Capitol Spine and Rehabilitation Intake Form

Appointment Time/Date_____ Patient DOB _____/_____/_____

Patient's Name _____ SS#_____-_____-_____

Address_____ City _____ State _____ Zip_____

Home Phone_____ _____-_____ Work # ____ _____-_____ Cell # ____ _____-_____

Cell Phone Carrier_____E-Mail _____ Facebook User Y N

Emergency Contact _____ Ph ____-____-_____Marital Status M S D W

Employer _____Employer Phone _____-_____-_____

Chief Complaint _____ Referred By _____

Primary Care Physician_____ PCP Ph_____-_____-_____

Case Type: __Personal Injury __Medicare/Medicaid __Workers Comp __Insurance __Massage Only

(Ins. Pt(s) only) Is Massage therapy covered? _____

Attorney/Adjustor Name and Number _____

Date of Accident _____/_____/_____ Claim # _____

Insurance Company_____Insurance Ph _____-_____-_____

Policy Holder_____ DOB _____

Policy/Member # _____Group # _____

Contact Person_____ Effective Date_____/_____/_____

Co-Pay Amt $_____ Deduct Amt $_____ X-Ray Included? Yes / No Deduct Met? Yes / No

Max visits per year_____ Visits used _____ Dollar max/year _____

Authorization for Chiro? Yes / No LO631? Yes / No E0730? Yes / No L3030? Yes/ No MRI? Yes / No

Authorization #_____

Spoke to _____ Ref #_____ Initials_____

Notes: _____

_____

_____

Capitol Spine and Rehabilitation Medical History Form

Name			Age:
Address			Height:
City	State	Zip Code	Weight:

Please select any of the following conditions that may apply to your medical history:		Please select any of the following conditions that may apply to you medical history:	
☐ Frequent Colds	☐ Kidney Condition	☐ Chickenpox	☐ Whooping Cough
☐ Frequent Sore Throat	☐ High Blood Pressure	☐ Measles	☐ Tuberculosis
☐ Frequent Headaches	☐ Anemia	☐ Rubella	☐ Diabetes
☐ Allergies	☐ Mental Depression Depression	☐ Mumps	☐ Hepatitis
☐ Gastrointestinal Condition	☐ Serious Injury	☐ Scarlet Fever	☐ Ulcers
☐ Heart Condition	☐ Arthritis	☐ Asthma	☐ Epilepsy
☐ Chest Pain	☐ Hearing Condition	☐ Lung Disorder	☐ HIV/AIDS
☐ Dizziness	☐ Swelling	☐ Cancer	
☐ Neck and Back Pain	☐ Difficulty Breathing		

- Please give details/explain any of the conditions checked above:_____
  _____
- Have you been involved in an automobile accident within the last 5 years prior to your recent accident? Yes or No
  Explain _____
- Are you currently taking any medications? If yes, please list _____
- Are you allergic to any medications? If yes, please list _____
- Have you had any inpatient/outpatient surgeries? If yes, please describe _____
  _____
- Have you recently been tested for HIV/AIDS? Yes or No If so, date _____/_____/_____
- Are you currently pregnant? Yes or No
- Do you smoke? If yes. How often? __ Daily __ Occasionally __ Never __ Formerly
- Do you drink alcohol and/or wine? __ Daily __ Occasionally __ Socially __ Rarely __Never __Formerly
- Have you ever abused prescription/ illegal drugs? __Daily __Occasionally __Socially __ Rarely __ Never __Formerly
- Are you ____Single ___Married Do you have any children? ___ Yes ___ No How many? _____
- Do you work or go to school and/or both: full-time or part-time. What is your occupation? _____

Patient Basic Information

Personal Information: SS# _____-_____-_____

Last Name:	First Name:	Initial
Address:	City, State	Zip Code
Home Phone: ( )	Work Phone ( )	DOB: / /
Date of Injury/Onset: / /	Dominant Hand: ❑ Right ❑ Left ❑Both	
Insurance information: Policy Holder (if different than patient):		Policy No.

Special Note: If your injury involved a motor vehicle skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/injury/Onset

Enter a full description of the accident injury or onset in the space below:

2. Your condition during and immediately after injury/onset:

Enter the details of your condition during and immediately after your injury/onset.

