North Louisiana
Orthopaedic & Sports Medicine Clinic

Experience You Can Trust Since 1951

Doctor's Name _____

Patient Information

Patient # _____ Appt. Date _____ Social Security # _____ Driver's License # _____

First Name _____ Middle Name _____ Last Name _____ Sex M F

Date of Birth _____ Age _____ Marital Status _____ Race/Ethnicity _____

Patient's Employer _____ Work Phone # _____

Patient's Mailing Address _____ City _____ State _____ Zip _____

Patient's Email Address _____ Home Phone # _____ Cell Phone # _____

Spouse's Name _____ Referring Doctor's Name _____ Referring Doctor's City, State _____

Family Doctor's Name _____ Family Doctor's City, State _____

Primary Insurance

Insurance Company Name _____ Insurance Company Address _____

Insurance Group # _____ Insurance Policy # _____ Policyholder's Name _____

Policyholder's Date of Birth _____ Policyholder's Social Security # _____

Secondary Insurance

Insurance Company Name _____ Insurance Company Address _____

Insurance Group # _____ Insurance Policy # _____ Policyholder's Name _____

Policyholder's Date of Birth _____ Policyholder's Social Security # _____

Guarantor Information (for Children)

Guarantor's Name _____ Guarantor's Employer _____

Guarantor's Phone # _____ Guarantor's Social Security # _____ Guarantor's Date of Birth _____

ALL CHARGES ARE DUE IN FULL AT TIME OF TREATMENT

I declare that the above information is true and correct to the best of my knowledge.

I hereby make an irrevocable assignment of benefits or proceeds from any claim, health insurance, or worker' compensation in an amount sufficient to satisfy my indebtedness to North Louisiana Orthopaedic & Sports Medicine Clinic for services rendered for injuries sustained on or about _____, 20 _____.

I acknowledge receipt of the **Notice of Health Information Privacy Practices.**

_____ _____

Patient's Signature
(Parent or Guardian, if Minor)

Date

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Doctor's Name _____

Patient Name _____ Date _____

Date of Birth _____ Age _____ Height _____ Weight _____ Sex M F

CHIEF COMPLAINT

What part of the body are we checking today? _____

Please circle RIGHT or LEFT if it applies to above question.

Date of injury or when symptoms began _____

Explain your problem. _____

Have you been seen by another physician for this problem? YES NO

If yes, what physician and when? _____

Have you been seen at the emergency room for this problem? YES NO

If yes, which ER and when? _____

Have you been treated in the past for this condition? YES NO WHEN? _____

X-RAYS

Have you had recent X-rays, scans, or MRIs taken that pertain to this problem? YES NO

If yes, when and where? _____

ALLERGIES YES NO If yes, please list below.

Drug	Reaction	Drug	Reaction
1.		3.	
2.		4.	

DO YOU HAVE A HISTORY OF LATEX ALLERGY? YES NO

ARE YOU PREGNANT? YES NO

MEDICATIONS Include diet pills and/or nutritional supplements.

Drug	Dosage	Drug	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

YOUR Past Medical History

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
Hypertension			Diabetes			Osteoporosis			Stroke		
Anigina			HIV			Gout			Renal Dialysis		
Heart Disease			Cancer			Sleep Apnea			Osteoarthritis		
Heart Failure			Rheumatoid Arthritis			Prostate Disorders			Heart Attack		
Asthma			Escophageal Reflux			Renal Disorders			Heart Stent		
COPD			Thrombophlebitis			Hepatitis			Other:		

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Patient Name _____ Date _____

Date of Birth _____

Please state your occupation and job duties. _____

Social History

Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Living Arrangements ❒ Home Alone ❒ Home With Family ❒ Assisted Living ❒ Nursing Home

Smoking/Smokeless Tobacco Status

Circle which applies: Never Smoked Current Smoker Former Smoker Smokeless Tobacco Unknown

The amount and how often you use tobacco: _____

Do you drink alcohol? ❒ Regularly ❒ Occasionally ❒ No

If regularly or occasionally, please list the amount and type ingested. _____

Do you use recreational drugs? ❒ Yes ❒ No

Were you referred here? If so, by whom? _____ Family Doctor _____

FAMILY Medical History (Do you have a family history of any of the following illnesses?)

