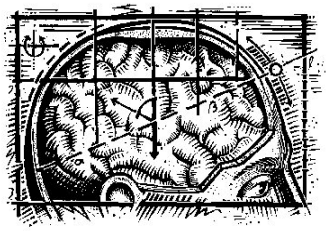


155 Hospital Drive
Suite 100
Lafayette LA 70503
Phone: 337-534-8680
Fax: 337-769 9934

Jason Cormier, M.D.
Neurological Surgery – Spine □
Neurological Surgery – Brain □

Please fill out packet in its entirety:

Please Print. The following information becomes part of your confidential medical record.

Patient Name**:** _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
SSN: _____-_____-_____ Date of birth: _____/_____/_____ Age: _____
□ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed
Race: _____ Ethnicity_____ Primary Language: _____
Preferred Pharmacy: _____ Phone_____ Fax_____
Home Phone:_____-_____-_____ Work Phone:_____-_____-_____ Cell Phone:____-____-_____
E-mail address: _____ Employer: _____
Emergency Contact: _____Relationship: _____ Phone: _____-_____-_____

Spouse /Parent Information

Name: _____ Date of birth: _____
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)
   Spouse _____
   Parent _____
   Child or Children _____
   _____
   Other _____
2. May we leave a detailed verbal message or send written correspondence to:
   _____Home Number _____Work Number _____Cell Phone _____Fax _____Home Address

   ____*Yes*____Billing Address _____Work Address _____Other (Please list) _____

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

_____ _____
Patient or Responsible Persons Signature Date

Patient Name: _____

Please complete if you are Group Health, Medicare or Medicaid:

Primary Insurance Carrier: _____
Address: _____City: _____ State: _____ Zip: _____
Phone: _____ Fax #: _____
Name of Policy Holder: _____
SS# for Policy Holder: _____DOB for Policy Holder: _____
Policy Number: _____ Group Number: _____
Employer (if group Policy) _____
[ ] I would like a copy of my clinic note sent to this insurance carrier.

Secondary Insurance Carrier: _____
Address: _____City: _____ State: _____ Zip: _____
Phone: _____ Fax #: _____
Name of Policy Holder: _____
SS# for Policy Holder: _____DOB for Policy Holder: _____
Policy Number: _____ Group Number: _____
Employer (if group Policy) _____
[ ] I would like a copy of my clinic note sent to insurance carrier.

Referring Physician: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like a copy of my clinic note sent to this doctor.

Attorney: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like my attorney to receive a copy of my clinic note.

Please list ALL physician's that you see:

Primary Physician Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like a copy of my clinic note sent to this doctor.

Cardiologist Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like a copy of my clinic note sent to this doctor.

Neurologist Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like a copy of my clinic note sent to this doctor.

Patient Name: _____

Orthopedic Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like a copy of my clinic note sent to this doctor.

** Please List ANY other Physicians that you see on a separate piece of paper.***

All the above information is true and correct to the best of my knowledge.

_____ _____
Signature: Date:

Chief Complaint:

Please describe your chief complaint in detail and include the duration of the symptoms (onset of problem, location of pain numbness, tingling, rate your pain level, etc…)
_____
_____
_____
_____
_____

If this is the result of an accident please give date of accident: (month date year) _____
_____Motor Vehicle Accident _____Work Related Injury _____Slip & Fall _____No apparent cause
_____Altercation _____ Assault other: _____

The onset of your symptoms has been:
_____Suddenly _____ Gradually _____ Lifting _____Fall _____Bending _____Pulling _____Insidious
_____ Twisting (right left) Other: _____

What makes the pain worse?
_____ Nothing _____ During exercise _____ After exercise _____ Prolonged sitting –length _____
_____ Prolong standing - length _____ _____ Walking length _____ _____Bending forward
_____ Bending backward _____ Pushing _____ Pulling _____ Squatting _____Night pain
_____ Changing Position _____ Laying down Other: _____

What makes the pain better?
_____Nothing _____ Lying down _____Sitting _____Standing _____Walking _____ Medication
_____Shifting/changing position _____Exercising Other: _____

Please check off which of the following you have had done:
_____ X-ray _____ MRI _____ Discography _____CT Scan _____ EMG/NCS _____ Myelogram/CT
_____ Bone Scan Other (Please Specify): _____

