

OB GYN

ALBERT I. TYDINGS, M.D.

William N. Landry M.D.

Patient Name: _____ Date of Birth: _____

Marital Status: S / M / D / Other AGE: _____ Social Security Number: _____

Mailing Address: _____
Street Address/Post Office Box City State Zip Code

Home Phone Number: _____ Cell _____ Email _____

EMERGENCY CONTACT: _____
NAME PHONE RELATION TO PATIENT

Who is your Primary Care Physician? _____ Phone _____

Are you a student? Yes No Full Time Part Time Other: _____

Patient Employment Information: Are you employed? YES NO Employment Status: Full Time Part Time Other

Who is your employer? _____ Phone _____

ONLY COMPLETE THIS SECTION IF THE PATIENT IS UNDER THE AGE OF 18

Parent/Guardian Name: _____ Phone _____

Is the person listed above the custodial parent? YES NO If not, who has custody? _____

Custodial Parent Address: _____

Custodial Parent Phone Number: _____ Employer: _____

INSURANCE INFORMATION

Primary Insurance: _____ Are you the policy holder? YES NO

Policy Holder Name: _____ DOB _____ SS# _____
Relationship to Patient: _____

Secondary Insurance: _____ Are you the policy holder? YES NO

Policy Holder Name: _____ DOB _____ SS# _____
Relationship to Patient: _____

PATIENT SIGNATURE: _____ DATE _____

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and any other health plans to Albert I. Tydings, MD and William Landry MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that if any action in getting my account settled is taken, that I am responsible for ALL attorney fees. I hereby authorize said assignee to release all information necessary to secure payment.

OFFICE POLICY

Appointment Policy

You will receive an automated call to confirm your appointment. Please respond to the call. We will receive a report daily from our company stating if your phone line was busy, a message was left on voicemail, confirmed, phone was answered and no response was given, or if your line was busy. You will still be charged accordingly (\$25) for NO SHOW appointments, and appointments that are cancelled with less than a 24 hour notice.

Reminders are a courtesy. All patients are responsible to keep up with their own appointments. If you need to cancel your appointment, please call us as soon as possible. If you have any problems that concern you throughout the day please make every effort to contact us during office hours.

Patient Information

You are responsible for keeping us informed of **new telephone numbers; address changes and insurance changes.** If you do not notify us of new insurance coverage at the time of your visit and we file a claim to your insurance company and it is denied, we will not refile the claim to the new insurance company. The bill will then become your responsibility to pay, and you may file a claim to your insurance to be reimbursed. If you have a primary care doctor assigned to you by Medicaid you need to make sure your referral is up to date when you come in for your visit. You will be expected to call and obtain the referral. You will not be seen without a referral.

Emergencies

If you have an emergency at night or during the weekend please contact Dr. Tydings before going to the ER. Please call the answering service at (985) 796-6174.

Medical Leave/FMLA Paperwork

If you will need paperwork completed for time off during or after your pregnancy or surgery, there is a \$25 fee for each set of paperwork that must be completed. We require the fee to be paid before the paperwork is completed, and we ask for 7 days for completion.

Transferring Patients

In the event that you should transfer to another physician you are responsible for completing a Medical Release of Health Information form. We will need a 7 day notice to have your records transferred to another healthcare facility. There will be a fee for medical records requested by the patient, insurance company, attorney etc.

Test Results

We encourage patients to call Quest at the number that is provided to you on your clinical summary upon checkout to obtain results. If your results are abnormal we will attempt to call you. We will mail a notice if our attempt to contact you is unsuccessful.

Phone Calls and Prescriptions

Please understand that the nurses and our physicians are seeing patients all day. Please be courteous when we ask you to leave a message. It is in your best interest to give us the most information possible so that when the nurse or physician returns your call, we can have an answer or solution to your problem or concern.

Patient Signature

Date

OB*GYN

ALBERT I. TYDINGS, M.D.

William N. Landry M.D

121 Lakeview Circle, Suite C
Covington, LA 70433
Phone (985) 892-1111
Fax (985) 892-1116

ACKNOWLEDGMENT FORM

I have been provided a copy of the Notice of Privacy Practices and I am aware of how my medical information will be used and/or disclosed.

Print Name: _____

Signature: _____

Date: _____

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PATIENT AUTHORIZATION

As required by the Health Information Portability and Accountability Act of 1996, Albert I. Tydings, MD and William N. Landry MD may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the disclosure and/or use described herein. You may revoke this authorization at any time.

The privacy of your medical information is important to us. We understand that your medical information is person, and we are committed to protecting it. We create a record of the care and services that you receive at our organization. We need this record to provide you with quality care and to comply with all legal requirements.

We may use or disclose your medical information to:

- Staff members, other doctors, nurses, technicians, laboratory corporations or other health care providers via mail, telephone and electronic systems.
- For payment purposes to collection agencies and insurance companies via mail, telephone and electronic systems.
- Family members and/or care givers.
- Funeral directors, coroner, medical examiner and/or clergy.
- Government agencies.
- Court orders, judicial administrative proceedings.
- Public health, legal authorities, and/or abuse agencies.
- Workers Compensation.
- Law Enforcement officials required by law.
- Health plan organization.
- Pharmacies and/or pharmaceutical companies.

I, _____, (print name) hereby authorize the use and/or disclosure of the health information that pertains to me. I understand that information disclosed pursuant to the authorization may be re-disclosed to additional parties. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of my health information. I have been provided a copy of the Notice of Privacy Practices and I am aware of how my medical information will be use and/or disclosed.

