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.
D/B/A Cane River Surgery Center
740 Keyser Avenue Suite D
Natchitoches, LA 71457
(318) 354-2555

INSURANCE INFORMATION

INSURANCE COMPANY: _ _____

ADDRESS: _____

CITY: _____STATE:_____ZIP:_____

PHONE: _____

GROUP #: _____POLICY#: _____

MEMBER #: _____

MEMBER NAME:_____

MEMBER DATE OF BIRTH: _____

MEMBER SOCIAL SECURITY NUMBER: _____

CONTACT FOR EMERGENCIES: _____

RELATIONSHIP: _____HOME PHONE:_____

ALTERNATE PHONE: _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance, PPO Plans, and all other health plans to William A. Ball, Jr., M.D., F.A.C.S. This assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information needed to secure the payment.

SIGNATURE: _____DATE: _____

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

William A. Ball, Jr. M.D., F.A.C.S., APMC
DBA Cane River Surgery Center 740 Keyser Ave Suite D | NATCHITOCHES LA, 71457 | (318) 354-2555

Written Financial Policy

Thank you for choosing William A Ball Jr MD FACS APMC. Our primary mission is to deliver the best and most comprehensive surgical care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- NO INTEREST[1] Payment Plans[2] from CareCredit
    - Allow you to pay over time with NO INTEREST[1]
    - Convenient, low monthly payment plans[2] also available
    - No annual fees or pre-payment penalties

Please note:

William A Ball Jr MD FACS APMC requires payment in FULL at the time of service for any and all services rendered, regardless of any insurance benefits payable or pending.

We accept payment plans. For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3] If you require a referral from your insurance company, it is YOUR responsibility to obtain this referral or your appointment will have to be rescheduled and you will be assessed the $25 fee for missed appointments.

A fee of $25 is charged for patients who miss or cancel any appointments without 24-hour notice.

William A Ball Jr MD FACS APMC charges $25 for returned checks.

Any unallocated accounts will be turned over to our Collection Agency and patient will be held responsible and billed for any fee's or attorney's fees. Also, any NSF checks will be turned over to the Natchitoches Parish District Attorney's Office and patient will be responsible and billed for these additional fees.

I HAVE READ THE ABOVE STATEMENT AND ACCEPT SERVICES ON THE TERMS AS STATED ABOVE. If you have any questions, please do not hesitate to ask. We are here to help you get the surgical care you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

HIPAA Notice of Privacy Practices

William A. Ball, Jr. M.D. F.A.C.S.
D/B/A/ Cane River Surgery Center
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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