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 **DATE**
Or Personal Representative

AMBULATORY SURGERY CENTER
PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

Patient's have:

1. The right to quality care and treatment given with respect, consideration and dignity.
2. The right to appropriate privacy.
3. The right to the privacy of information regarding patient's diagnosis, treatment options, communication, and the potential outcomes of the treatment as well as access to information contained in his/her medical record.
4. The right to participate in decisions concerning care and treatment.
5. The right to know if the physician performing his/her procedure may have financial interest or ownership in this ASC.
6. The right to be informed of patient responsibilities, conduct, and ASC rules affecting the patient's treatment.
7. The right to knowledge of services provided at this facility.
8. The right to discharge instructions, including information about after hours' care.
9. The right to detailed information regarding service fees and all charges.
10. The right to refuse participation in experimental research.
11. The right to receive the policy on advance directives, and living wills in the facility and to be given information upon request.
12. The right to receive information on this ASC's non participation in advanced directives.
13. The right to knowledge of the medical staff credentialing process, upon request.
14. The right to know the names of those treating the patient.
15. The right to truthful marketing or advertising utilized by the facility.
16. The right to be informed if the physician does not carry malpractice insurance.
17. The right to address a grievance.
18. The right to refuse a treatment, as permitted by law. One can refuse treatment and still receive alternate care.
19. The right to be fully informed regarding one's condition.
20. The right to understand and sign an Informed Consent form before receiving care.
21. The right to appropriate assessment and management of pain.
22. The right to continuity of care. If overnight care is required, staff will arrange for transportation of a patient to the transfer hospital.
23. The right to respectful, safe care and treatment free from seclusion, restraints, abuse and harassment.
24. The right to have a family member notified of his/her admission as well as notification of his/her personal physician, if requested by the patient.
25. The right to leave the facility against the advice of his/her physician.
26. The right to express spiritual and cultural beliefs.
27. You have the right to exercise the above without being subjected to discrimination or reprisal.

Patient Responsibilities

1. The patient is responsible for providing accurate/complete information related to his/her health; reporting perceived risks in his/her care, and for reporting unexpected changes in his/her health.
2. The patient and family are responsible for asking questions when they do not understand, what a staff member has told them about the patient's care or expectations of what they are to do.
3. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
4. The patient is responsible for notifying the ASC office when unable to keep a scheduled appointment.
5. The patient is responsible for providing his/her healthcare insurance information, and assuring the financial obligations of his/her care are fulfilled as promptly as possible.
6. The patient is responsible for the consequences if he/she refuses treatment or fails to follow the practitioner's instructions.
7. The patient is responsible for being respectful and considerate of other patients and organizational personnel.

These rights and responsibilities outline the basic concepts of service here at the Ambulatory Surgery Center. If you believe, at any time, our staff has not met one or more of the statements during your care here, please ask to speak to the Medical Director or Nurse Manager. We will make every attempt to understand your complaint/concern. We will correct the issue you have if it is within our control, and you will receive a written response.

Kristen Cole, RN, DON One Day Surgery, LLC 531-B Jefferson Terrace Blvd. New Iberia, LA 70560-4949 337.560.0880	Jenny Haines, Certified Program Manager (DHH) P.O. Box 3767 Baton Rouge, LA 70821-0629 Phone: 225.342.9348 Fax: 225.342.0157 Complaints can also be filed online through the LA Department of Health and Hospitals website: http://www.dhh.louisiana.gov	Karen Price, Medicare Beneficiary Ombudsman for Louisiana Phone: 225.342.7100 Web site for the Office of the Medicare Beneficiary Ombudsman: visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) or use www.cms.hhs.gov/center/ombudsman

ASSIGNMENT OF BENEFITS

Patient:_____
Primary Insurance_____ Policy Number_____
Secondary Insurance_____ Policy Number_____
Patient/Policyholder SS#/ID_____

I hereby assign and authorize payment made directly to the above health provider for covered insurance benefits. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. **Any payment made directly to me by my insurance company for services, will be endorsed by me and forwarded to the billing office above.** I fully understand that I am financially responsible for and agree to pay all charges not paid by my health coverage, including deductibles, co-insurance and payments from insurance companies sent directly to me. I hereby agree to pay the provider any balance due within 30 days from presentation of my bill. Should my account become delinquent and collection efforts become necessary, I agree to pay all collection or attorney's fees incurred.

