BATON ROUGE PHYSICAL MEDICINE
PATIENT INFORMATION SHEET

(PLEASE PRINT)

Patient #: _____ Today's Date: _____

Name: _____ Social Security#: _____-____-_____

Date of Birth: _____ Sex of Patient: Male | Female

Address: _____

City, State, & Zip: _____

Cell#: _____ Home#: _____ Work#: _____

Date of Accident: _____ Is this a Workers Compensation Claim: Yes | No

Type of Accident: Auto____ Slip and Fall____ other_____

Have you ever treated with us before? Yes | No When?_____

Auto Insurance Information

(please give information of the party responsible for payment)

Company: _____ Adjustor: _____

Policy #: _____ Claim #: _____

Phone #: _____ Fax #: _____

Address: _____

City, State, & Zip: _____

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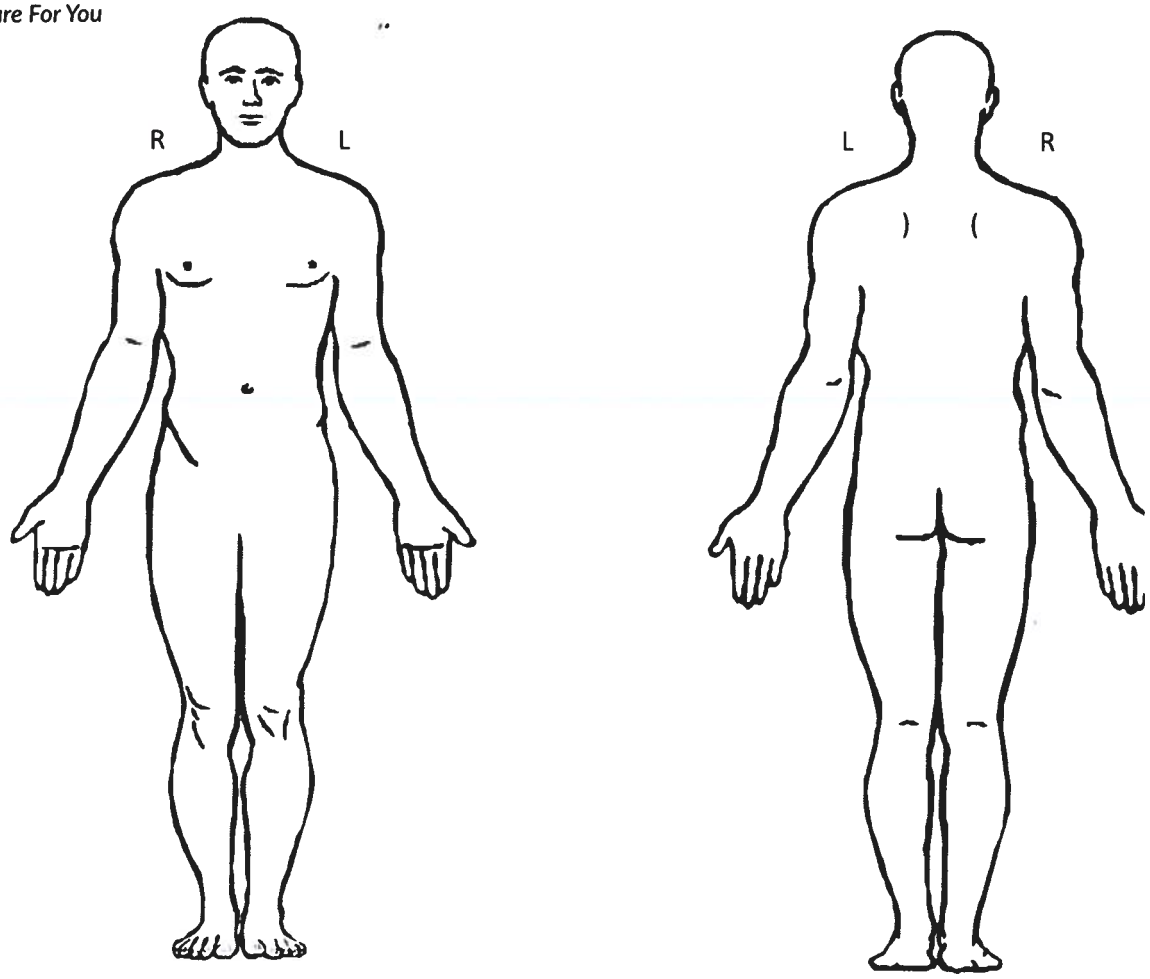
INJURY INFORMATION SHEET

(Please shade in anywhere you are hurting from your accident)



Please check any activity that causes an increase in pain:

__ Lying Down	__ Sitting Down	__ Turning Head
__ Bending	__ Reaching	__ Sneezing
__ Standing	__ Lifting	__ Coughing

Please check any symptoms you are currently experiencing:

__ Headaches	__Loss of balance	__ Fainting
__ Dizziness	__Blurred Vision	__ Diarrhea/constipation
__Numbness_____	__ Insomnia	__ Nausea
__ Fatigue	__ Tingling_____	__ Trouble Breathing
__ Humming in ears	__Depression	__ Muscle Spasms

Did you suffer receive any cuts or scrapes in the accident? __Yes __No

If so Where_____

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MEDICAL & SOCIAL HISTORY INFORMATION SHEET

(This sheet is **very important** to your treatment please fill it out **completely!)**

PERSONAL & FAMILY HISTORY

Please check the proper column for any that apply either to yourself or your family **(self=S/ family=F)**

S__F__ Anemia	S__F__ Gout	S__F__ Migraines(chronic)
S__F__ Aneurism	S__F__ Heart Murmur	S__F__ Osteoporosis
S__F__ Arthritis	S__F__ Heart Disease	S__F__ Pneumonia(chronic)
S__F__ Asthma	S__F__ Hepatitis	S__F__ Psoriasis(liver)
S__F__ Cancer	S__F__ Herpes	S__F__ Seizures/Epilepsy
S__F__ Chronic Bronchitis	S__F__ Hypertension	S__F__ Stroke
S__F__ Diabetes	S__F__ HIV/AIDS	S__F__ Tetanus
S__F__ Eczema	S__F__ Kidney Disease	S__F__ Thyroid Disease
S__F__ Glaucoma	S__F__ Mental Illness	S__F__ Ulcers(peptic)

Allergies(list)_____ Are you pregnant? Yes or NO

Do you have any prosthesis? Yes or No History of claustrophobia? Yes or NO

Do you have any implants including a pacemaker? Yes or NO Any metal fragments? Yes or NO

List any major surgeries with the year: _____

Prior to this incident have you ever had any serious injuries? Yes or No

If so please list the injury and year:_____

SOCIAL HISTORY

Marital Status: Married Widowed Single **Number of Children?**_____ **How many over 18?**_____

Do you smoke? Yes or No **If so how much?**_____

Do you drink? Yes or No **If so how often?**_____

Do you do drugs? Yes or No **If so what type and how often?**_____

Do you exercise? Yes or No **If so how often?**_____

Most current weight?____**lbs.** **How many hours of sleep do you normally get a night?**_____

Other

If there is any other health or social history information not covered on this page that you feel it is important for us to know please list it here: _____

_____

_____

_____

_____

BRPM
We Care For You

Baton Rouge Physical Medicine

8149 Florida Blvd, STE 300
Baton Rouge, La 70806
Phone: (225)924-2555 Fax: (225)927-0404

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: **Medical Records Department**

At: _____ Fax#: _____

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

SSN: _____ **Date of Accident:** _____

I hereby authorize _____ to release to **Baton Rouge Physical Medicine**

any and all medical records on or between the dates of _____ to be used

for my personal file; and hereby release them of any consequences thereof.

Patient Signature: _____ **Date:** _____

BRPM Representative: _____

MEDICAL RECORDS INFORMATION

Did you seek treatment immediately following or within 48hrs of the accident? ___Yes ___No

Where at: _____

Have you treated at any other therapy office for this accident? ___Yes ___No

Where at: _____

Have you had any testing (x-ray, CAT scan, MRI, ect...) done in relation to this accident? ___Yes ___No

Where at: _____

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We Care For You

ACCIDENT DETIALS

Name: _____ Date of Accident: _____

Type of accident: ___Auto ___Workers Comp. ___Slip & Fall ___Other

Location of accident: _____

In your own words please give a brief description of how the accident happened:

_____

_____

_____

_____

Auto related _____

I was a: ___Pedestrian ___Driver ___Front seat passenger ___Back seat passenger

In or on a: ___Car ___Truck ___SUV ___Bus ___Other_____

Were you wearing a seat belt? Yes | No Was a police report made?(we will need a copy) Yes | No

General _____

Following the accident were you: ___Conscious ___Semi-conscious ___Unconscious

Did you experience: ___Seeing Stars ___Blurry Vision ___feeling Faint ___Nausea

Did you experience immediate numbness? Yes | No If so where_____

Did you experience immediate pain? Yes | No If so where_____

Did you receive treatment from first responder at the scene? Yes | No

Were you taken to the hospital from the scene? Yes | No By whom?_____

Were you admitted? Yes | No how long was your stay? _____

Were you taken to the hospital or urgent care clinic but not from the scene? Yes | No when_____

Have you been prescribed any medication? Yes | No If so what type?_____

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JOB INFORMATION SHEET

(If you are not currently employed you may skip this page)
(If you have more than one job please ask for an additional paper)

Name: _____ Occupation: _____

Name of Employer: _____ Are they aware of the accident? Yes | No

Job Activities

If your job requires you to do any of the following please circle yes and indicate the time length for each activity.

