICATION HISTORY_____YES_____NO.

INFORMATION REGARDING ANY OF THE ABOVE MY ALSO BE LEFT ON MY ANSWERING MACHINE OR VOICE MAIL. _____YES_____NO

_____I DO NOT AUTHORIZE ANYONE TO RECEIVE INFORMATION REGARDING MY MEDICAL CARE.

_____ _____

Patient Signature or Legal Guardian Date

CANE RIVER SURGERY CENTER

William A. Ball, Jr., M.D., F.A.C.S.
General Surgery
Board Certified by American Board of Surgery

PATIENT CONSENT FOR USE AND RELEASE OF INFORMATION AND IMAGES

I authorize CANE RIVER SURGERY CENTER and WILLIAM A. BALL, JR., M.D. and its affiliates or contractors to photograph and record (on film, videotape or otherwise) me or my child, during interviews, events, treatments or other medical procedures or to turn, tape, photograph, place on computer media or record my (or my child's) information for the following purposes:

Please check all that apply.

☐ News ☐ Marketing/Promotion ☐ Medical Education/Training ☐ Chart Documentation

I grant and release to Cane River Surgery Center and Dr. Ball any and all rights, title, and interest that I might have in these photographs, movies or videotapes, reproductions, negatives, computer media or copies of same and give permission for its full and exclusive use, either in conjunction with or without my name, and to make changes or alterations in such visuals and associated copy as Dr. Ball deems proper.

I understand that information will not be released unless my signature is included at the bottom of this form.

I grant consent to copyright, use and reuse reproductions and simulations of my likeness or my child's likeness in printed publications, Web sites, radio and television broadcasts.

I release Cane River Surgery Center and Dr. Ball, its trustees, officers, employees, insurers and agents from all claims, demands and liability in connection with the above and this release shall be binding on my heirs and executors.

I understand that Cane River Surgery Center and Dr. Ball cannot control how the recipient uses or shares this information and that laws protecting patient confidentiality cannot protect this information once it has been disclosed.

I understand that I can decline to sign this authorization and, if I do so, it will not affect my treatment, payment, health plan enrollment, or eligibility for benefits.

This authorization: ***(check one)*** ☐ does not expire ☐ is valid for five years ☐ is valid for two years ☐ other (specify)_____

I do further certify that I am of full age and possessed of full legal capacity to execute this authorization and release or to do so on behalf of the person named below.

PRINT NAME_____ WITNESS* PRINT NAME _____

SIGNATURE_____ WITNESS SIGNATURE _____

SIGNATURE PARENT/GUARDIAN (if minor) _____

PRINT NAME OF PARENT/GUARDIAN (1 minor) _____ DATE_____

ADDRESS _____

PHONE_____ E-MAIL_____

Do you need a copy of this form? ☐ NO ☐ YES (copy sent or made _____) *Must be 18 years or older.

HIPAA Notice of Privacy Practices

William A. Ball, Jr. M.D. F.A.C.S.
D/B/A/ Cane River Surgery Center
740 Keyser Avenue Suite D
Natchitoches, La 71457
(318)354-2555

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These

activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means 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. You may also request 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 as described in this Notice of Privacy Practices. 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 restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____

Patient's Signature or Legal Guardian Date