I have disclosed the names of all my health insurance providers including secondary and any liability coverage and I represent that such health care coverage is in full force and effect at this time. I have indicated in the record if my pain is the result of an injury or motor vehicle accident. I agree to promptly notify your office of any change of address or changes of insurance coverage. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

This Assignment shall apply to all services now rendered and to be rendered in the future until it is revoked by myself in writing. A photocopy of this Assignment shall be considered as effective and valid as the original.

I have had an opportunity to discuss with the physician or his staff to my satisfaction the nature of the services provided. I acknowledge that no guarantees have been made to me as to the results. I am satisfied that I fully understand this assignment and its significance.

I hereby authorize on my behalf, the provider to appeal any disputed unpaid health claims with the party responsible for payment. I authorize my provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____
Signature of Policyholder/Patient Date

ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE

I hereby assign and authorize payment made directly to **Radiology Associates of Iberia** of the covered insurance benefits, including major medical benefits, whether payable to me by Medicare, Medicaid, or Medigap. **I fully understand that I am financially responsible for and agree to pay all charges not paid by my health coverage, including deductibles, co-insurance, and payments from insurance companies sent directly to me. In consideration of the medical services furnished to me, I hereby agree to pay Radiology Associates of Iberia any balance due within sixty days from presentation of my bill. If my account should become delinquent and collection efforts become necessary, I agree to pay any reasonable collection or attorney's fees incurred.**

This assignment shall apply to all services now rendered and to be rendered in the future until it is revoked.

I have disclosed the names of all my health insurance providers including secondary and tie-in coverage and I represent that such heath care coverage is in full force and effect at this time.

I authorize the release of medical information as may be required to process the claims for payment of the medical services rendered and it is expressly understood that the right of such information to be privileged is hereby waived.

If prior authorization or certification for medical services is required under my health care coverage, I agree to obtain and furnish such authorization or certification.

I have had an opportunity to discuss with the physician or his staff to my satisfaction the nature of the services provided. **I acknowledge that no guarantees have been made to me as to the results.** I am satisfied that I fully understand this assignment and significance.

I agree to promptly notify your office of any change of address or changes in insurance coverage.

A copy of this assignment shall be considered as valid as the original.

X_____ **X**_____

Signature of Patient **Signature of Guarantor (if applicable)**

Date _____ Date _____

Social Security # _____ Social Security # _____

Employer-Firm _____ Employer-Firm _____

Insurance Company _____ Insurance Company _____

(Primary) (Secondary)

SIGN BELOW IF YOU HAVE A MEDIGAP INSURANCE POLICY (A secondary policy to Medicare)

MEDICARE LIFETIME MEDIGAP ASSIGNMENT

I assign and authorize payment of Medigap benefits to Houma Radiology for any services furnished to me by them. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

X_____ Date _____

Signature of Patient

Medigap No. _____ Medigap Insurer _____

(This assignment covers the physician's charges for their services.
Surgicenter or Hospital charges are billed separately.)

Headache & Pain Center, AMC
Day Surgery, Inc. / One Day Surgery, LLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

The following questions allow us to communicate with you regarding your personal health for treatment, payment of treatment, and healthcare operations.