Patient Name:_____

What treatments have you had for this problem? (Check all that apply)
_____ Nothing _____ Chiropractic Care _____ Injections
□ **Physical Therapy:**
_____ Stretching □_____ Strengthening _____ Traction _____ Tens _____ Pool Therapy
_____ Massage _____Ultrasound _____ Heat/Ice
□ Medications**:**
_____ Muscle Relaxants _____ Pain Medications _____ Anti-Inflammatory (Prescriptions)
_____ Anti-Inflammatory – Over the Counter (Aspirin, Tylenol, Advil, etc)
_____ Other: (please specify): _____
If so, did you get relief? _____ No _____ Slight _____ Marked _____ Moderate

Course or Progression of Symptoms?
_____ Improving _____ Unchanged _____ Worsening

Do you have any mobility needs?
_____ Cane _____ Wheelchair _____ Crutches _____ Walker

Social History

Age: _____ Weight: _____ Height: _____
Patient is: □ Right handed or □ Left handed
Occupation/Employer:_____

Tobacco:	None	Cigarettes	Cigars	Chew	Quit: _____
Caffeine	None	Colas	Coffee	Tea	Amount: _____
Alcohol:	None	Yes	No	Amount: _____	

Current work status?
_____Regular Employment – No Restriction
_____Full – Time with Restrictions
_____Part – Time by choice
_____Part – Time for Medical Reasons
_____Retired by Choice
_____Retired by Medical Reasons
_____Unemployed
_____Currently not working for medical reasons
_____ Student
_____Other –Specify _____

Patient Name: _____
Past Surgical History: Please list all surgeries:

Type of Surgery	Date of Surgery	Physician

Please use a separate sheet of paper to write any additional surgeries

Patient Past medical History/Family Past Medical History

	Self	Father	Mother	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather	Brother	Sister
Allergies									
Arthritis									
Asthma									
Bleeding Disorder									
Cancer									
COPD									
Diabetes									
Hearing Loss									
Heart Disease / heart Problems									
Hepatitis									
High/low Cholesterol									
Hypertension									
Kidney Problem									
Osteoporosis									
Seizure Disorder									
Stomach/Gastric Problems									
Stroke									
Thyroid Problems									
Urinary Problems(infections)									
Vascular Disease									
Age(s) if living									
Age(s) if deceased									

List any others: _____
_____
_____

Patient Name:_____

Current Medications: List all current medications
List all medications including dosage, frequency and medical problem:

Medication	Dosage (mg)	Frequency	Medical Problem

Please use a separate sheet of paper to write any additional medications

Allergies

Name of Allergies	Type of Reaction

Please use a separate sheet of paper to write any additional allergies

Do you have any allergies to iodine? [ ] No [ ] Yes
If yes, describe the nature of the reaction: _____
_____

Patient Name:_____

Review of Systems:

Please check any Symptom(s) that you have or have had over the last year.

GENERAL:
- □ Appetite loss
- □ Chills
- □ Dietary changes
- □ Fatigue
- □ Feeling well
- □ Fever
- □ Medication changes
- □ Night sweats
- □ Obesity
- □ Persistent infections
- □ Tiredness
- □ Weight gain > 10lbs
- □ Weight loss > 10lbs.
- □ Unable to sleep lying flat
- □ Shakiness

Heent:
- □ Headache (How often _____)
- □ Head injury (When _____)
- □ Blurred vision
- □ Color blindness
- □ Decreased night vision
- □ Diplopia (double vision)
- □ Eye pain
- □ Eye redness
- □ Glaucoma
- □ Peri-orbital puffiness
- □ Visual disturbances
- □ Visual loss
- □ Wears glasses/contact lens
- □ Hearing loss/deafness
- □ Ear discharge
- □ Ear infection/pain

SKIN:
- □ Bruising
- □ Clamminess
- □ Dryness
- □ Excessive sweating
- □ Hives
- □ New lesions
- □ Pruritus (localized itching)
- □ Pallor (deficiency of color)
- □ Rash
- □ Ulcer
- □ Cold skin

Neck:
- □ Neck mass
- □ Neck pain
- □ Neck stiffness
- □ Neck swelling
- □ Swollen glands

Respiratory:
- □ Bloody sputum
- □ Chronic cough
- □ Decreased exercise tolerance
- □ Dyspnea (difficulty breathing/or labored)
- □ Hemoptysis (expectoration (coughing up) Of blood
- □ Snoring
- □ Sputum production
- □ Wheezing

