LOUISIANA MEDICAL CLINIC
CONFIDENTIAL PATIENT INFORMATION

FOR CLINIC USE ONLY:
CHART # _____ DATE OF INFORMATION _____

PATIENT DATA

NAME _____ S.S.# _____
FIRST M. INTIAL LAST
ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ D.O.B. _____ GENDER _____ MARITAL STATUS _____

HM. PHONE # _____ CELL# _____, EMAIL ADDRESS _____

OCCUPATION _____ EMPLOYER _____ WORK # _____

SPOUSE'S NAME _____ D.O.B. _____

ADDRESS _____ HM. PHONE # _____

OCCUPATION _____ EMPLOYER _____ WORK # _____

NAME OF NEAREST RELATIVE _____ PHONE # _____
(NOT LIVING WITH YOU)

LIST ANY SURGERIES YOU HAVE HAD: _____

LIST ANY MEDICAL PROBLEMS YOU ARE CURRENTLY BEING TREATED FOR: _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? _____

WHAT MEDICATIONS ARE YOU ALLERGIC TO? _____

DO YOU HAVE A HISTORY OF SUBSTANCE/DRUG ABUSE? _____

DO YOU HAVE A HISTORY OF MENTAL ILLNESS OR DEPRESSION? _____

EMERGENCY CONTACT _____ PHONE#: _____

INSURANCE INFORMATION:
Clinic policy requires payment arrangements to be made on the first visit.
NAME OF PERSON RESPONSIBLE FOR PAYMENT _____ PHONE # _____
DO YOU HAVE INSURANCE? _____ NO ____ YES COMPANY _____
GROUP NO. _____ POLICY NO. _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I permit this office to endorse co-insurance remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

PATIENTS SIGNATURE _____ DATE _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physiotherapy and diagnostic testing to include x-rays, digital ROM on me (or on the patient named below for whom I am legally responsible) by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now or in the future treat me while employed by, working, associated with, or serving as a back-up for the doctor of Chiropractic named below or any other office or clinic.

I understand and am informed that as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment, including but not limited to fracture, disc injuries, strokes, dislocations, and sprains. I do not except the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known is my best interests.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent 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(s) and for any future condition(s) for which I see treatment.

PATIENT'S NAME (PRINT)

SIGNATURE OF PATIENT

DATE SIGNED

TO BE COMPLETED BY REPRESENTATIVE OF PATIENT (MINOR, PHYSICALLY OR MENTALLY INCAPACITATED)

PATIENT'S NAME (PRINT)

REPRESENTATIVE OF PATIENT (PRINT)

SIGNATURE OF REPRENTATIVE OF PATIENT

RELATIONSHIP OF REPRESENTATIVE OF PATIENT

DATE SIGNED

INFORMED CONSENT CONTRACT FOR TREATMENT
Controlled Substance Therapy for Pain Management
@ Louisiana Medical Clinic

AGREEMENT CONTRACT

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship, and that the doctors undertake to treat me based on this Agreement.

I understand that this mode of treatment will be stopped, and that I may be discharged from the doctors care if any of the following occur:

a. I give away, divert, sell, or misuse the prescribed medication.

b. Any of the doctors find me non-compliant with his recommendations or with any of the terms of this agreement.

c. I develop rapid tolerance or loss of effect from the prescribed medications.

d. I develop side effects that are significant in view of the doctors.

e. My functional activities decrease.

f. I attempt to obtain narcotic analgesics or any other controlled substances from sources other than the doctors.

g. I fail to keep scheduled office visits with the doctors.

h. I agree to use _____ Pharmacy to fill all prescriptions given to me from the doctors.

I have read this agreement, and have had an opportunity to ask questions and have had all my questions answered satisfactorily.
I consent to the use of narcotics and other controlled substances under the terms outlined in this agreement.

Patient Signature: _____

Physician Signature: _____

Witnessed by: _____

Date: _____

LOUISIANA MEDICAL CLINIC

LETTER OF PROTECTION

I hereby authorize my attorney, _____, to pay directly to Louisiana Medical Clinic sums as owed for bills incurred for medical services rendered to me in connection with my accident, which occurred on _____, and to withhold sums from any settlement, judgment or verdict as maybe necessary to adequately protect Louisiana Medical Clinic. I hereby further lien my case to Louisiana Medical Clinic against any and all proceeds of my settlement, judgment or verdict which maybe paid to Louisiana Medical Clinic or said attorney as a result of the injuries which have been treated at Louisiana Medical Clinic in connection with said accident.

I agree never to withdraw this document. I understand that a withdrawal 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 by which I may eventually recover funds.

