Tubal Reversal Center, LLC
Natchez Morice, MD, MBA, LLC
1216 N. Victor II Blvd., Suite 100 Morgan City, La. 70380
(844)376-6742 Phone (866)702-0120 fax (985)-518-4449 Nurse Cell

We Welcome Our Patients

Thank you for choosing our practice for your obstetric and gynecologic care. On behalf of the entire staff, we are delighted you have placed your confidence in us. We are committed to providing the best possible medical care. A doctor/patient relationship is a very special arrangement, one that requires the sharing of information. That is why we have prepared this letter. Please take a moment to read it carefully. It is designed to let you know how our office operates and what to expect when you visit.

Scheduling Your Appointments

Our office is open from Monday through Thursday 7:45am to 5:00pm. We are closed for lunch from 12:00 p.m. to 1:00 p.m. Patient appointments are scheduled Monday through Friday. We start seeing patients at 7:45am with the last appointment being at 4:00pm. When your condition requires urgent attention, we will make every effort to meet your needs. In return, we would appreciate your being on time for appointments and letting us know when you can't keep an appointment. If you need to cancel, please let us know as far in advance as possible to allow the substitution of others who would like to schedule an appointment. **For the consideration of other patients, you will be rescheduled if you are 15 or more minutes late for your appointment.**

Telephone Consultations

If you need to talk to the doctor, please make non-emergency calls during regular office hours when your records are available. Our receptionist will take some preliminary information and let you know when to expect a return call. If you call to request a prescription to be refilled, please be sure to call during office hours and be prepared to give the receptionist your pharmacy's telephone number. Our answering service will answer when the office is closed. Non-emergency messages can also be left with this service. All calls will be returned. Please let us know if your phone call has not been returned.

Emergency Situations After Office Hours

Dr. Morice will provide care after hours. Our answering service will immediately forward messages concerning your needs to the doctor on call. In a major emergency when there isn't time to call, you should go directly to the nearest emergency room. We prefer that you go to Thibodaux or Teche Regional Medical Center. The hospital will notify the physician on call immediately.

Filing Insurance Claims

Payment for medical care is expected at the time of service. Our office will file insurance claims for you. Should you prefer to file your insurance yourself, you may do so with itemized bill provided. Please understand that coverage varies significantly among the many insurance carriers, therefore, it is your responsibility to thoroughly understand the coverage and exceptions of our particular policy. Awareness of the unique provisions of your policy will aid in meeting your deductible and limiting complicated paperwork for you. Please notify our receptionist of any changes to your insurance coverage.

Confidentiality of Your Medical Records

All your medical records and any information you give any staff member are confidential. No information about you or your medical history will be released unless we have a written authorization from you to do so.

Your Suggestions Are Welcome

Again, we appreciate your selecting our practice. The entire staff is committed to providing the highest quality medical care. Our goal is to do this in a pleasant environment with courtesy and attention to your individual needs. Please feel free to share your comments with any member of our staff. Your suggestions are most welcome.

Paying the Bill

1. Tubal Reversal Center, LLC **will not** submit claims to insurance plans, insurance does not pay for this procedure. The total surgery cost is due in full before the surgery is performed and is payable by CASH, cashiers check, credit card, or care credit(**we do not accept care credit payments over the phone, also the cardholder must be present and must have two forms of id at the time of payment…NO PERSONAL CHECKS accepted**). The total price of the procedure is **$5,500.00**, anyone paying in **cash** will receive a **discounted of 250.00**. A non-refundable deposit of $1,500.00 is required to reserve a date for Dr. Morice to perform the tubal reversal procedure.

2. Anyone with a **BMI of 40-45 is an extra $500.00, BMI of 46-50 is an extra $1,000.00, and we cannot operate on patient with BMI over 50**. *Please be aware that you will be asked to pay the extra fees if your BMI is 40-50 on the day of your pre-op appointment. If you cannot pay the fee, your surgery will be cancelled and you will forfeit you $1,500.00 deposit.