Gastrointestinal:
- □ Abdominal mass
- □ Abdominal pain
- □ Abdominal swelling
- □ Belching
- □ Black, tarry stool
- □ Diarrhea
- □ Dysphagia (difficulty swallowing)
- □ Food intolerance
- □ Gets full quickly at meals
- □ Hematemesis (vomiting blood)
- □ Heartburn
- □ Hemorrhoids
- □ stool incontinence

Patient Name:_____

Review of Systems: Continued

Breast:
- ☐ Breast mass
- ☐ Breast swelling
- ☐ Nipple discharge
- ☐ Recent breast size changes

Cardiovascular:
- ☐ Hypotension
- ☐ Bradycardia
- ☐ Chest pain
- ☐ Syncope (fainting)
- ☐ Edema
- ☐ Heart stent (how many ____)
- ☐ Hypertension
- ☐ Tachycardia
- ☐ Leg cramps/pain
- ☐ Orthopnea (difficulty breathing while lying down/but relieved when you sit up)
- ☐ Palpitations
- ☐ Paroxysmal nocturnal dyspnea (respiratory distress that awakes you from sleep, related to posture)
- ☐ Phlebitis (inflammation of a vein)

Female Genitourinary:
- ☐ Frequency
- ☐ Bladder contractions
- ☐ Hematuria (blood in urine)
- ☐ Amenorrhea (abnormal absence of menstruation)
- ☐ Dysmenorrhea (painful menstruation)
- ☐ Dyspareunia (difficult/painful sexual intercourse)
- ☐ Dysuria (painful/difficult urination)
- ☐ Excessive menstrual bleeding
- ☐ Flank pain (side)

Musculoskeletal:
- ☐ Back pain
- ☐ Claudication
- ☐ Decreased range of motion
- ☐ Fasciculation's (involuntary twitching of muscles)
- ☐ Joint pain
- ☐ Joint redness
- ☐ Joint swelling
- ☐ Muscle atrophy
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Myalgia (muscle pain)
- ☐ Physical disability

Psychiatric:
- ☐ Anxiety
- ☐ Delirium
- ☐ Delusions
- ☐ Depression
- ☐ Disorientation
- ☐ Easily irritated
- ☐ Fearful
- ☐ Frequent crying
- ☐ Hallucinations
- ☐ Impaired cognitive function
- ☐ Inability to concentrate
- ☐ Insomnia
- ☐ Memory loss
- ☐ Mood changes
- ☐ Nervousness
- ☐ Panic attacks
- ☐ Suicidal ideation
- ☐ Appetite changes
- ☐ Cold intolerance

Patient Name:_____

Review of systems: Continued

Neurological:
- ☐ Attention deficit
- ☐ Auras
- ☐ Decreased memory
- ☐ Dizziness
- ☐ Dysarthria (difficulty articulating words)
- ☐ Dysesthesia (distortion of sense, mainly touch)
- ☐ Headaches
- ☐ Hyperactivity
- ☐ Incoordination
- ☐ Loss of consciousness
- ☐ Numbness
- ☐ Seizures
- ☐ Parathesia (burning, prickling, tingling with no apparent physical cause)

Endocrine:
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Sexual dysfunction
- ☐ Polydipsia (excessive thirst)
- ☐ Appetite changes
- ☐ Cold intolerance
- ☐ Decreased sweating
- ☐ Excessive sweating
- ☐ Heat intolerance
- ☐ Hot flashes
- ☐ Libido change