Home Phone #: _____

☐ DO / ☐ DO NOT Leave messages on my home answering machine or cell phone
☐ DO / ☐ DO NOT Leave messages with family members

Whom may we speak with _____

Cell Phone #: _____

☐ DO / ☐ DO NOT Contact me by cellular phone
☐ DO / ☐ DO NOT Text me with appointment confirmation

Work Phone #: _____

☐ DO / ☐ DO NOT Contact me at work

PRIMARY PHONE NUMBER TO CONTACT PATIENT: _____

MAIL:

Contact me at the following address: ☐ Same as mail address
☐ Other _____

Headache & Pain Center, AMC / Day Surgery, Inc. / One Day Surgery, LLC considers patient privacy extremely important. There are times that we need to speak with family members or significant others about your care. Your PHI can be redisclosed by these individuals without providers consent. We ask that you list those persons that take an active part in your healthcare. This list can be changed, altered, or revoked at any time by providing a written request of a change of authorization. I have read and understand this authorization.

NAME:	RELATION:	PHONE:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature of Patient _____ **Date** _____

If not signed by the patient, please indicate Relationship: ☐ Parent or Guardian of Minor patient
☐Guardian or conservator of an incompetent patient ☐ Other _____

FOR OFFICE USE ONLY:

Signed Form received by: _____

Acknowledgment refused:
Efforts to obtain: _____
Reasons for refusal: _____

DISCLOSURE OF OWNERSHIP

The information provided is designed to disclose ownership and to answer any questions you may have regarding your medical care while you are a patient at Headache and Pain Center, AMC, Day Surgery, Inc. or One Day Surgery, LLC. Headache and Pain Center, AMC and all equipment therein is owned and operated by Jimmy N. Ponder, Jr., M.D. This includes open MRI, X-ray, and Bone Density testing. Your provider may order diagnostic tests during your treatment at Headache and Pain Center, AMC. Advanced Imaging will be performed at Headache and Pain Center, AMC unless you notify us on your first visit.

HOURS OF OPERATION

Headache and Pain Center, AMC operational hours are 7:00 a.m. to 5:00 p.m. Monday and Thursday, 8:00 a.m. to 5:00 p.m. Tuesday and Wednesday and 8:00 a.m. to 12:00 p.m. Friday. Except on occasion, Day Surgery, Inc. is closed Tuesday and Wednesday and open 8:00 a.m. to 4:00 p.m. Monday, Thursday, and Friday. Except on occasion, One Day Surgery, LLC is closed Monday, Thursday, and Friday and open Tuesday and Wednesday 8:00 a.m. to 4:00 p.m. We will make every effort to perform scheduled procedures on time.

FEES AND PAYMENT

You will receive separate statements which require separate payment to each company listed below if you are sedated for procedures performed at Day surgery, Inc. or One Day Surgery, LLC.

(1) Headache and Pain Center, AMC (physician's surgical/professional services).
(2) Day Surgery, Inc. (for use of the surgical facility in Gray, LA.).
(3) One Day Surgery, LLC (for use of the surgical facility in New Iberia, LA.).
(4) Advanced Anesthesia Services, LLC (if intravenous anesthesia is used for your procedure).

If you have insurance, including Medicare, we will help you receive maximum benefits by filing for you; however, we will expect payment of co-pays, co-insurance, and deductibles at the time of service. The undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim of any charges related to this account whether the above entity is in network or out of network. If charges remain unpaid, it may become necessary to turn the account over to a collection agency or attorney, these fees will be your responsibility.

PERSONAL VALUABLES AND MEDICATIONS

It is understood and agreed that Headache and Pain Center, AMC, Advanced Anesthesia Services, LLC, Day Surgery, Inc., or One Day Surgery, LLC will not be liable for any loss or damage to valuables, including but not limited to money, jewelry, glasses, dentures, fur items, documents, canes, or personal medical equipment or supplies, clothing, shoes or other apparel.

LIVING WILL/ADVANCED DIRECTIVES

Do you have a living will/advanced directives? __Yes__No. If yes, please provide a copy in the event you are transferred from our facility to another facility. If no, you may request information or forms regarding living will/advanced directives, alternative facilities, as well as Louisiana law and documents. I understand that the providers have not consented to honor a living will/advance directive and will not be liable for its terms.