Sitting:	Yes | No	Duration of time: _____	Times per day: _____
Walking:	Yes | No	Duration of time: _____	Times per day: _____
Standing:	Yes | No	Duration of time: _____	Times per day: _____
Squatting:	Yes | No	Duration of time: _____	Times per day: _____
Climbing:	Yes | No	Duration of time: _____	Times per day: _____
Kneeling:	Yes | No	Duration of time: _____	Times per day: _____
Twisting:	Yes | No	Duration of time: _____	Times per day: _____
Bending:	Yes | No	Duration of time: _____	Times per day: _____
Lifting:	Yes | No	Duration of time: _____	Times per day: _____

In relation to lifting please check all that apply:
One handed___ Both hands___ Floor to waist___ Waist to shoulder___ Above shoulder___

Do you:
push weight? Yes | No pull weight? Yes | No carry weight for long distances? Yes | No

What is the Maximum amount of weight you are required to push, pull or lift? _____lbs.

Does your job require you to drive? Yes | No If so how many hours per day? _____

Does your job require you to operate Machinery? Yes | No how many hours per day? _____

What types of machinery? _____

If you spend more than 5 hours a day sitting please check the activities that you do on a regular day:
Typing ___ Answering Phones ___ Filing Papers ___ Other _____

How long have you been at your current job? _____

WORKER'S COMPENSATION INFORMATION SHEET

(If this was a work related injury please complete all information below)

Name: _____ Employer: _____

Employer's Address: _____

City, State, & Zip: _____

Phone #: _____ Fax #: _____

Supervisor: _____ Is Employer Aware of the Accident: _____

Worker's Compensation Insurance: _____

Address: _____

City, State, & Zip: _____

Case Worker: _____ Claim #: _____

By signing this form I authorize B.R.P.M. to release any and all information necessary to process this claim and request that payment be made directly to B.R.P.M. for any services rendered on my behalf. I also understand that I am financially responsible for any charges not covered by my attorney or my workers compensation insurance company.

Patient's Signature: _____ Date: _____

We Care For You

AUTHORIZATIONS & CONSENTS

AUTHORIZATION TO RELEASE MEDICAL DOCUMENTS

I hereby authorize Baton Rouge Physical Medicine to release any and all protected health information pertaining to my condition to my guarantor of payment, medical offices needing it to continue my treatment or any other entity possessing an authorization signed by me. This includes but is not limited to chart notes, medical reports, billing and diagnostic testing.

_____ Initial

AUTHORIZATION TO RELEASE SETTLEMENT DOCUMENTS

I hereby authorize Baton Rouge Physical Medicine to receive upon verbal or written request any and all pertinent settlement documents pertaining to my case from the insurance company or my attorney. This includes a copy of the original settlement check and payment breakdown.

_____ Initial

CONSENT TO TREAT A MINOR

If this section does not pertain to you put NA in the initial box

I _____(parent/guardian name) hereby authorize Baton Rouge Physical Medicine to treat my minor child _____(patient's name). This also allows my child to be treated in or out of my presence.

_____ Initial

CONSENT TO CHIROPRACTIC CARE

I hereby consent to the performance of chiropractic adjustments performed by any licensed chiropractor employed by Baton Rouge Physical and other physiotherapy prescribed to myself or the patient I am legally responsible for. I understand that as with any medical procedure, there are some risks to chiropractic care including but not limited to fracture, dislocation, minor burns, disc injury and sprains. I do not expect the doctor to be able to anticipate all risks and complications and hereby release the doctor and Baton Rouge Physical Medicine from any and all liability for injury that may occur during or as a result of care rendered to me.

_____ Initial

I HAVE READ AND UNDERSTAND ALL THE ABOVE CONTENT

PATIENT SIGNATURE:_____ **DATE:** _____

We Care For You

HIPPA & BRPM PROTOCOLS AND EXPLANATIONS

Please read all sections of this document carefully

HIPPA COMPLIANCE EXPLANATION

I. I understand the all authorizations signed in this packet (with the exception of agreement to pay fees) will expire on _____ or six months after my date of discharge from BRPM.