Infectious Disease (Lifetime):
- ☐ MRSA
- ☐ VRE

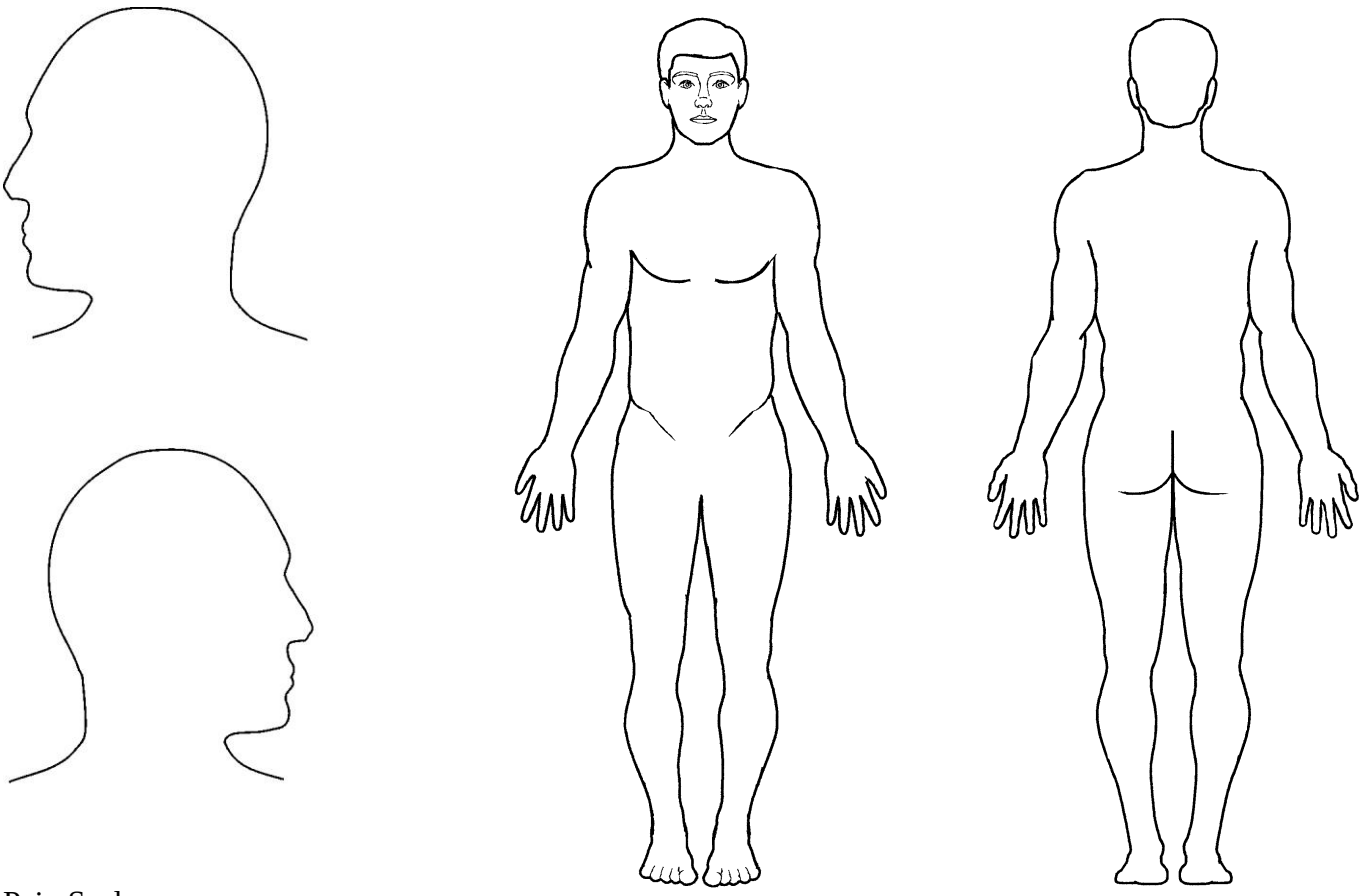
Hematology:
- ☐ Anemia
- ☐ Blood clots
- ☐ Epistaxis (noise bleeds)
- ☐ Excessive bleeding
- ☐ Painful lymph nodes
- ☐ Petechiae (small purple spot on skin Caused by hemorrhage)
- ☐ Prolonged bleeding
- ☐ Spontaneous bleeding

Male Genitourinary:
- ☐ Difficulty with erection
- ☐ Discharge
- ☐ Dysuria (painful/difficult urination)
- ☐ Flank pain (side pain)
- ☐ Frequency
- ☐ Hematuria (blood in urine)
- ☐ Impotence
- ☐ Incontinence
- ☐ Nocturia (urinating at night)
- ☐ Penile lesions
- ☐ Polyuria (excessive urination)
- ☐ Testicular mass
- ☐ Urinary retention
- ☐ Testicular pain
- ☐ Urethral discharge
- ☐ Urgency
- ☐ Urine leakage

Patient Name: _____

Mark the areas of your body where you feel pain and/or sensations below, using the appropriate symbols/

Aching/Pain	Numbness	Pins & Needles	Burning	Stabbing
^^^^^^	------	000000	XXX	//////



Pain Scale:

This is a pain scale from "0" (no pain) to "10" (torture pain). Please choose a number that best fits your pain complaints for your "AVERAGE pain and your "WORST" pain in whatever area(s) hurt.