Yes	No	Illness	If yes, then please list the type of family member (i.e., father, mother, grandmother, etc.).
		Cancer	
		Heart Disease	
		Hypertension	
		Osteoarthritis	
		Diabetes	
		Rheumatoid Arthritis	
		Tuberculosis	

PAST SURGICAL HISTORY

Year	Name of Operation	Year	Name of Operation
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

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Review of Systems

Patient Name _____ Date _____

	Yes	No		Yes	No		Yes	No
Systemic Symptoms			**Cardiovascular Symptoms**			**Skin Symptoms**		
Weight change			Chest pain or discomfort			Pruritus (itching)		
Weight change			Fast heart rate			Skin lesions		
Fever			Palpitations			Rashes		
Night sweats			**Gastrointestinal Symptoms**			**Endocrine Symptoms**		
Malaise (feeling tired/ poorly)			Difficulty swallowing			Excessive sweating		
HEENT Symptoms			Heartburn			Excessive thirst		
Headache			Nausea			**Hematological Symptoms**		
Eyesight problems			Vomiting			Easy bleeding		
Nosebleeds			Abdominal pain			Easy bruising tendency		
Neck Symptoms			Diarrhea			**Neurological Symptoms**		
Neck pain			**Genitourinary Symptoms**			Dizziness		
Neck stiffness			Blood in urine			Vertigo		
Lump or swelling in neck			Painful urination			Motor disturbance		
Pulmonary Systems			Increased urinary frequency			Sensory disturbance		
Shortness of breath			Decreased kidney function			**Psychologic Symptoms**		
Cough						Sleep disturbances		
Coughing up blood						Anxiety		
Night sweats						Depression		
Wheezing								

What is your pharmacy name and address? _____

North Louisiana Orthopaedic & Sports Medicine Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PATIENT FINANCIAL POLICY

In order to reduceconfusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office financial manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- The patient is always responsible for payment of any applicable co-pay, co-insurance, and/or deductibles at the time of his/her visit. However, as a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor (in other words you agree to have your insurance pay the doctor directly). If your insurance company does not pay the practice within a reasonable length of time (i.e. within 45 days) you will be responsible.
- With few exceptions (i.e. PPO Contracts), your insurance policy is a contract between you and your insurance company, the doctor is not involved.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. For other services, such as X-rays, fracture care, durable medical equipment supplies, etc., these claims are processed under your major medical with all applicable deductibles and co-insurance to be collected at the time of service.
- **If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.**
- If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim form for you. Therefore our charges for your care and treatment are due at the time of service.
- Unless you have made other arrangements in advance, full payment is due at the time of service. For your convenience, we will accept VISA, MasterCard, Discover and AMEX. We also offer CareCredit as a means of paying your bill.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge.
- For all services provided by our physicians in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.
- There is a $35 fee charged for each disability form completed by our office and for disability continuation forms the fee is $15.
- In order to provide the best possible service and availability to all our patients please call us as early as possible is you know you need to reschedule your appointment. There is a $50 No Show or same day cancellation fee on our MRI appointments.
- I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient or Responsible Party if Minor | Date

Please Print Name of Patient | Account Number

Revised June 2021

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Patient Questionnaire

1.Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, releasing your medical records, and healthcare operations):

Name_____ Relationship_____ Phone number_____

Name_____ Relationship_____ Phone number_____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Relationship_____ Phone number_____

Name_____ Relationship_____ Phone number_____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent: _____

_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":
Yes_____ No_____

5. Please print the alternative daytime telephone number (s) where you would like to receive communications regarding your appointments, lab, and x-ray results, and other healthcare information:

( )_____ ( )_____
I am aware that a cellular phone is not a secure and private line.

6. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?
Yes_____ No_____

7. Would you be interested in receiving orthopedic educational information via email?

Email addr._____ Yes_____ No_____

PATIENT NAME_____

_____ _____
Patient/Guardian (if under 18) Signature Date

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FALL RISK SCREENING

Date _____

Patient's Name _____

Patient's Date of Birth _____

Please answer the below questions by checking the appropriate box.