I have read, or have had read to me, the above information and have received a copy of the Patient Rights and Responsibilities.

_____ _____

Patient Signature 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.

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 health care provider, a health plan, your employer, or a health care clearinghouse, and that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care 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, and 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) health care operations. Here are some examples of how we intend to use of your PHI in regard to your treatment, payment, and health care operations.

Treatment. In connection with treatment, we will, for example, use and disclose your PHI to provide, coordinate, or manage your health care 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 description of your condition(s), our treatment, your diagnosis, supplies and drugs we used, etc.

Health Care 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 health care; 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 health care 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 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 health care 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 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 health care 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: _____

Effective Date

The effective date of this revised Notice of Privacy Practices is March 26, 2013.

Patient Intake Form

123 Frontage Rd A, Gray, LA 70359
Phone #: 985.580.1200 ● Fax #: 985.580.1218

531 Jefferson Terrace Blvd., New Iberia, LA 70560
Phone #: 337.560.0880 ● Fax #: 337.560.0870

●Today's date _____

●When did your pain begin? _____

● How did you find out about Headache & Pain Center? _____

● Who referred you to us? _____

● Who is your primary care physician (family doctor / PCP)?_____

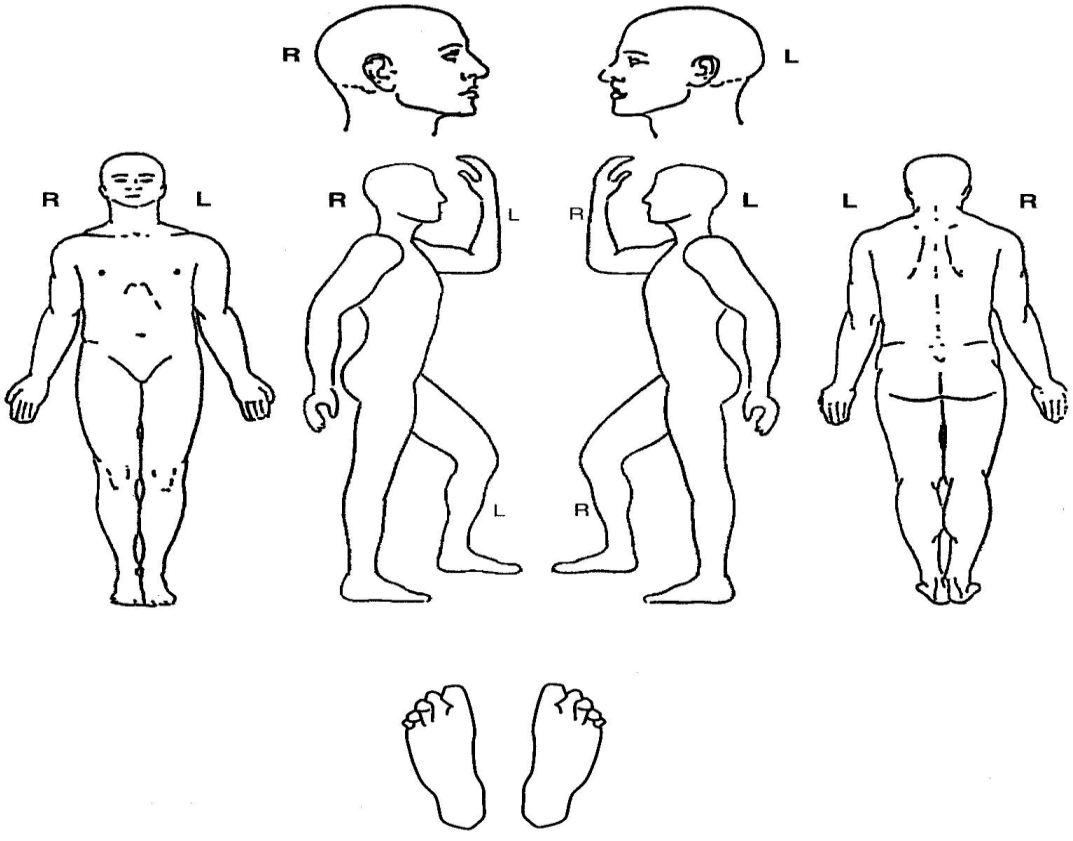
● List your other current doctors:_____

● To which doctors should we send our clinic notes? _____

● Have you seen anyone else for this problem (doctors, therapists, chiropractors)? Who?