3. The remainder of you payment is due at your pre-op appointment. If you are paying with cash the remainder will be $3,750.00. If you use any other payment methods your remainder will be $4,000.00, as you will not receive the cash discount. **Personal Checks are not accepted.**

TUBAL REVERSAL CENTER, LLC
MORGAN CITY, LA

Starting April 14, 2003, the Health Insurance Portability and Accountability Act (HIPPA) became law. In an effort to simplify this for out patients, we offer this brief overview as an explanation.

BY LAW, we are required to give you the patient, a Notice of Privacy Practices disclosure and have you, the patient sign an Acknowledgment of Receipt.

WHAT THIS MEANS IN OUR PRACTICE IS, We agree to show good faith and effort to keep your medical records private. With your signed acknowledgment, we will have your permission to provide necessary information to your family physician, and to your insurance company, or give to an institution that we deem necessary for payment of your account. If you have any questions, feel free to ask us.

NOTICE OF PRIVACY PRACTICES, this notice describes how health information about you may be used and disclosed and how you can get access to this information, please review it carefully.

Keeping the medical and health information we have about you secure is one of out most important responsibilities. We value your test and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information when considering a request from you or when exercising our rights under the law or any agreement with you.

PROTECTION & STORAGE OF YOUR HEALTH INFORMATION, YOUR PERSONAL HEALTH INFORMATION IS STORED ON OUR SECURE SERVER AT Atchafalaya Gynecology & Obstetrics. We have a firewall to prevent individuals from accessing information with authorization. Physical access to our server requires individual authorization and authentication.

KEEPING YOUR HEALTH INFORMATION ACCURATE AND UP-TO-DATE IS VERY IMPORTANT, if you believe the health information we have about you is incomplete, inaccurate or not current, please call, write us or come by our facility. We will take the appropriate action to correct any erroneous information as quickly as possible through a standard of practices and procedures.

HOW AND WHY INFORMATIN IS SHARED; we limit who receives information and what type of information is shared.
Sharing information within the office, we share information within our office to deliver you health care services. We share information with the doctors that referred you to our facility.
Sharing information with companies that work for us, we share information with companies that work for us, such as reference labs. But these companies are obligated contractually to keep your information that we provide to them confidential. If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so. Except as required by law or as described above, we do not share information with parties, including government agencies. This office does not share any patient information with third-party marketers who offer their products to our patients.

COUNT ON OUR COMMITMENT TO YOUR PRIVACY, you can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us—whether it is at our office, over the phone, or by mail.

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Patient/Client Information: **Sign in Time:** _____ **Date of Birth:** _____

Last Name: _____ **First Name:** _____ M.I. _____ Age _____

Mailing Address: _____**City**_____ **State** _____ **Zip code**_____

Physical Address: _____City_____ State_____ Zip Code _____

Phone # _____**Cell phone #** _____ **Social Security#**_____

Ethnicity & Race: _____ Employer_____ Phone #_____

Pt. Email Address: _____ **Marital Status:** Single, Married, Divorced, Widowed

Spouse's Name:_____ Spouse's DOB: _____ Spouse's SS#: _____

Spouse's Phone: _____ Spouse's Employee:_____

Emergency Contact (nearest relative not living with you)

Name: _____ Relationship _____Phone # _____

Primary Insurance: (please give picture ID and insurance card to receptionist)

Carrier: _____ ID#: _____ Group#:_____

Secondary Insurance: (please give insurance card to receptionist)

Carrier: _____ ID#: _____ Group#: _____

Guarantee of Account: FEES ARE DUE AND PAYABLE AT TIME OF SERVICE. I understand that my fees are due in full at the time of service. I agree to pay a $25.00 service charge for each NSF check issued. If my insurances and physicians are under contract, I agree to pay applicable co-payments as required. I further understand that I am fully responsible for services not covered under my policy benefits. In the event my overdue account is place for collection, I agree to pay ALL costs, including reasonable attorney fees, court costs and service charges up to fifty percent (50%) of the amount owed.

Patient's Signature: _____Date:_____

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.

