Dr. William Brennan, M.D., FACS
105 Patriot Avenue   Suite 101
Lafayette, LA 70508
Ph: 337-981-2125 Fax: 337-981-2174

Welcome to Neurosurgical Solutions of Lafayette!

In this information packet, you will find enclosed the required paperwork for you to read and sign prior to your scheduled appointment. All paperwork must be completed and signed by the patient. Please bring your completed paperwork with you along with a pictured identification card and your insurance card(s).

Your scheduled appointment is:

**PATIENT NAME:** ____________________

**REFERRING DOCTOR:** ____________________

**DATE:** M TU W TH F SA____________________

**TIME:** ____________________

For directions to our office or further information, please visit our website at www.lafayetteneuro.com. Of course, you are always welcome to call our office.

Please note that any cancelations less than 48 hours before your appointment are considered no shows and are subject to charge.

We look forward to meeting you,
The Staff of Neurosurgical Solutions of Lafayette

## PLEASE REMEMBER TO BRING YOUR MRI/CT/XRAY ON PLASTIC DISC!!

# PATIENT DEMOGRAPHIC FORM

Name: ______________________________ Date: ____/____/____

Birth Date: ____/____/____ SSN: ____/____/____

Address: ______________________ Apt #: ____ City: ____________ State/Zip: __________

Primary Phone: (W H M) ______________ Secondary Phone: (W H M) ______________
Circle one Circle one

Referring Provider Dr. ______________________ City: ______________________

Family Doctor (same as above) ☐ Dr. ______________________ City: ______________________

Cardiologist Dr. ______________________ City: ______________________

**Primary Insurance Information:**

Name: ______________________________________________

ID#: ______________________ Group #: ______________________

Guarantor: ______________________ Guarantor's SSN: ____/____/____

Guarantor's Birth Date: ____/____/____

**Secondary Insurance Information:**

Name: ______________________________________________

ID#: ______________________ Group #: ______________________

**Pharmacy Information:**

Pharmacy: ______________________ Phone: ______________________

Pharmacy Location: ______________ City: ______________ State/Zip: __________

**Emergency Contacts:**

Name: ______________ Phone: ______________ Alt Phone: ______________

Relationship to patient: ______________________

Name: ______________ Phone: ______________ Alt Phone: ______________

Relationship to patient: ______________________

Name: ______________________________ Age: __________

Problem that brings you in today: ______________________________

How long has this problem been going on? ______________________________

Is this problem the result of an **auto accident**? Yes ☐ No ☐ Date: ______/______/______

Is this problem the result of an **on the job injury**? Yes ☐ No ☐ Date: _____/_____/______

Is there a legal case going on? Yes ☐ No ☐ Name of attorney: ______________________________

What treatment have you tried or been prescribed? ______________________________

Have you ever had a similar problem? ________ If yes, when: ______________________________

Are you working now? ☐ Yes ☐ No ☐ Disabled Off work since ___/___/_____

What other doctors have you seen about this problem? Dr. ______________ Town ______________

Dr. ______________ Town ______________

When did you last see your **family doctor** Dr. ________________ ___weeks ___months ____ years

**Medications:**

Medication Allergies: None ☐ Which ones? ______________________________

Do you take blood thinners? **Yes** ☐ **No** ☐ **Which ones?** ______________________________

**List of Medications:**

| Name | Dose | Times Per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
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## Social History:

Single ☐ Married ☐ Widow/er ☐

Any children? Yes ☐ No ☐ How many? 1 2 3 4 5 ___

Do you smoke? Yes ☐ No ☐ Quit ☐ How many pack a day? ½ 1 2 3

Do you drink alcoholic beverages? Yes ☐ No ☐ Drinks per week: 1-3 ☐ 4-7 ☐ 8-10 ☐

**Review of Systems:** Are you having any problems in these areas that your family doctor DOES NOT KNOW ABOUT?

1 Constitutional
2 Eyes
3 Ears, nose, mouth and throat
4 Cardiovascular
5 Respiratory
6 Gastrointestinal
7 Genitourinary
8 Musculoskeletal
9 Integumentary (Skin)
10 Neurological
11 Psychiatric
12 Endocrine
13 Hematologic/Lymphatic
14 Allergic/Immunologic

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Medical History (Check all that apply)

| Medical Condition | ✓ | |
|---|---|---|
| Diabetes | | |
| High Blood Pressure | | |
| Heart Disease (CAD) | | |
| Congestive Heart Failure | | |
| Heart Attack | | |
| Heart Rhythm Problem | | |
| Cardiac or Vascular Stent | | |
| Elevated Cholesterol | | |
| Stroke | | |
| Seizures | | |
| Peripheral Vascular Disease | | |
| Cancer | | |
| Type | | |
| COPD | | |
| Emphysema | | |
| Bronchitis | | |
| Pneumonia | | |
| Hepatitis | | |
| HIV/AIDS | | |
| Fractures | | |
| Infections | | |
| Stomach disease | | |