0 None	2 Mild	4 Discomforting	6 Distressing	8 Horrible	10 Excruciating

Worst pain you've ever had		0	1	2	3	4	5	6	7	8	9	10
Current neck pain	Average	0	1	2	3	4	5	6	7	8	9	10
	Worst	0	1	2	3	4	5	6	7	8	9	10
Current arm Pain	Average	0	1	2	3	4	5	6	7	8	9	10
	Worst	0	1	2	3	4	5	6	7	8	9	10
Current Mid Back Pain	Average	0	1	2	3	4	5	6	7	8	9	10
	Worst	0	1	2	3	4	5	6	7	8	9	10
Current low Back pain	Average	0	1	2	3	4	5	6	7	8	9	10
	Worst	0	1	2	3	4	5	6	7	8	9	10
Current leg Pain	Average	0	1	2	3	4	5	6	7	8	9	10
	Worst	0	1	2	3	4	5	6	7	8	9	10

Jason Cormier, MD
Consent for Treatment and Financial Authorization

Patient Name: _____ Date: _____

I hereby give consent to Jason Cormier, MD 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 to Jason Cormier, MD 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 request payment of authorized Medicare benefits and/or any other insurance benefits to be made either to me or on my behalf to Jason Cormier, MD for any medical services furnished to me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If item 9 of HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I hereby authorize the release of my medical records to Jason Cormier, MD. 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.

Both State and Federal law require your physician to disclose his/her ownership in any healthcare facility or entity to which you are referred as a patient. Jason Cormier, MD has financial interest in Lafayette Surgical Specialty Hospital, LLC. If you require further information, please speak with Jason Cormier, MD directly.

ATTENTION: Effective 1/1/2012 there will be a $50.00 **charge** for all New Patient **NO SHOWS** and a $25.00 charge for all return Patient who **NO SHOW**.

Patient's Signature (Parent/Guardian if minor child) _____
Date _____ Witness Signature _____

Lifetime Medicare B Signature Authorization (Please circle one)

1. Do you or your spouse work for a company that provides you with health insurance?	YES	NO
2. Are you entitled to Medicare because of a disability or End Stage Renal Disease?	YES	NO
3. Is this illness or injury the result of an automobile accident or injury?	YES	NO
4. Is this illness or injury the result of an accident or illness that occurred at work?	YES	NO
5. Has treatment for this accident or illness been authorized by the Veteran's Administration?	YES	NO
6. Are you entitled to any benefits under the Federal Black Lung Program?	YES	NO

Note: If you answered yes to any of the above questions, Medicare may be secondary.

MEDICARE PATIENTS ONLY: Medicare Part B Signature Authorization (Lifetime)

I certify that the information given by me in applying for payment under Tide XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Patient's Name_____ Patient Signature _____
Medicare # _____ Date _____

Jason Cormier, MD
Authorization to Release Health Information

***ALL ASTERISKED ITEMS MUST BE COMPLETED.**

***Patient Name: _____** *** Date of Birth: _____**

***Patient Number: _____** *** Social Security # _____**

***Address: _____**

***Provider authorized to release the Health Information:**
(Name of releasing entity)

_____
_____
_____
_____

***Entity to receive the Health Information**
Jason Cormier, M.D.
155 Hospital Drive
Suite 100
Lafayette LA 70503
337-534-8680 Phone
337-769-9934 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
_____ Immunizations
_____ Laboratory tests
_____ Other (Please Specify): _diagnostic studies, op notes, consultant reports, history & physical
_____ Radiology Report
_____ Specific Physician
_____ Specific Medical Dept.

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 Dr. Jason Cormier Medical Records Department.
The patient has the right to refuse to sign this authorization. Dr. Jason Cormier 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: _____

Jason Cormier, MD
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:**
Jason Cormier M.D.
155 Hospital Drive
Suite 100
Lafayette LA 70503
337-534-8680 Phone
337-769-9934 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:

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_____ Specific Physician
_____ Specific Medical Dept.

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_____ 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 Dr. Jason Cormier, Medical Records Department.
The patient has the right to refuse to sign this authorization. Dr. Jason Cormier 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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OR

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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: _____

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 Jason Cormier, M.D. to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notices of Privacy Practices

Jason Cormier, M.D. 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 acknowledgement 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:

Jason Cormier, M.D.
155 Hospital Drive, Suite 100
Lafayette, LA 70503
(337) 534-8680

Acknowledgement and Consent

I have received a copy of Jason Cormier, M.D.'s 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