PATIENT INFORMATION:

Last Name: First Name: MI: SSN:

DOB: Gender: Email:

Address: City: State: Zip:

Home Ph: Work Ph:

Cell Ph: Cell Ph. Carrier:

__ I agree to have appt. reminders and clinic communications sent to me via text message or voice message at the cell phone # above.

__ I agree to have email appt. reminders and clinic communications sent to me at the above email address.

If you do not want phone messages to be left for you, please note that here:

EMERGENCY CONTACT:

Relationship: Phone: Name:

I grant permission to the below person(s) to make decisions, handle any paperwork, payment information, scheduling appointments, and/or access to my medical records on my behalf.

_____ _____

HOW DID YOU HEAR ABOUT US?

__ Facebook __ Website __ Internet Search __ Yellow pages __ Newspaper __ Billboard __ Facility/agency
__ Friend/relative __ Physician __ Payer __ I was a prior patient
If applicable, who can we thank for referring you to our office? _____

EMPLOYER: __ Retired ___ Not employed __ Student

Company Name: __ Full time __ Part time

Phone: City: State:

What is your occupation?

PRIMARY INSURANCE:

Insurance:	Subscriber Name:
Member ID: Group #	Subscriber DOB/Relationship:

SECONDARY INSURANCE:

Insurance:	Subscriber Name:
Member ID: Group #	Subscriber DOB/Relationship:

TERTIARY INSURANCE:

Insurance:	Subscriber Name:
Member ID: Group #	Subscriber DOB/Relationship:

ACKNOWLEDGMENTS/CONSENTS: Initial each line

_____ I authorize payment and release of information requested by my insurance plan for payment. I understand that I am financially responsible for any balance due. I agree to allow said facility to evaluate and treat my condition and symptoms.

_____ I hereby acknowledge that I have reviewed the Notice of Privacy Practices and have been offered a copy. This office utilizes a variety of measure to protect your identity and others.

_____ I agree to freely participate in evaluation, treatment, and re-evaluation as deemed necessary by the facility and/ or practitioner. I authorize the information I disclose to my therapist throughout the course of treatment is accurate to the best of my knowledge. I agree to notify the said facility within 24hrs. should I experience any adverse reactions to treatment I received at this facility.

_____ I authorize release of information from other medical providers to «Clinic Name» by fax to «Clinic Fax»

_____ I authorize information obtained by this facility may be disclosed to other medical providers for collaboration or to insurance providers and/or guarantors as requested in order for payment to be considered.

Patient/Guardian Signature: **Date:**

OTHER SERVICES:

Have you received any home nursing services, home health, or hospice services in the past 60 days? Yes / No
If yes, what agency? Recent Discharge Date:_____/_____/_____

Who have you seen for this condition before today? ___ No one
__ Physician __ Massage Therapist __ Chiropractor __ Acupuncturist __ Athletic Trainer
__ Physical Therapist __ Occupational Therapist __ Speech Therapist Other: _____
Have you received ANY PT/OT/or chiropractor treatment this calendar year? _____If yes, where/how many visits? _____

Have you had x-rays, MRI, CT Scan for this condition? When and where?

REASON FOR TREATMENT:

Referred by: Primary Care Physician:

Describe your current Problem and how it began:

Is your injury work related? Yes / No | Onset/Injury/Surgery Date:

Is your injury the result of a motor vehicle accident? Yes / No If yes, what state did the accident occur in?

Do you have an attorney helping you with the resolution of this injury? Yes / No
If yes, please include the attorney name and Phone #:

Height: Weight: Dominant Hand: Left / Right

Choose the most appropriate response to the following:

Symptoms are? __ Constant 76-100% of the day __ Come/Go 26-75% of the day __Only with activity
Symptoms are? __ Getting worse __ Not changing __ Getting better

Please select ALL responses that apply:

Do you have any difficulty with: __ Sleeping __ Seeing __ Hearing __ Talking __ Memory __ Swallowing
__ I care for myself and others __ I live alone and do everything without help
I get some help from others for:

Which activity causes you the most pain/ most difficulty performing? _____

Function: Rate your ability to perform the above activity

0 1 2 3 4 5 6 7 8 9 10
Difficult No difficulty

Pain at Worst: Highest pain in the last 7 days.

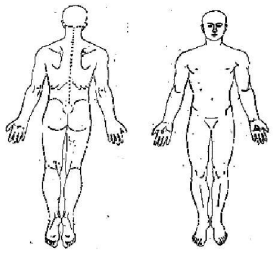
0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain imaginable

Pain at Best: Lowest pain in the last 7 days.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain imaginable

Is the pain worse at a particular time of day? _____

Indicate below where you have pain or other symptoms:



Is the nature of your pain: __ Burning __ Tingling
__ Sharp __ Dull/ache __ Numb __ Shooting
Pain is aggravated by: _____
Pain is better with: _____

PAST MEDICAL HISTORY:

Have you been diagnosed or treated for:
__ Arthritis/ RA __ Cancer __ Balance issues
__ COPD __ Hepatitis __ cardiac conditions
__ Diabetes __ Epilepsy __ headaches/migraines
__ TB __ Hypertension __ Neurological conditions
Do you have a pacemaker? Yes / No
Other:

Prior Injuries:

Prior surgeries & year performed:

MEDICATIONS:

Name:	Taken for:

LETTER OF PROTECTION REQUIRED FOR ALL LIABILITY INJURIES

Patient Name: **Patient DOB:**
Patient Address:

I. NOTICE OF PRIVILEGE

This Notice of Privilege is being sent on behalf of The Therapy Center of Jefferson Davis Parish, Inc. and/or Lemoine Therapy Services of CENLA, Inc., located at «Clinic Address» «Clinic City» , «Clinic State» «Clinic Zip» (individually and collectively referred to herein as "The Therapy Center"). This Letter of Protection shall serve as formal written notice of The Therapy Center's privilege pursuant to La. R.S. 9:4751, et. seq., for the treatment and supplies rendered to the above identified Patient as a consequence of injuries sustained on _____ ("Injury Date"). The Therapy Center is required by law to provide an itemized statement of charges within thirty (30) days of request.

II. PATIENT RESPONSIBILITY

I _____, in consideration of The Therapy Center providing physical/ occupational/ speech therapy treatment, do hereby authorize and direct my attorney or liability insurance to pay directly out of the proceeds resulting from any settlements, judgments, or verdict in or of my case to The Therapy Center for the reimbursement of reasonable charges made for services rendered to me by The Therapy Center. I further acknowledge that this Letter of Protection establishes a lien against the proceeds of any settlement, judgment, or verdict in or of my case for the costs of any physical / occupational / speech therapy treatment provided to me by The Therapy Center arising out of injuries suffered on the Injury Date.

I understand that I am directly responsible to The Therapy Center for all professional bills submitted by The Therapy Center for services rendered to me and that this Letter of Protection is made solely for The Therapy Center's. additional protection and in consideration of its awaiting payment. I also understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover moneys.

Furthermore, should I choose to retain different legal representation, I will notify The Therapy Center within 10 (ten) days of such a change.

I agree to provide the names of all attorneys and insurance companies involved in this claim, as well as the person(s)/company alleged to be liable for the injuries I sustained in "Exhibit A".

Signed: _____Date: _____
Patient's signature or legal guardian

Exhibit A

1. Attorneys involved in this claim: _____
   _____
2. Insurance companies involved in this claim: _____
   _____
3. Person(s)/Company/Employer alleged to be liable for injuries giving rise to this claim:
   _____