_____

PLEASE **SHADE** IN, ON THE DRAWINGS BELOW, THE AREAS WHERE YOU FEEL PAIN.



PLEASE CIRCLE WHICH TREATMENTS YOU HAVE HAD FOR PAIN:

	DATE	HELPFUL	BY WHOM
EPIDURALS / NERVE BLOCKS / Other INJECTIONS (describe)		Yes / No	
Spine or Joint Surgery		Yes / No	
Therapy (Physical, Occupational, other)		Yes / No	
TENS / Neuromuscular Stimulator		Yes / No	
Chiropractor		Yes / No	
Biofeedback / Counseling		Yes / No	
Acupuncture		Yes / No	
Other:		Yes / No	

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD TO EVALUATE YOUR PAIN?

TEST	DATE DONE*	WHAT PART OF BODY *	WHAT FACILITY *	RESULTS IF KNOWN *
MRI				
CAT (CT) SCAN				
X-RAY				
EMG (TEST FOR NERVE DAMAGE)				
MYELOGRAM				
BONE SCAN				
LABORATORY (BLOOD TEST)				
BONE DENSITY				
EKG				
OTHER:				

***Please answer completely to the best of your knowledge.**

Are you **ALLERGIC** to medications, foods, or latex?_____

What medicine:	What happens? (ie rash, swollen throat, can't breathe etc):	What medicine:	What happens? (ie rash, swollen throat, can't breathe etc):

MEDICATIONS

What **medications** are you taking **now**?

Include prescriptions, vitamins, herbal supplements, & over the counter medications.

Medication & Dose	How do you take it?	Why Prescribed?	**Doctor** who prescribed it

Pharmacy name and location: _____**Phone #:**(___)_____

Are you on any of the following over the counter medications? (*Circle*) Aspirin, Angelica, Cloves, Danshen, Dong Quai, Feverfew, Garlic, Ginger, Gingko Biloba, Ginseng, Glucosamine, Green Tea, Horse Chestnut, Red Clover, St. John's Wort, Turmeric, Vitamin E.

Are you taking any **BLOOD THINNERS**? *Circle all that apply* **(Aggrenox, Persantine–Dipyridamole; Coumadin, Jantoven-Warfarin; Plavix-Clopidogrel; Ticlid-Ticlopidine, Pletal-Cilostazol, Effient-Prasugrel, Brilinta-Ticagrelor, Xarelto-Rivaroxaban, Trental (Pentoxifylline), Pradaxa (Dibigatran, Etexilate). Why?**_____

LIST medications tried in the past for pain or headaches that **did not** work:

_____

MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD OR PRESENTLY HAVE:

- ☐ Pacemaker
- ☐ Diabetes
  - Diet Controlled? Y/N
  - Do you take insulin? Y/N
  - Oral Medications? Y/N
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Irregular Heart Beat (explain type_____)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Easy Bleeding
- ☐ Claustrophobic
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Cancer Type:_____
  - Has it spread? Y / N
  - Where? _____
- ☐ Sleep Apnea
- ☐ Ulcers/Gastric Reflux
- ☐ Kidney Problems (Describe:_____)
- ☐ Lung Problems (COPD, Emphysema, Asthma)
- ☐ Current /Recent Infection
- ☐ Other Medical Problems or Diseases:_____ _____
- ☐ Seizures

Are you pregnant or plan to become pregnant? Y / N

Do you have any metal implants, orthodontic braces, metal piercings, or tattoos? Y / N

If yes, explain:_____

HEADACHE QUESTIONS

PLEASE FILL OUT IF YOU HAVE HEADACHES.