1. Have you had one or more falls within the past 12 months? ☐ YES ☐ NO

    1a. Number of falls in the past 12 months _____

2. Have you had a fall with an injury? ☐ YES ☐ NO

3. Do you have any problems with gait or balance? ☐ YES ☐ NO

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Disclosure of Physician-Owned Facility

During the course of your treatment with North Louisiana Orthopaedic & Sports Medicine Clinic, you might be referred to the Advanced Surgery Center of Northern Louisiana for an outpatient procedure/surgery. A number of our physicians are part owners of the facility. You, the patient, have the right to have the outpatient procedure at an alternate facility not owned by the physicians.

By signing below I acknowledge that I have been informed of physician ownership of Advance Surgery Center of Northern Louisiana. I am aware that I have the option to have the procedure/surgery performed at Advance Surgery Center of Northern Louisiana or at an alternate facility.

Physicians with ownership in Advance Surgery Center of Northern Louisiana:

R. Brian Bulloch, M.D. Jeffrey R. Counts, D.O. Stanley Crawford, D.O. Martin J. deGravelle Jr., M.D.
Grant A. Dona, M.D. White "Sol" Graves, IV, M.D. Elliott B. Nipper, M.D. Kristopher C. Sirmon, M.D.
Timothy "Daven" Spires, Jr., M.D. David M. Trettin, M.D.

During the course of your treatment with North Louisiana Orthopaedic & Sports Medicine Clinic, you might be referred to physical or occupational therapy. We offer these therapy services here at our office and all of our physicians are part owners of this rehabilitation department. You will be given a list of therapy agencies in the area in which to choose from. If you do not receive this list please notify our Office Manager or CEO.

Also, during your course of treatment here, you may be referred to have an MRI. All of our physicians are part owners of our MRI machine located here at our office. At the time your MRI is scheduled, you will be given a list of other area providers who perform MRIs. If you do not receive this list, please notify our office manager or CEO.

By signing below, I acknowledge that I have been informed of physician ownership in the rehabilitation department and the MRI department located in North Louisiana Orthopaedic & Sports Medicine Clinic.

_____

PATIENT NAME

_____ _____

PATIENT SIGNATURE **DATE**

North Louisiana Orthopaedic & Sports Medicine Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex.

North Louisiana
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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.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. § 164.520

Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("PHI"). PHI consists of individually identifiable health information, which may include demographic information we collect from you or create or receive by another healthcare provider, a health plan, your employer, or a healthcare clearinghouse and that relates to (1) your past, present, or future physical or mental health or condition; (2) the provision of healthcare to you; or (3) the past, present, or future payment for the provision of healthcare to you.

We must provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to PHI and make new privacy policies effective for all PHI that we maintain. We will post a copy of our current Notice of Privacy Practices in the waiting room and keep a copy of the revised Notice at the registration desk and provide you with a copy upon your request. If we maintain a website, we will post our Notice of Privacy Practices on our website.

Examples of Uses and Disclosures of Your PHI Relating to Treatment, Payment & Operations

HIPAA privacy regulations give us the right to use and disclose your PHI without your consent to carry out (i) treatment, (ii) payment, and (iii) healthcare operations. Here are some examples of how we intend to use of your PHI in regard to your treatment, payment, and healthcare operations.

Treatment. In connection with treatment, we will, for example, use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. We will disclose your PHI to other providers who may be treating you. Additionally, we may disclose your PHI to another provider who has been requested to be involved in your care.

Payment. We will use your PHI to obtain payment for our services, including sending claims to your insurer or to a federal program, such as Medicare, that pays for your treatment and sending you a bill for any amounts due which your insurer does not pay. We may also employ business associates, such as a billing company or collection agency, to help us bill and collect. The PHI will include items such as a description of your condition(s), our treatment, your diagnosis, supplies, and drugs we used, etc.

Healthcare Operations. We will use your PHI to support our business activities, such as allowing our auditors, consultants, or attorneys access to your PHI to audit our claims to determine if we billed you accurately for the services we provided to you, or to evaluate our staff to see if they properly cared for you or to send information about you to third-party business associates so they may perform some of our business operations.