AUTOMOBILE ACCIDENT DESCRIPTION

Please answer the questions below. If you do not know the answer to any questions, do not answer that question.

1. Vehicle Type

❑Car ❑Station Wagon
❑Van ❑Pickup Truck
❑Large Truck ❑Bus
Other_____

2. Your position in vehicle

❑Driver ❑Front Passenger
❑Left Rear Passenger
❑Right Rear Passenger
Other_____

3.What was your vehicle doing at the time of accident?

❑Stopped at intersection ❑Stopped in traffic ❑Stopped at light
❑Making a right turn ❑Making a left turn ❑Parking
❑Proceeding along ❑Slowing down ❑Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's
Speed: _____mph
Their vehicle's
Speed: _____mph
Damage to your vehicle
❑Mild ❑Moderate
❑Totaled

5. Details of Accident

Visibility at time of accident
❑Poor ❑Fair ❑Good

Who hit who or what?
❑You hit other vehicle
❑Other vehicle hit you
You hit....(object)
_____

6. Road Conditions

Road conditions at time of accident
❑Icy ❑Wet ❑Sandy ❑Dark ❑Clean and Dry

Point of Impact
❑Head-On ❑Left Front ❑Right Front
❑Rear-End ❑Left Rear ❑Right Rear

7. Body Position, etc.

Did you see the accident coming: ❑Yes No ❑
Were you braced for the impact? ❑Yes No ❑
Did you have a seat belt on? ❑Yes No ❑
Did you have a shoulder harness on? ❑Yes No ❑

Does your vehicle have a headrest? ❑Yes ❑ No
What was the position of your headrest at the time of the impact?
❑Even with top of head ❑Even with bottom of head ❑Middle of neck
What was the direction of your head at the time of impact?
❑Facing straight foward ❑Turned to the right ❑Turned to the left

Did driver side air bags deploy? ❑Yes ❑No Did passenger side airbags deploy? ❑Yes ❑No Did side air bags deploy? ❑Yes ❑No

8. Additional Information

In the case of a motor vehicle accident, enter additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? ❑Yes ❑No
If yes, describe: _____
_____
Did you lose consciousness during the injury? ❑Yes ❑No
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle:
Did police show up at the scene? ❑Yes ❑No
Was an accident report fill out? ❑Yes ❑No

10. After the accident

Check off your symptoms right after and a few days following:

❑Headache	❑Dizziness	❑Mid back pain	❑Cold hands
❑Neck pain	❑Nausea	❑Low back pain	❑Cold feet
❑Neck stiffness	❑Confusion	❑Nervousness	❑Diarrhea
❑Fainting	❑ Fatigue	❑Loss of taste	❑Depression
❑Ringing in ear	❑Tension	❑Toe numbness	❑Anxious
❑Loss of smell	❑Irritability	❑Constipation	❑Chest pain
❑Pain behind eyes	❑Shortness of breath	❑Sleeping problems	

Others: _____

11. Emergency Room:

Where did you go after the accident?
❑Home ❑Work ❑Hospital ❑ER ❑Private Doctor
How did you get there?
❑Drove Self ❑Somebody else ❑Ambulance ❑Police
Were X-rays done? ❑Yes ❑No Was lab work done? ❑Yes ❑No
Body parts X-rayed? _____
The X-rays revealed: _____
Treatment: ❑Cervical Collar ❑Ice ❑Other
Medications:_____
Follow-up Instructions:_____
_____

12. Treatment History:

Fill in any other doctor(s) prior to your first visit to this office.
1. Dr._____First visit date: ___/___/___
Specialty: _____X-rays done? ❑Yes ❑No
Types of treatments received?_____
How many treatments received? ___Currently treating? ❑Yes ❑No
Did treatments benefit you? ❑Yes ❑No
Last visit date: ____/____/___
2. Dr._____First visit date: ___/___/___
Types of treatments received? _____
How many treatments received?___Currently treating? ❑Yes ❑No
Did treatments benefit you? ❑Yes ❑No
Last visit date: ____/____/____