Which physician are you scheduled to see today? (Please circle one)

Natchez "Trey" Morice, MD Elizabeth Zabel, MD Rhandi Wise, MD David Autry, MD

Kristin Plaisance, FNP-C Celina Hargenrader, FNP-C, IBCLC Bethanie Thibodaux, FNP-C

How did you hear about us? _____

_____

_____

What is the reason for your visit today? (Please give brief description.)

_____

_____

_____

_____

_____

_____

Thank you for selecting us as your health care provider

Consent to Use and Disclosure of Protected Health Information for Purposes of Treatment, Payment and Health Care Operations

As a condition of providing treatment to you, Tubal Reversal Center, LLC must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and the healthcare operations of Tubal Reversal Center, LLC.

You may revoke this consent at any time by notifying Tubal Reversal Center, LLC in writing, except to the extent Tubal Reversal Center, LLC has taken action and reliance on your consent.

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that office/staff may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

Tubal Reversal Center, LLC has reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request Tubal Reversal Center, LLC to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Tubal Reversal Center, LLC is not required, however, to agree to such requested restrictions. If, however, Tubal Reversal Center, LLC agrees to the requested restriction, office/hospital will honor the request and it will be binding to Tubal Reversal Center, LLC.

I hereby consent to the use and disclosure by Tubal Reversal Center, LLC, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

_____
Signature

_____
Signature of Personal Representative of Patient

_____
Description of Representative's Authority to Act for Patient

Date: _____

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Request for Confidential Communication of Protected Health Information

Patient's Name: _____ Date: _____

As the above referenced patient, I am requesting that any and all communications with me regarding my Protected Health Information be handled in the following confidential manner.

____ leaving a message to call the doctor's office on my answering machine at home

____ leaving a message to call the doctor's office with whoever answers the phone at home

____ leaving a message to call the doctor's office on my cell phone

____ leaving a reminder of a scheduled appointment on my answering machine at home

____ leaving a reminder of a scheduled appointment with whoever answers the phone at home

____ no restrictions on communicating with me regarding Protected Health Information

____ other restrictions (please describe below)

_____

_____

_____

The following person(s) may have information (example: lab results, appointment times) about me:

_____

_____

Please be advised that we may be unable to comply with certain requests for confidential communication of your Protected Health Information. In such an event, we will notify you.

_____

Patient or Responsible Person's Signature

PLEASE READ AND SIGN ONLY STATEMENTS YOU AGREE TO

_____ _____

Print Patient's Name: **Social Security #**

PATIENT'S, INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or the party who accepts assignments as a contracted provider. I authorize payment of medical benefits to the physician or supplier for services billed from the contracted provider.

_____ _____

Signature **Date**

SPECIALIZED LABORATORY REQUEST: I realize the physician regardless of my insurance will order studies that will be sent to a specialized certified laboratory to process for my specific treatment. I agree to assume responsibility for payment of charges for lab tests not covered by my healthcare insurer.

_____ _____

Signature **Date**

NOTICE OF PRIVACY ACT: By signing, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notices of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please specify)

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Authorization to Release Medical Records

**Patient Phone #: _____

**I, _____ who resides at _____in the city of _____ in the state of _____hereby authorize:

(If you have seen an **Ob/Gyn** before, please list their name below so that we may request your records from them.)

****Physicians Name:_____ What year? _____ Phone:_____**
Address: _____City, St., Zip: _____

Physicians Name:_____ What year? _____ Phone:_____
Address: _____City, St., Zip: _____

To disclose the following specific medical information by _X_mail __X_fax to:

Physician: Natchez Morice MD
Name: Tubal Reversal Center, LLC
Address: 1216 Victor II Blvd, Suite 100
City, St., Zip: Morgan City, La, 70380

Phone: (844)376-6742 **Fax: (866)702-0120**

For the purpose of: Continuing Care Transferring Care Consultation 2nd Opinion **(circle one)**

My authorization extends only to those data elements/documents marked below:

_____ **Prenatal Records and Deliveries**
_____ Copies of records or reports provided to the above named (**hospital, lab, and clinic. Etc**)
_____ Progress notes
_____ Photographs, videotapes, digital or other images
____X____ **Operative Notes & Discharge Summary**
_____ History and physical examination
_____ Last **5 years** of **pap smear** results
_____ All of the above
____X____ **Other (must be specific)** **BTL: OPERATIVE NOTES & PATHOLOGY**
_____ Mental Health and or alcohol and drug abuse treatment
_____ AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) information
_____ Hepatitis information

This authorization is given freely with the understanding that:

1. **Any and all record, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.**
2. **A photocopy or fax of this authorization is as valid as the original.**
3. **I may revoke this authorization at any time, except where information has already been release. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.**
4. **Atchafalaya Ob/Gyn, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.**
5. **Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.**
6. **Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.**

_____ _____ _____
****Patient's Signature (or guardian, if a minor)** **** D.O.B.** ****Patient's Printed Name**

****Date: _____ Exp Date: _____ **Social Security #_____**
(If other than 1 year)

_____ _____
Patient's Personal Representative **Witness**

Please fax this sheet back with the records. Thanks

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History & Physical

Date _____ Name _____ Birth date _____

Have you ever been hospitalized for a major illness or had surgery?

Date _____ Reason/Surgery _____
Date _____ Reason/Surgery _____
Date _____ Reason/Surgery _____

Are you allergic to any medicines or foods? If yes, please list them and the reaction you had to each one.

_____

Medical History (Please circle any conditions you currently have or have had in the past.)

Abdominal pain
Allergies/Hay fever
Appetite-Loss of
Arthritis/Rheumatism
Asthma/Wheezing
Back Pain-Recurrent
Bronchitis
Cancer
Cancer-Colon
Chest Pain
Convulsions/Seizures
Diabetes
Diarrhea/Constipation
Dizziness/Fainting
Fatigue-(recurrent)
Gall Bladder Trouble
Hair Loss
Headaches-Frequent
Heart Murmur
Hemorrhoids
Hernia
High Blood Pressure
Indigestion/Heartburn
Jaundice/Hepatitis
Kidney Stones
Leg Pain
Memory Loss
Moodiness-Excessive
Mumps
Muscle Weakness
Nausea/Vomiting (recurrent)
Osteoporosis
Psoriasis/Eczema
Rashes/Hives
Sexual/Menstrual Problems
Sinus Trouble
Stools-Bloody/Tarry
Stroke
Thyroid Disease
Urethral Discharge
Urinary Problems:
loss of control
more than twice per night
painful
Varicose veins
Venereal disease
Weight loss-recent

Are you pregnant? _____How many times have you been pregnant? (include any miscarriages/abortions) _____
Number of Miscarriages _____ Abortions _____ Live Births _____

Date of last mammogram: _____ Normal/ Abnormal
Approximate date of last pap test: _____ Normal / Abnormal
Have you ever had an abnormal pap smear?_____, If yes, when _____
Are you currently using any type of birth control? _____Birth control method: _____

Family History:

	Father	Mother	Siblings	Father's Parents	Mother's Parents	
Bleeding Disorder	□	□	□	□	□	
Breast Cancer	□	□	□	□	□	**age @ diagnosis** _____
Colon Cancer	□	□	□	□	□	**age @ diagnosis** _____
Diabetes	□	□	□	□	□	
Endometrial Cancer	□	□	□	□	□	**age @ diagnosis**_____
Epilepsy	□	□	□	□	□	
Heart Disease	□	□	□	□	□	
High Blood Pressure	□	□	□	□	□	
Kidney Disease	□	□	□	□	□	
Ovarian Cancer	□	□	□	□	□	**age @ diagnosis**_____
Stroke	□	□	□	□	□	
Thyroid disorder	□	□	□	□	□	

Are you married?_____ If yes, how long have you been married?_____

Do you drink alcohol? _____ If yes, how often _____

Do you smoke _____ If yes, how much per day? _____ How long have you been a smoker? _____ years

Do you use drugs?_____ If yes, which ones_____ How often_____

Have you ever had a blood transfusion? _____ If yes, when_____