

Today's Date: ____/____/____ **Referring Physician:** _____

Primary Care Physician (Family Doctor): _____

First Name: _____ **Last:** _____ **Middle Initial:** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physical Address: _____ **City:** _____ **State:** _____ **Zip:** _____
(if different than mailing address)

Home Phone#: _____ **Cell#:** _____

Date of Birth: ____/____/____ **Social Security#:** _____ - _____ - _____

SEX: Male Female **Marital Status:** Married Single Widow Divorced Other

Present Employer: _____ **Occupation:** _____

Employer Address: _____ **Work Phone #:** (____) _____ - _____

Emergency Contact Name: _____ **Emergency Contact Ph #:** (____) _____ - _____

How did you hear about us? Friend/Family member Phone Book Internet Newspaper Other: _____

Who is responsible for this account? Health Insurance Workers Comp Insurance Attorney Auto Insurance Self

If Attorney, name of attorney: _____ **→Has a lawsuit been filed?** YES or NO

If insurance, name of insurance company: _____ **Insured Name:** _____

Insurance Policy #: _____ **Insured DOB:** ____/____/____

Patient Relationship to Insured: spouse child **Insured SS#:** ____/____/____

Date last worked: ____/____/____ **Were you given any previous work restrictions by a physician?** _____

If so, Physician name: _____ **Date given restriction:** ____/____/____

WAS YOUR PAIN CAUSED BY AN "ACCIDENT"? Yes No *(If yes, complete the box below)*

WHEN DID YOUR PAIN BEGIN? _____

ACCIDENT INFORMATION

Was your pain immediate or gradual? *(circle one)*

Check one of the following: Employment related accident
 Auto accident
 Other



DATE OF ACCIDENT

____/____/____
 month day year

Briefly explain the accident: _____

PLEASE CIRCLE THE NUMBER YOUR PAIN RATES ON A SCALE OF 1 to 10:



How frequently do you have pain? CONSTANT COMES & GOES OTHER

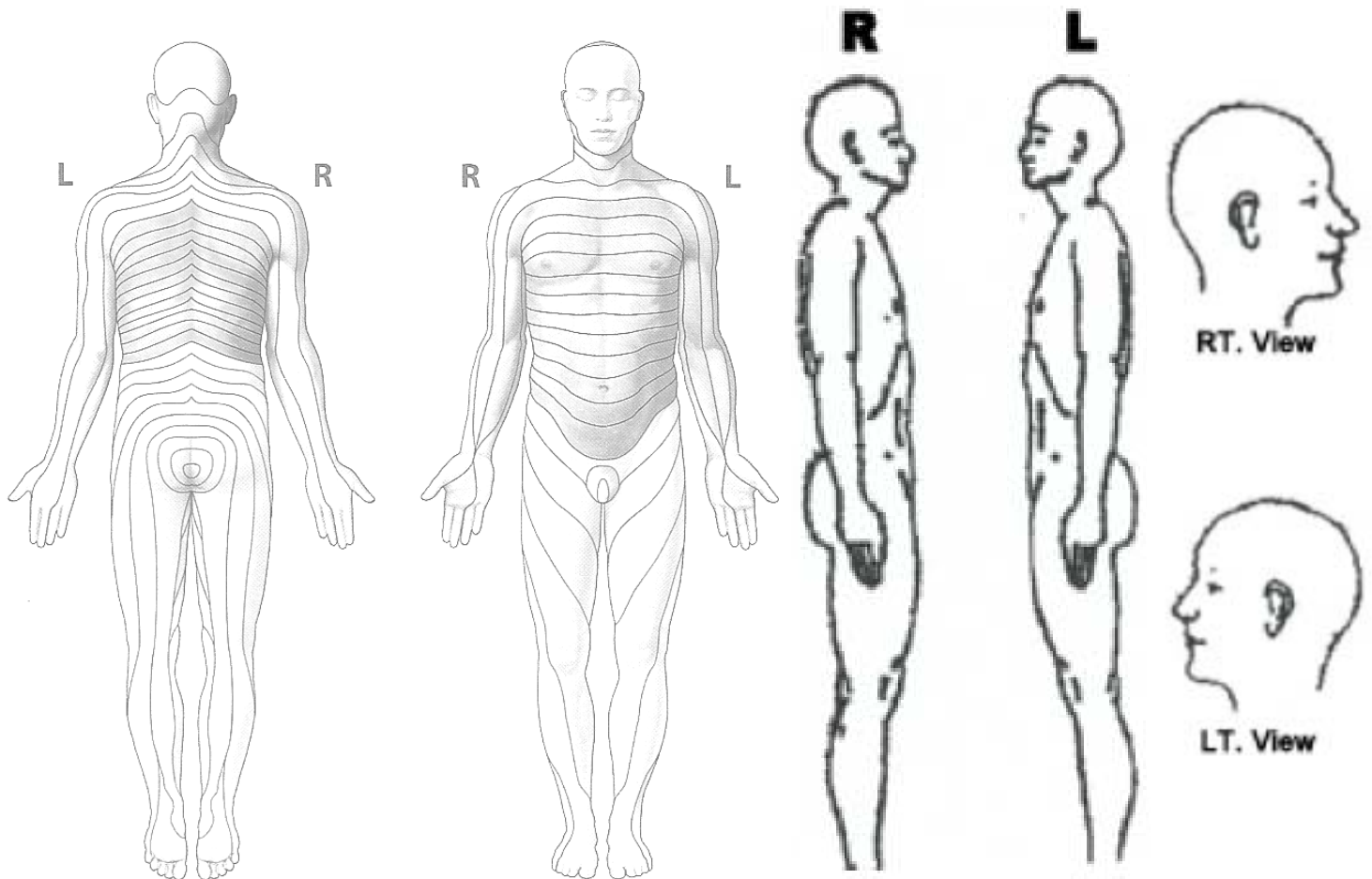
CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE:

- | | | |
|--|--|--|
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> NUMBNESS | <input type="checkbox"/> SHOOTING |
| <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> TINGLING | <input type="checkbox"/> CRAMPING |
| <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> BURNING SENSATION | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> MORE PAIN AT NIGHT | <input type="checkbox"/> STABBING | <input type="checkbox"/> WEAKNESS |
| <input type="checkbox"/> INABILITY TO SLEEP | <input type="checkbox"/> THROBBING | <input type="checkbox"/> URINARY ABNORMALITIES |
| <input type="checkbox"/> OTHER Explain : _____ | | <input type="checkbox"/> BOWEL ABNORMALITIES |

What **INCREASES** your pain?

- | | | |
|--|--|---|
| <input type="checkbox"/> STANDING, WALKING | <input type="checkbox"/> DRIVING | <input type="checkbox"/> BENDING FORWARD |
| <input type="checkbox"/> DAMP WEATHER | <input type="checkbox"/> BENDING AT NECK/WAIST | <input type="checkbox"/> BENDING BACKWARD |
| <input type="checkbox"/> OTHER Explain : _____ | | |

PLEASE SHADE IN THE DRAWING BELOW, THE AREAS WHERE YOU FEEL PAIN:



SOCIAL HISTORY:

	YES	NO
DRUG ABUSE HISTORY?		
ALCOHOL ABUSE HISTORY?		
DO YOU DRINK?		
DO YOU SMOKE?		
ARE YOU PREGNANT?		
FAMILY HISTORY OF DRUG ABUSE?		
FAMILY HISTORY OF ALCOHOL ABUSE?		
PRIOR ARREST(S) FOR VIOLENCE?		
PRIOR ARREST(S) FOR DWI?		
PRIOR ARREST(S) FOR POSSESSION OF ILLEGAL SUBSTANCE?		
Other (describe):		

REVIEW OF SYSTEMS:

	YES	NO		YES	NO
FEVER			ERECTILE DYSFUNCTION		
WEIGHT LOSS			BLADDER PROBLEMS		
WEIGHT GAIN			HEADACHES		
BLURRY VISION			BACK PAIN		
DOUBLE VISION			NECK PAIN		
VISION LOSS			MUSCLE PAIN		
SHORTNESS OF BREATH			RASHES		
SNORING			DEPRESSION		
WHEEZING			SUICIDAL THOUGHTS		
DIFFICULT SWALLOWING			MENTAL PROBLEMS		
ABDOMINAL PAIN			LOSS OF BALANCE		
CONSTIPATION			MUSCLE WEAKNESS		
BLOODY STOOL			NUMBNESS		
HEART PROBLEMS			TINGLING		
BLEEDING DISORDER			ALLERGIES		
THYROID PROBLEMS			DIABETES		

MEDICAL HISTORY:

	YES	NO		YES	NO
EASY BLEEDING			STROKE		
CANCER			SEIZURES		
HAS YOUR CANCER SPREAD?			TUBERCULOSIS		
DIABETES			ULCERS		
DO YOU TAKE INSULIN?			KIDNEY PROBLEMS		
HEART PROBLEMS			EMPHYSEMA		
HAVE YOU HAD A HEART ATTACK?			ASTHMA		
IRRREGULAR HEART BEAT			SLEEP APNEA		
HEART FAILURE			ARTHRITIS		
HIGH BLOOD PRESSURE			HEPATITIS B		
HIV			HEPATITIS C		
OTHER			OTHER		

COMMENTS: _____

NOTICE OF PRIVACY PRACTICES

Effective Date May 15, 2007, revised April 19, 2011

**NOTICE FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

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.

1. Uses and Disclosures: *Michael S. Haydel, MD, APMC d/b/a Haydel Spine & Pain Specialty Care Center and/or Anesthesia Associates of Louisiana, APMC* is permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment and health care operations of *Michael S. Haydel, MD, APMC d/b/a Haydel Spine & Pain Specialty Care Center and/or Anesthesia Associates of Louisiana, APMC*. For treatment purposes, such disclosures may be made to physicians and other health care providers as necessary to effectuate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third party payors for the purpose of obtaining payment for services provided. *Michael S. Haydel, MD, APMC d/b/a Haydel Spine & Pain Specialty Care Center and/or Anesthesia Associates of Louisiana, APMC* may also use personal health information to carry out day to day operations such as scheduling and quality review.

2. Required Authorizations: *Michael S. Haydel, MD, APMC d/b/a Haydel Spine & Pain Specialty Care Center and/or Anesthesia Associates of Louisiana, APMC* will not disclose any patient’s personal health information for any purpose aside from payment, treatment and health care operations, without patient’s authorized consent to such disclosure. Upon request for such authorization, patient shall have the right to refuse and/or revoke any disclosure of patient’s personal health information.

3. Privacy Compliance: In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 (the “Privacy Regulations”), *Michael S. Haydel, MD, APMC d/b/a Haydel Spine & Pain Specialty Care Center and/or Anesthesia Associates of Louisiana, APMC* has adopted privacy policies regarding usage of patients’ personal health information. We are committed to compliance with the Privacy Regulations and all other laws and regulations regarding patients’ right to privacy.

4. Additional Information: For additional information regarding our privacy policy or for a copy of this notice, please contact our Privacy Officer. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. We will post a copy of the current notice. The notice will contain the effective date.

The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.

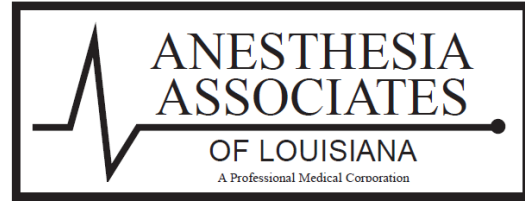
X _____
Signature of Patient (or Legal Representative) Printed Name Date

Haydel



Spine & Pain
Specialty Care Center

A Professional Medical Corporation



FINANCIAL POLICY

Thank you for choosing Michael S. Haydel, MD, APMC d/b/a Haydel Spine & Pain Specialty Care Center and/or Anesthesia Associates of Louisiana, APMC as your health care provider(s). We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to any treatment.