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| Ulcer or Bleeding disorder | | |
|---|---|---|
| Intestinal/Colon disease | | |
| GERD | | |
| Gout | | |
| Hyper Thyroid | | |
| Hypo Thyroid | | |
| Kidney Disease | | |
| Osteo Arthritis | | |
| Rheumatoid Arthritis | | |
| Fibromyalgia | | |
| Skin disease | | |
| Cataracts | | |
| Retinal disease | | |
| Double Vision | | |
| Inner ear disease | | |
| Nose, mouth or throat disease | | |
| Anxiety | | |
| Depression | | |
| Schizophrenia | | |
| Bipolar | | |

Do you have a history of substance abuse: Yes ☐ No ☐ If yes what substance:

______________________________________________________________________________

Other medical problems:

______________________________________________________________

**Past Surgical History:** None: ☐

| Procedure | Surgeon/City | Year |
|---|---|---|
| | | |
| | | |
| | | |
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Any Surgery Complications? No ☐ Yes ______________________________

Any Surgery Infections? No ☐ Yes ______________________________

**Family History:** Check the following health problems that occur in your family.

| | Mother | Father | Sister | Brother | Grandparent |
|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ | ☐ | ☐ |
| Strokes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding Disorder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer<br>Type? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Infections | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |

**Signature** ________________________________ **Date:** _____/_____/_____

# AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skilled and high quality care. The medical services provided to you by our office are services you have elected to receive which may imply a financial responsibility on your part.

CO-PAYS: Co-pays are due at the time of service.

MEDICARE: We are a participating Medicare provider. Medicare, as well as your secondary insurance (if any), will be billed for you. You are responsible for co-payments or deductible amounts as stated by Medicare and your secondary insurance company.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any), after payment and/or explanation of benefits (EOB) is received for your primary insurance company.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates to us that when you visit a specialist, such as ours, you must have a referral from your primary care physician prior to seeking specialty care; Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services performed, upon completion of the visit. You will also be given the option to reschedule your appointment.

PATIENT BILLING: You will be sent three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover. An additional $45.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance. I have read that above policy regarding my financial responsibility to Neurosurgical Solutions of Lafayette for providing medical services to me or the below named patient. I agree to pay Neurosurgical Solutions of Lafayette any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if no health insurance coverage exists.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contract you as needed. You will also be provided with a HIPAA Privacy Notice for this office.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Neurosurgical Solutions of Lafayette all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of any deductible, co-payments and non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

(PRINT) Patient Name: ____________________ Signature: ____________________ Date: ___/___/___

FINANCIALLY RESPONSIBILITY PARTY

(PRINT) Name: ____________________ Signature: ____________________

Relationship to Patient: ____________________ Date: ___/___/___

Neurosurgical Solutions
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# HIPAA
# RECEIPT OF NOTICE OF PRIVACY PRACTICES
# WRITTEN ACKNOWLEDGEMENT FORM

I, ________________________________________, have received and reviewed a copy
*(Patient Name)*
of the Notice Of Private Practices from Neurosurgical Solutions of Lafayette.

Our goal is to assure privacy and deliver care in the best possible manner. Our center uses the methods outlined in our Notice of Privacy Practices for patient identification purposes or to communicate your protected health information. Please indicate below any objections to the information contained in our Notice of Privacy Practices. (Alternative methods MUST BE GIVEN if you indicated any objections.) If necessary, my Protected Health Information may be released to the following person(s)

Name: _________________________________ Relationship: _____________________

Name: _________________________________ Relationship: _____________________

Name: _________________________________ Relationship: ______________________

*If you would like anyone other than yourself to be able to call our office and discuss your account or medical information you must print their name in the space provided above. This includes spouses.
I understand that if I should have any questions or concerns they are to be directed to the Office Manager.

___________________________________________________________________________
*Signature of Patient or Legal Guardian* Date: _____/_____/______

___________________________________________________________________________
*Facility Witness Signature* Date: _____/_____/______

Rev 6.22.15

# Consent to Use Protected Health Information
# For Treatment, Payment and Health Care Operations

I consent to allow **Neurosurgical Solutions of Lafayette** to use or disclose my protected health information for treatment, payment and health care operations.

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursements for the provision of health care.
- Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; E-mail correspondences with health insurance providers such as worker's compensation carriers as well as third party payers and business management and general administrative activities of **Neurosurgical Solutions of Lafayette.**

I consent to allow **Neurosurgical Solutions of Lafayette** to disclose my protected health information for treatment activities of another health care provider.

I consent to allow **Neurosurgical Solutions of Lafayette** to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow **Neurosurgical Solutions of Lafayette** to disclose protected health information to another covered entity for health care operations activities, provided that **Neurosurgical Solutions of Lafayette** and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment or health care operations or for the purpose of health care fraud and abuse detection or compliance.