Description of Other Required or Permitted Uses and Disclosures of Your PHI

Appointment Reminders. We will call you to remind you of an appointment. We may call your residence, office, or any other number we have on file. We will leave a message if you are not in, and we will state the name of our clinic, the date and time of the appointment, and the address at which the appointment is to be kept. We may also mail you a notice of your appointment to any address we have on file.

As Required by Law. We will use and disclose your PHI when required to by federal, state, or local law. For example, we may receive a subpoena for which we are required by law to provide copies of your medical file.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your PHI to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Workers' Compensation. We will use and disclose your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. If you are an inmate, we will use and disclose your PHI to a correctional institution or law enforcement official only if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with healthcare, to protect the health and safety of others, or for the safety and security of the correctional institution.

Other Services and/or Fundraising. We may use your PHI to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your PHI to contact you in an effort to raise funds for our operations; however, you have the right to opt out of receiving any fundraising communications by sending a letter to our Privacy Officer in writing at the address at which you are treated.

Uses and Disclosures to Which You Have an Opportunity to Object

Others Involved in Your Care. We may provide relevant portions of your PHI to a family member, a relative, a close friend, or any other person you identify as being involved in your medical care or payment for care. If you bring someone with you into a treatment room, you are hereby notified that you will have identified that person to us as being involved in your care or payment for your care by voluntarily bringing them in the room. If you do not object to us discussing your PHI in front of them, we may discuss your PHI in their presence because you did not object. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest but will tell you about it after the emergency and give you the opportunity to object to future disclosures to family and friends.

Uses and Disclosures That Require Your Signed Authorization

There are certain uses and disclosures of your PHI that require your written authorization. For example, most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require your signed authorization. Also, any use or disclosure of your PHI not described in this Notice requires your signed authorization.

Your Right to Revoke Your Authorization

If you sign an authorization allowing us to use or disclose your PHI outside of the uses and disclosures made in this Notice, you may revoke that authorization by advising us in writing with a letter addressed to Privacy Officer at the address where we treat you. Your revocation will become effective as soon as we are reasonably able to enter it into our records, which is typically within 5 business days after we receive the letter. Your revocation will not affect our prior reliance on your authorization prior to the effective date of revocation.

Your Right to Restrict Certain PHI to a Health Plan

You have the right to require us to restrict any disclosure of your PHI to a health plan regarding an item or service for which you (or someone on your behalf—other than a health plan) paid out of pocket to us the entire amount due for the healthcare item or service which we provided and billed to you. You must make such a request in writing to us with a letter addressed to Privacy Officer at the address where you receive your treatment. If you make such a request, we are required to honor it.

Notification in Case of Breach of Unsecured PHI

In the event of an unauthorized or improper use or disclosure of your PHI (i.e., a "breach"), you have the right to receive, and we will notify you of the circumstances surrounding, the breach, what we have done to investigate and mitigate it, and how to best protect yourself in our opinion.

Patient Rights Related to PHI

In addition to your other rights provided herein, you have the right to:

Request an Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our Privacy Officer stating what information is incomplete or inaccurate and the reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason that we believe supports the request. We may also deny your request if the information was not created by us or if the person who created it is no longer available to make the amendment.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or healthcare operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to the Privacy Officer addressed to the address at which you receive care. We are not required to agree to your request. If we do agree, we will comply with your request except for emergency treatment.

Inspect and Copy. You have the right to inspect and copy the PHI we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer at the address at which you receive treatment. We will have

30 days to respond to your request for information that we maintain at our facility. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay. HITECH expands this right, giving individuals the right to access their own e-health record in an electronic format if we maintain your records in an electronic format and to direct us to send the e-health records directly to a third party. We may only charge for labor costs under electronic transfers of e-health records.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made that were not for treatment, payment, or healthcare operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12 months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests; however, we will not accommodate a request that we perceive is an attempt to avoid receiving notice of a bill for the payment of our services.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us or directly to the Secretary of the United States Department of Health and Human Services: U.S. Department of Health & Human Services, 200 Independence Avenue S.W., Washington, D.C. 20201, Phone: (202) 619-0257, Toll Free: (877) 696-6775. To file a complaint with us, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer at the address at which you were treated. No patient will be retaliated against for making a complaint.