I have been advised that if my attorney does not wish to cooperate in protecting the medical clinic's interest, Louisiana Medical Clinic will not await payment but will require me to make payments on a current basis.

Patient: _____

Signature: _____

The attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as necessary to adequately protect Louisiana Medical Clinic.

URG-HAB

LETTER OF PROTECTION

I hereby authorize my attorney, _____, to pay directly to URG-HAB sums as owed for bills incurred for medical services rendered to me in connection with my accident, which occurred on _____, and to withhold sums from any settlement, judgment or verdict as maybe necessary to adequately protect URG-HAB. I hereby further lien my case to URG-HAB against any and all proceeds of my settlement, judgment or verdict which maybe paid to URG-HAB or said attorney as a result of the injuries which have been treated at URG-HAB in connection with said accident.

I agree never to withdraw this document. I understand that a withdrawal 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 by which I may eventually recover funds.

I have been advised that if my attorney does not wish to cooperate in protecting the medical clinic's interest, URG-HAB will not await payment but will require me to make payments on a current basis.

Patient: _____

Signature: _____

The attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as necessary to adequately protect URG-HAB.

Louisiana Medical Clinic
8558 Jefferson Hwy.
Baton Rouge, La. 70809
Phone: (225) 292-1969
Fax: (225) 292-1960

REQUEST FOR MEDICAL RECORDS

Patient's Name:_____ **Date:**_____

Date of Birth:_____ **Social Security #:**_____

Request records from _____
Address: _____
_____

Phone#: _____ Fax#: _____

Records to be sent to: _____
Address: _____
_____

Medical Records Requested:

____ All Records ___ Immunizations ___ EKG's
____ Consultation Report(s) ___ Lab Results ___ X-ray, CT, MRI Reports
____ Procedure Reports ___ ER Visit(s) Dates
____ Hospital H & P's, D/C Summary
____ Other _____

Date of records requested: _____ All Dates

____ Dates: From: _____ To: _____

_____ _____
Signature of Patient or Authorized Representative Date

*This authorization shall be valid and effective unless and until revoked by authorized representative or patient in writing. A photocopy or faxed copy may serve as an original.

8558 Jefferson Hwy
10466 Airline Hwy Suite C
1107 Government St

LOUISIANA MEDICAL CLINC

225.292.1969 (Ph
225.292.1960 (Fa

HIPAA/AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Print Name of Individual	Date of Birth	Date

I hereby authorize _____ to use and/or disclose the information checked and/or listed below for the time period beginning on ____/____/____ and ending on ____/____/____.

___Billing Statements ___Care Plans ___Complete Healthcare Records ___Consultant Reports ___Dental Records ___Diagnosis (including those relating to alcohol, drug abuse, mental health, AIDS or HIV status, if any) ___Discharge Status ___ER Department Record ___History and Physical Examination ___Lab Reports (including alcohol or drug screening, if any)	___Marketing, explain: _____ _____ ___Nurse's Notes ___Operative Report ___Pathology Report ___Photographs, Videos Tapes, Digital, or Other Images ___Physician's Orders ___Physician's Progress ___Notes/Integrated Progress Notes ___Psycho Social Assessment ___Psych Evaluation Based On Testing	___Verbal Reports ___X-Ray Reports ___MRI Reports ___ALL Records

The information checked and/or listed above is to be released to: _____

___Continuation of Treatment
___Application of Insurance
___At the Individual's Request
___Other (Specify) _____

___Processing of Insurance Claim
___Attorney (Name) _____

I **AUTHORIZE** you to disclose any information and records regarding the above named individual in your progression. This includes but is not limited to, your medical findings, diagnosis, treatment, treatment summaries, prognosis, clinic notes, diagnostic reports or radiology films, physical therapy records, pharmacy records, or any other health information in your records. I understand that based on the information released it may include information related to any substance abuse.

I **UNDERSTAND** that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I **UNDERSTAND** that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I **UNDERSTAND** that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Individual	Printed Name of Individual	Date

Signature of Witness	Printed Name of Witness	Date

8558 Jefferson Hwy
Baton Rouge, LA 70809

URGHAB

225.292.1969 (Ph)
225.292.1960 (Fax)

HIPAA/AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Print Name of Individual	Date of Birth	Date

I hereby authorize _____ to use and/or disclose the information checked and/or listed below for the time period beginning on ____/____/____ and ending on ____/____/____.

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___Other (Specify) _____

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Signature of Individual	Printed Name of Individual	Date

Signature of Witness	Printed Name of Witness	Date