1._____ Is this the worst headache of your life?

2._____ How frequently do you have headaches; has the severity or frequency increased?

3._____ Was this a sudden headache that woke you from sleep?

4._____ Where are your headaches located?

5._____ Have you or a loved one noticed disorientation, memory problems, etc? Explain_____

6._____ What time of day do your headaches start?

7._____ Does it start with exertion (i.e. bowel movement, straining, exercise)?

8._____ From the beginning of the headache, how long does it take to reach maximum intensity (minutes, hours, etc.)?

9._____ How long do your headaches last?

10._____ Do you notice any symptoms before the headache begins ("aura")? Please explain "aura"._____

11._____ How would you characterize the headache pain? Is it burning, shooting, sharp, dull, pounding or other?

12._____ Does anything help the headache?

13._____ List of medications you are (if not yet listed) presently taking or have taken for headaches: _____

14._____ List other therapies for your headaches: _____

16._____ Do you have family members who experience headaches:_____

17._____ Are the headaches a sudden onset after the age of 50?

15._____ Do you experience any of the symptoms listed below during your headache?

	(Please Circle)			(Please Circle)	
Neck Stiffness	Yes	No	Tingling	Yes	No
Dizziness	Yes	No	Sensitivity to Light	Yes	No
Vomiting	Yes	No	Sensitivity to Noise	Yes	No
Numbness	Yes	No	Need to Walk or Move Around	Yes	No
Confusion	Yes	No	Disorientation	Yes	No

Headache & PAIN CENTER amc
answertopain.com
Expert Pain Relief Since 1994

Patient's Demographic Information

Today's Date: _____

Patient's Name: _____

Spouse's Name: _____

Mailing Address: _____
Street City State Zip

Sex: _____ Date of Birth: _____ Age: _____ S.S. #: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Patient's Employer: _____ Phone #: _____

Self Employed: Yes / No Occupation: _____

Primary Insurance: _____ Secondary Insurance: _____

Guarantor's Name: _____ S.S. #: _____
(if different from patient)

Guarantor's Employer: _____ Phone #: _____

Was this condition due to an accident? Yes/No Date of Accident_____

Do you currently have any open claims? (If yes, please give detailed information): Yes / No

_____

Workers' Compensation? Yes / No Through Whom: _____

Attorney or Liability Insurance? Yes / No Through Whom: _____

This form was read and completed by whom? _____

Signature of Patient / Guardian: _____

Revised: 10/01/20 MT

HEADACHE & PAIN CENTER, AMC

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Patient Name:_____

Address:_____

Date of Birth:_____Social Security #:_____

I hereby authorize:

Facility/Provider Name:_____

Address:_____

Phone/Fax #:_____

To release copies of my health information, specifically:

_____ Any & all records
_____ Only the following test _____
_____ Only the following dates of treatment_____
_____ Other specific information

To:

Facility/Provider Name: HEADACHE & PAIN CENTER, AMC
Address: 531-A Jefferson Terrace Blvd., New Iberia, LA 70560
Phone/Fax #: Phone: 337-560-0880 Fax: 337-560-0870

Purpose of Disclosure:_____

THE PATIENT MUST READ AND INITIAL THE FOLLOWING STATEMENTS:

- **I understand that my healthcare and payment for my healthcare will not be affected if I do no sign this form.**
- **I understand that I may see and copy the information described on this form if I ask for it, and that the Headache & Pain Center, AMC will give me a copy of this form after I sign it.**
- **I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.**
- **I understand that I may revoke this authorization at any time by notifying the Headache & Pain Center, AMC in writing, but if I do revoke it, the revocation will not have any affect on any actions the Headache & Pain Center, AMC took before it received the revocation.**

_____ _____
Signature of Patient **Date**

_____
Printed Name of Patient