II. I understand that I may revoke these authorizations at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

III. I understand that information used or disclosed pursuant to this authorization may be subjected to disclose by the recipient and no longer be protected by Federal privacy regulations.

IV. By authoring this release of information, my health care and payment for health care will not be affected if I do not sign this form.

V. I understand I may see and copy the information described on this form if I ask for it.

VI. I have been informed that BRPM may receive financial or in-kind compensation in exchange for using or disclosing the health information described above for cause relation to copying records.

VII. I understand that in compliance with Louisiana statute, I will pay a fee of $___. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

BATON ROUGE PHYSICAL MEDICINE PROTOCOLS

I. I understand than Baton Rouge Physical Medicine may discharge me at any time for failure to comply with the doctors prescribed therapy regimen.

II. I understand that if given a prescription by Baton Rouge Physical Medicine any attempt to sell, give away, attempt to obtain narcotic medication elsewhere or misuse that prescription in any way will result in my discharge from the doctor's care. Furthermore if I develop a rapid tolerance or loss of effect from prescribed medication, I will be referred to a pain management facility and will no longer be prescribed medication by Baton Rouge Physical Medicine.

III. I hereby declare that I am not aware of nor involved in any fraudulent activity in connection with this claim.

IV. I understand that Baton Rouge Physical Medicine after having pursued every possible course of action to obtain payment for services rendered to me, will ultimately hold me financially responsible for any remaining balance owed to them.

I HAVE READ AND UNDERSTAND ALL THE ABOVE CONTENT

PATIENT SIGNATURE:_____ **DATE:** _____

BATON ROUGE PHYSICAL MEDICINE
LETTER OF PROTECTION

I, _____ hereby authorize and direct my attorney, _____

Attorney Name:_____
Address:_____
City_____, state _____, Zip_____
Phone#: _____ Fax#: _____

to pay directly to Baton Rouge Physical Medicine sums owed on my behalf for bills incurred for medical services rendered in connection with my accident, which occurred on _____, these sums are to be withheld from any settlement, judgment or verdict rendered to in an amount that adequately protects Baton Rouge Physical Medicine's final bill amount. I acknowledge I am incurring a legal obligation to pay for these services and am personally responsible for any charges not paid on my behalf.

I agree to never withdraw this document and understand that an attempt to withdraw will not be honored by my attorney. I hereby instruct that in the event that another attorney is retained in this matter, he/she will honor this lien as a condition to the settlement, judgment or verdict rendered in connection with this accident. I authorize the release of any information necessary to process this claim to my attorney. A copy of this document shall be valid as the original.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

I the attorney of record for the above patient do hereby agree to observe all the terms of the above and agree to withhold from any settlement, judgment or verdict rendered to in an amount that adequately protects Baton Rouge Physical Medicine.

Attorney Signature: _____ Date: _____

Baton Rouge Physical Medicine

8149 Florida Blvd, STE 300
Baton Rouge, La 70806
Phone: (225)924-2555 Fax: (225)927-0404

ASSIGNMENT OF BENEFITS

I, _____ the undersigned do hereby assign, transfer and convey Baton Rouge Physical Medicine any and all causes of action I have or may have against the party responsible for payment of charges I have incurred while receiving care at Baton Rouge Physical Medicine for injuries that resulted from an accident that occurred on _____. I agree that at all times I will cooperate with Baton Rouge Physical Medicine to institute said proceedings as are necessary to collect any and all sums that are due and owing. I authorize Baton Rouge Physical Medicine to compromise, settle, or release all claims made by them on my behalf within its sole discretion.

NOTICE TO HEALTH CARE PROVIDER

To: _____ Fax#; _____

Claim#:_____ Adjuster: _____

Baton Rouge Physical Medicine a health care provider licensed to practice in Louisiana Tax ID#: 26-3139477, in regards to our patient _____. Who was injured on _____. The party alleged to be liable for health care expenses resulting from this injury is _____

This notice is provided in accordance with R.S. 9:4751 through R.S. 9:4755 to secure the health care provider privilege provided by law in favor of Baton Rouge Physical Medicine for charges and fees incurred by above patient to be paid directly to Baton Rouge Physical Medicine. Under those provisions if any entity who, having received this notice in accordance with above statutes, pays over any moneys subject to the privileges created herein, to the injured person, or the attorney, heirs, or legal representative of injured person, shall be liable to Baton Rouge Physical Medicine for the amount thereof.

Patient Signature:_____ Date: _____

BRPM Representative: _____ Date: _____

Assignment of Benefits for _____
Patient Name

I hereby authorize payment of my insurance benefits otherwise payable, to me be paid directly to Baton Rouge Physical Medicine in the amount of the final bill.

Patient Signature: _____ Date: _____