Risk Factor Accidental Questionnaire

Patient's Name _____

1. Are you a female with a small build frame?	__ Yes	__ No
2. Did your pain start immediately after the accident occurred?	__ Yes	__ No
3. Is this your first time ever experiencing neck and/or back pain?	__ Yes	__ No
4. Are you having any difficulty with making decisions since the accident?	__ Yes	__ No
5. Did you suffer with more than one injured areas as a result of the accident?	__ Yes	__ No
6. Were you wearing a seat belt and/or shoulder harness during the accident?	__ Yes	__ No
7. Do you have a history of neck pain and/or headaches?	__ Yes	__ No
8. Do you have osteoarthritis of your neck and/or back?	__ Yes	__ No
9. Have you been told that you have loss of any curvature in your neck?	__ Yes	__ No
10. Are you considered a middle age or older person in age?	__ Yes	__ No
11. Were you a front seat passenger or driver in the vehicle in the accident?	__ Yes	__ No
12. Do you have a metabolic disorder like diabetes?	__ Yes	__ No
13. Do you have congenital anomalies of your spine?	__ Yes	__ No
14. Do you have a history of herniated disc of your spine?	__ Yes	__ No
15. Do you have rheumatoid arthritis, or other arthritides affecting your spine?	__ Yes	__ No
16. Do you have ankylosing spondylitis of your spine?	__ Yes	__ No
17. Do you have scoliosis or curvature of the spine?	__ Yes	__ No
18. Do you have a medical history of spinal surgery?	__ Yes	__ No
19. Do you have a medical history of prior vertebral (spinal) fracture?	__ Yes	__ No
20. Do you suffer osteoporosis?	__ Yes	__ No
21. Do you suffer with Paget's disease, or other disease of the bone?	__ Yes	__ No
22. Are you a paraplegic or quadriplegic?	__ Yes	__ No
23. Do you have a medical history of prior spinal injury?	__ Yes	__ No

NOTIFICATION OF HEALTH CARE PROVIDER LIEN UNDER

LSA – R.S. 9:4751 ET SEQ.

Certified Mail/Return Receipt # _____

TO:

_____

_____

Pursuant to the provisions of LSA – R.S. 9:4751 et seq. you are hereby given notice of the undersigned's health care privilege arising from services provided to the following named person(s):

Name: _____

Address:_____

For injuries received on or about _____. Based on information provided by my patient(s) your client(s) it is our understanding that the liable party or parties for the injuries are:

Third party: _____

HEALTH CARE PROVIDER: **___CAPITOL SPINE AND REHABILITATION_____**

ADDRESS:_____5333 FLORIDA BLVD. BATON ROUGE, LA 70806_____

PHONE: (225) 926-1900 **FAX: (225) 926-1901**

A statement of my charge through _____is attached. Please consult with this office for total amount of charges prior to the release or disbursement of funds.

Signature_____

LSA – R.S. 9:4754 provides:

Any person who, having received notice in accordance with the provisions hereof, pays over any monies subject to the privilege created herein, to any injured person, or to the attorney, heirs, or legal representatives of any injured person, shall be liable to the licensed health care provider, hospital, or ambulance service having such privilege for the amount thereof, not to exceed the net amount paid. See: In re: Charles W. Dittmer,Jr., 743 So.2d.195 (La,1999); Charity Hospital of La. V Band, 593 So.2d 1392 (La.4cir.1992)

CAPITOL SPINE & REHABILITATION
5333 Florida Blvd
Baton Rouge LA **70806**
225.926.1900 225.926.1901 (Fax)
www.capitolspine.com

Informed Consent for Chiropractic, Dry Needling, Physiotherapy, Massage Therapy and Rehabilitation Treatments (including Telemedicine)

I hereby request and consent to the performance of Chiropractic, Dry Needling, Physiotherapy, Message Therapy, Rehabilitation and other chiropractic procedures, including various modes of physical therapy on myself (or the person named below, for whom I am legally responsible), by the Doctor name below and/or other licensed doctors and/or therapist who now or in the future treat me while employed by working or associated with or serving as back-up for the doctor named below. I have had the opportunity to discuss with the doctor named below and/or with the other office personnel the nature and purpose of dry needling and other procedures.

I understand and am informed that as in the practice of medicine, in the practice of dry needling, chiropractic and physical therapy there are some risks to treatment including, but not limited to soft tissue sprains/strains and muscle soreness. I do not expect the doctor to be able to anticipate and explain all the risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at that time, based upon the facts then known is in my best interest.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and of any future conditions for which I seek treatment.