Patient Signature: _____

Date: _____

APPOINTMENT CANCELLATION AND NO SHOW POLICY

All appointments that are not cancelled with a minimum of 24 hours notice will be considered a "No Show". By signing this form you are acknowledging our office policy on appointment cancellations and No Shows. A \$25 fee will be charged for each appointment that does not meet this criteria.

Signature of patient: _____ Date _____

Albert I. Tydings, M.D. and WM Nick Landry, M.D.

OBYGYN

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider and or staff at Dr. Albert Tydings and Dr. Landry's office to discuss your protected health information (including appointment information) with your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

PLEASE SELECT ONE OF THE FOLLOWING:

_____ I **DO NOT** authorize Dr. Tydings & Dr. Landry's office and/or staff to release any or all information concerning my medical care/appointments to any individual.

_____ I **DO** authorize Dr. Tydings & Dr. Landry's office and/or staff to release any or all information concerning my medical care/appointments to any individual listed below.

_____ I **DO** authorize Dr. Tydings & Dr. Landry's office and/or staff to release _____ information (you can specify the type of information you would like us to release) concerning my medical care/appointments to any individual listed below.

I authorize the following individuals to receive the information specified above:

NAME

Relationship to Patient

NAME

Relationship to Patient

PATIENT NAME (PRINT)

DOB

PATIENT SIGNATURE

DATE

OBS&GYN

Albert Tydings, M.D.

William N. Landry, M.D.

121 Lakeview Circle, Suite C

Covington, Louisiana 70433

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Authorization To Disclose Medical Information

Patient Name: _____

Birth Date: _____ Social Security Number: _____

Medical Information From:

Release to:

I request and authorize the above named healthcare provider to disclose the medical information specified below to the organization, agency, or individual name on this request.

INFORMATION REQUESTED:

Date of service: _____

Information to be disclosed: _____

Purpose of disclosure : _____

I understand that the information to be disclosed may include information regarding the following conditions:

- Drug and/or alcohol abuse (Protected by State/Federal Law)
- AIDS (Protected by State Law)
- Psychological or psychiatric conditions (Protected by State Law)

Authorization: I certify that this request is made voluntarily and that the information given is accurate and to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. This authorization will expire in _____ days unless revoked at an earlier time.

Re-disclosure of my medical information by those I hereby authorize to receive the above specifications information should not be made without my further written consent. I agree that the healthcare provider is not responsible for the misuse, and cannot guarantee the confidentiality of medical information once it is released to another party. I hereby release the healthcare provider from any liability, which may result from furnishing the information requested as authorized. A copy or fax of this authorization will be as valid as the original.

SIGNATURE: _____ DATE: _____
(Patient, Parent/Guardian if patient is a minor)

RELATIONSHIP (if other than patient) _____

WITNESS: _____ DATE: _____

FEDERAL PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization of the release of medical or other information is NOT SUFFICIENT FOR THIS PURPOSE. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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SURGERY NO SHOW & CANCELLATION POLICY

Attention Patient

In order for us to maintain our efficiency in the operating room, as well as giving full consideration to the hospital and anesthesia staff, it is necessary for us to implement a No Show/Cancellation policy. It is important that when you schedule your surgery/ procedure you have thoroughly checked your personal calendar to make sure that your scheduled surgery date is ideal for you. Cancelling your surgery/procedure requires multiple phone calls to the hospital or outpatient facility, insurance company, and you the patient.

Once your surgery/procedure is scheduled, if you cancel or no show there will be a \$75 cancellation/no show fee. This fee will not be applied toward your surgery/procedure and will be added as a charge to your account, not billable to your insurance. This fee must be paid to our office. Your surgery/procedure will not be rescheduled until this payment is made in full.

We thank you in advance for your cooperation and understanding of the surgical scheduling process.

Dr. Albert Tydings

Dr. William N. Landry

Patient Name

DATE

Patient/Guardian Signature

Please list the pharmacy in which you would like us to ELECTRONICALLY send your prescriptions to:

Pharmacy Name : _____ Pharmacy #: _____

Pharmacy Address/Location: _____

Family History Please list any past or present health issues with your family members listed below

Mother Alive/Deceased _____

Father Alive/Deceased _____

Maternal Grandmother Alive/Deceased _____

Paternal Grandmother Alive/Deceased _____

Maternal Grandfather Alive/Deceased _____

Paternal Grandfather Alive/Deceased _____

Social History

Do you smoke? YES / NO / FORMER

Do you drink Caffeine? Yes No

Do you drink alcohol? Yes No

Do you use Marijuana or other recreational drugs? Yes No

How many cigarettes per day? ____ For how long? ____

How many caffeinated drinks per day? ____ Week? ____

How many alcoholic drinks per day? ____ Week? ____

If so, please specify: _____

Surgeries Please list ALL surgeries you have had with dates (month/year)

Allergies Please list all allergies you have to MEDICATIONS with reactions.

Are you allergic to LATEX? Allergic Sensitive

Medications Please list all medications (prescriptions, over the counter & supplements) that you are currently taking, including dosages and frequency.

1. _____ Dose: _____ Frequency: _____

2. _____ Dose: _____ Frequency: _____

3. _____ Dose: _____ Frequency: _____

4. _____ Dose: _____ Frequency: _____

5. _____ Dose: _____ Frequency: _____

6. _____ Dose: _____ Frequency: _____

PATIENT'S SIGNATURE: _____ DATE: _____