Name of patient: ______________________________________________
(Please Print)

______________________________________________
Signature of Person Authorizing Consent

______________________________________________
Relationship to patient

____________/___/____________
Date

Neurosurgical Solutions
of Lafayette

# X-Ray/MRI/CD Storage Policy

Our office relies on the images you bring to deliver to you our neurosurgical recommendations. These X-Rays, MRI's and CT Scan's are copies of original documents from the imaging facility that produces them for you.

Once delivered to our office for your visit, we require 3 business days to return them to you if you wish to have them returned to you. This is to insure that our transcribed dictation accurately matches your images.

After your visit with us, we will hold these copies here until we no longer need them to make medical recommendations to you. The facility that produced the images is required to keep the originals available to you for several years. If we need them for comparison in the future, we will request them.

At such time when we no longer need the images onsite and we have not received a request from you to have them returned to you, these copies will be destroyed or returned to the facility that produced them at the discretion of Neurosurgical Solutions of Lafayette.

For questions regarding this policy please contact our Office Manager.

Thank You

I have received the NSL X-Ray/MRI/CD storage policy.

______________________________________________

Patient Signature

________/________/__________

Date

Rev 6.22.15

Neurosurgical Solutions
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# Pain Medicine Policy

Welcome to our practice. Our goal is to assist your referring or primary care physician in determining if your condition requires surgical care.

We will always recommend non-surgical care before considering surgery. Your pain medication needs are important and will be managed in the following way.

After your evaluation, your condition will be in one of three categories:

1. Needing a non-surgical care plan under our supervision.
2. Needing surgery.
3. Not needing a neurosurgical supervised treatment plan.

If your condition requires a non-surgical care plan under our supervision, we will provide pain medication until your care plan is completed. If you are successful in non-surgical management from our office, we will return your care and pain medication needs to your primary or referring physician.

If you require surgery, we will provide pain medication until the recovery is completed and further refills will be referred to your primary or referring physician.

**If no surgical care plan is needed, we will not be prescribing pain medications.**

*TWO BUSINESS DAYS WILL BE REQUIRED ON ALL PAIN MEDICATION REFILL REQUESTS.

_______________________________________________

*Signature of Patient or Legal Guardian* Date: _____/_____/_____

# Cancellation Policy of
# Neurosurgical Solutions of Lafayette

Patients of Neurosurgical Solution of Lafayette that are established may be subject to a penalty of $100 for appointments that are "no show" status.  Please reschedule no later than 48 business hours prior to your appointment if you feel you may not be able to keep the appointment.

Patients who schedule surgery with our office and "no show" for pre-operative appointments or surgery itself may be subject to a $500 penalty.  Please let us know as soon as you can regarding changing scheduled appointments of this nature.

______________________________________________________________

*Print Name*    Date: ____/____/______

______________________________________________________________

*Signature of Patient*    *Date:* ____/____/______

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.

If you have any questions about this notice, please contact our Privacy Contact (Office Manager) Jada Begnaud at 337-981-2125.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that is 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 my identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain both before and after the change. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

You will be asked by your physician to sign this Notice of Privacy Practices. We will make a good faith effort to obtain a written acknowledgement that you received this Notice of Privacy Practices for Protected Health Information the first time we provide services to you after April 14, 2003, or as soon as reasonably practicable under the circumstances. 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 propose of providing health care services to you. Your protected health information may also be used and disclosed to obtain payment for your health care bills and to support the operation of the physician's practice.

Uses and Disclosures of Protected Health Information

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures which may be made by our office.

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 that may need access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating 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.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. 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 will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

**Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. 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.

**Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Facility Directories. Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation.

Others Involved in Your Healthcare. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that is it in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies. We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your acknowledgement of our Privacy Practices as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your acknowledgement, but is unable, he or she may still use or disclose your protected health information for treatment, payment and health care operations.

Communication Barriers. We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain an acknowledgement of our Privacy Practices from you, but is unable to do so due to substantial communication barriers.

**Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your acknowledgement or authorization. These situations are:

- ★ Required By Law
- ★ Legal Proceedings
- ★ Health Oversight
- ★ Criminal Activity

★ Law Enforcement
★ Public Health
★ Inmates
★ Workers' Compensation
★ Research
★ Communicable Diseases
★ Food and Drug Administration
★ Abuse or Neglect
★ Coroners, Funeral Directors, and Organ Donation
★ Required Uses and Disclosures
★Military Activity and National Security

Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

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. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have any questions about access to your medical record.

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 a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restrictions you wish to request with your physician. You may request a restriction by submitting a written request to our Privacy Contact.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny you request for an amendment. If we deny your request for an 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. Please contact our Privacy Contact if you have any questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations and valid authorizations or incidental disclosures as described in this Notice of Privacy Practices. It excludes disclosures 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. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of his notice from us, upon request, even if you have agreed to accept this notice electronically.

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.

Our Privacy Officer is Dr. William A. Brennan and he can be reached at 337-981-2125

This notice was published and becomes effective on April 14, 2003

HIPAA Health Insurance Reform
Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. Visit this site to find out about pre-existing conditions and portability of health insurance coverage.

HIPAA Administrative Simplification
The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.