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

Contact Person

You may contact our Privacy Officer at the following phone number for any questions:
Phone number: (318) 323-8451

Effective Date

The effective date of this revised Notice of Privacy Practices is March 2018.

North Louisiana
Orthopaedic &
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Experience You Can Trust Since 1951

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document entitled, "Notice of Privacy Practices," which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

_____ _____

PATIENT SIGNATURE
Or Personal Representative

DATE

North Louisiana
Orthopaedic &
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Unsuccessful Attempt at Obtaining Acknowledgment of Notice

Pursuant to 45 C.F.R. § 164.520, the covered healthcare entity or provider named below must document any unsuccessful attempt at gaining an individual's **signed acknowledgment** of receiving a notice of privacy practices from the provider. This form shall constitute documentation of compliance with the aforementioned regulation.

_____ _____

NAME OF ENTITY/PROVIDER **NAME OF PATIENT**

_____ _____

SIGNATURE OF PERSON ATTEMPTING TO OBTAIN ACKNOWLEDGMENT **DATE**

DESCRIBE ATTEMPT AT GAINING ACKNOWLEDGMENT:

EXPLAIN WHY ACKNOWLEDGMENT COULD NOT BE OBTAINED:

North Louisiana Orthopaedic & Sports Medicine Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

North Louisiana Orthopaedic & Sports Medicine Clinic

commonwell HEALTH ALLIANCE

Dear _____ (Print Patient Name) Date _____

We believe that patients and your caregivers should have easy access to your medical information, no matter where you receive care. That's why we're participating in CommonWell, a service that allows a network of healthcare providers to identify you, securely send and receive your medical information, and help ensure that you receive optimal care.

What is CommonWell?

A *free, secure service* offered by your doctor, so your health information can be available to you and your doctors regardless of where you've received care.

You simply need to enroll in the service with a driver's license and then confirm the other CommonWell network doctors you see. Don't worry if you don't have a government-issued picture ID, you can still register.

How do we use the health information we share through CommonWell?

- ***Better coordinate your care across different doctors*** — We'll provide and request to receive your information *where* and *when* it's needed for your healthcare provider to deliver the care you need as you move from doctor to doctor.
    - Only healthcare staff directly involved in your care will access your medical information shared through CommonWell.
- ***Support better care decision-making*** — With timely access to information from other healthcare providers you've seen, your doctors may be able to make better decisions about your health.
    - This information will only be used to help improve your care; and won't be shared without your permission or unless it's required by law.
- ***Deliver care more promptly and efficiently*** — With less time wasted on tracking down your test results and other health information, your healthcare providers can treat you more efficiently, and spend less time on paperwork and more time on your care.
    - We do need your help in confirming the other doctors or hospitals you've visited when you enroll in CommonWell.
- ***Securely and confidentially*** — Your Protected Health Information ("PHI") will always be confidential and used to inform the CommonWell participating healthcare providers. We won't use your PHI for discriminatory purposes of any kind or to deny medical treatment.
    - You can opt-out of this service anytime by calling or visiting this doctor's office and asking them to unenroll you from CommonWell.

How do I sign up?

It's quick and easy. Show the staff at the front desk or during patient discharge your government-issued ID (driver's license, etc.) and tell them what other doctors, hospitals and healthcare providers you've seen.

Patient Signature _____DOB_____ Driver's License_____

CommonWell Health Alliance

The CommonWell services are provided by the CommonWell Health Alliance trade association. We are devoted to the notion that patient data should be safely, securely and immediately available to patients and doctors regardless of where care occurs to deliver better care. We are committed to fostering standards that make this possible, and in having health information technology companies build these capabilities into their systems. The end results: higher quality, more timely, more cost-effective care that delivers better health outcomes. Participating vendors are: Allscripts, athenahealth, Cerner, CPSI, Greenway, McKesson, and Sunquest.