Completed By Patient

Patient's Name_____ Signature _____

Date Signed _____ Witness _____

Completed By Parent

Parent's Name_____ Signature_____

HIPPA ACT DISCLOSURE

Chiropractic Association of LA Authorization

We at Capitol Spine & Rehabilitation may need to disclose your name, address, phone number, billing information and your official records to the Chiropractic Association of Louisiana (CAL). We may also need to send you information in the mail, e.g. birthday card, reminder card, etc. This disclosure will be made if we need the CAL's assistance to receive reimbursement for services rendered, or, we need the CAL's assistance because the party responsible for reimbursing the services rendered has improperly processed your claim.

By signing this form you are giving us authorization to send the CAL or participating parties this information. You are also giving authorization to re-disclose your information to the party agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to whom your health care information is released or revoked your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment here at any time. (164.524), "This notice is effective as of _____." This authorization will expire six years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Your right to complain

You may complain to us or the Secretary of Health and Human Services if you feel that we have violated your privacy right. We respect your rights to file a complaint and will not take any action against for filing. While you may make an oral complaint at any time, written comments should be addressed to the Secretary of Health and Human Services. If you need any further information about our privacy practices, please contact us. This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created.

_____ _____

Patient Name Printed **Date**

_____ _____

Patient Signature **Parent or Guardian/Relationship to patient**

www.capitolspine.com

CAPITOL SPINE & REHABILITATION

5333 Florida Blvd.
Baton Rouge LA 70806
225.926.1900 225.926.1901 (Fax)

AUTHORIZATION TO DISCLOSE, RELEASE or REQUEST HEALTH INFORMATION

Patient Name _____

Address _____

Medical Record #_____ DOB _____/_____/_____

1. I authorize the use/disclosure/request of the above name individual's health information, as described below.
2. The following individuals or organization are authorized to disclose or request Health Information(from/to): _____
3. That the type and amount of information requested or disclosed is as follows (fill in the appropriate item(s), and include other information where indicated:
   _____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquire immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for drug and alcohol abuse.
5. This information may be disclosed to or requested by the following individuals or organizations:
   Name _____
   Address _____
6. This information may be disclosed to or requested for the following purpose(s):
   _____
7. I understand that I have the right to revoke the authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written vocation to the Office Manager or designee in the health information department at Capitol Spine and Rehabilitation. I understand that the revocation will not apply to the information that has been released in response to this authorization. I understand that the revocation will not apply to my Insurance company when the law provides my insurer with the right to consent a claim under my policy.
8. Unless otherwise revoked, this authorization will expire on the following date, even, or condition (within one year of my agreement) _____
9. I understand that once the information is disclosed/obtained pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by Federal Privacy Regulations.
10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits.
11. If you have questions about disclosures or requests regarding my health information, I can contact the Health information department of Capitol Spine and Rehabilitation.
12. I understand that after signing, I may have a copy of this form.

Signature of Patient or Legal Representative _____

If Legal Representative, Relationship to Patient _____
Signature of Witness _____ DOB ___/_____/_____

Capitol Spine & Rehabilitation
5333 Florida Blvd.
Baton Rouge, LA 70806
Ph: (225) 926-1900
Fax: (225) 926-1901

I, _____, do actively receive medically necessary treatment which includes, but is not limited to chiropractic and physical rehabilitation services at Capitol Spine & Rehabilitation. In having no other method of transportation, I am requesting to utilize transportations services via Capitol Spine and Rehabilitation. I do understand that transportation not for personal use. It is also with the understanding that after two no show pick-ups, all transportation expenses will be billed to my case for payment at time of settlement.

PLEASE REVIEW THE FOLLOWING. INITIAL, SIGN AND DATE YOUR SELECTION.

_____ I fully understand that while utilizing transportation services I am at risk. I do not wish to hold Capitol Spine and Rehabilitation or any of its agents liable for any injuries to self or damage to personal property.

_____ I do not wish to comply with this release of liability waiver.

PATIENTS NAME: _____

SIGNATURE: _____

WITNESS: _____

DATE: _____