All patients must complete our Information and Insurance Form before seeing the doctor.

FINANCIAL AGREEMENT:

We strive to provide the very best level of care and service to our patients. This includes working with many insurance companies and plans. In order to facilitate insurance billing, we require the most up-to-date insurance information at each visit, so that we may bill all services in a correct and efficient manner. All co-pays, deductibles, co-insurance or other patient financial responsibilities are due at the time of the appointment. We will bill your insurance carrier(s) for services; however, the patient is responsible for knowing his/her coverage and benefits, as there is no guarantee of payment from any insurance company or other payer. It is always best that you call your insurance company to better understand your benefits for this service as well.

Professional services are rendered to you, not to an insurance company and you are responsible for payment of any/all of the charges if the insurance company or other agency does not pay the bill. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, you are still responsible for any outstanding balances. If your insurance company has not paid your account in full within 45 days, the balance will automatically be your responsibility.

If payment is not made within 90 days from the statement issue date, your account will be considered delinquent. You should be aware that should your account become delinquent and collection proceedings are enacted against you, you will be responsible for all costs of collections including collection agency fees, court costs, and interest. **There will be a \$25.00 charge for all NSF checks;** we will ask for all subsequent payments to be made by cash or credit card. We cannot hold checks for a later deposit date, so please make sure there are sufficient funds in your account prior to writing a check to us.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

During your course of treatment you may be referred to a facility or service in which your health care provider has a financial or economic interest. These facilities include, but are not limited to, Gulf Coast Surgical Center, Bayou Region Surgical Center, Lafayette Surgical Specialty Hospital and Houma Medical Imaging. You have the right to choose where to receive services.

Thank you for understanding our policy and please let us know if you have questions or concerns.

I have read, understand and agree to this Policy.

Signature of Patient or guardian

Printed Name

Date

Haydel



Spine & Pain
Specialty Care Center

A Professional Medical Corporation

Michael S. Haydel, M.D., FIPP
Fellow of Interventional Pain Practice
Board Certified in Anesthesiology

Michael P. Charlet, M.D.
Board Certified Neurologist
Fellowship in Neuromuscular Diseases

315 Liberty Street, Houma, LA 70360
Phone (985) 223-3132 Fax (985) 223-3126

Authorization to Disclose Protected Health Information

I hereby authorize _____ to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

HAYDEL SPINE & PAIN SPECIALTY CARE CENTER.

Patient Name: _____

DOB: _____/_____/_____ Social Security # _____/_____/_____

Address: _____

Disclose the following PHI for treatment dates _____ to _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Abstract/Pertinent | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Consult | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Physical Orders | <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> ER Report |
| <input type="checkbox"/> Lab | <input type="checkbox"/> X-ray / Radiology Report | <input type="checkbox"/> entire Chart |
| <input type="checkbox"/> Radiology reports | <input type="checkbox"/> Other: _____ | |

Purpose for Release: **MEDICAL TREATMENT**

_____ I hereby acknowledge, and hereby consent to such, that the released information may
Initial contain alcohol and drug abuse, psychiatric, HIV, or genetic information.

This authorization shall expire upon this expiration date: _____.

If I fail to specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to **Haydel Spine & Pain Specialty Care Center**. I understand that the revocation will not apply to information that has already been released prior to this authorization. I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above. **PROHIBITION ON REDISCLOSURE:** This information has been disclosed to you from records whose confidentiality is protected by federal and/or state law. Federal and state regulations prohibits you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

A photo static copy of the form shall constitute my authorization to provide any information as described above.

Signature of Patient (or Guardian or Legal Representative)
(if signed by someone other than the patient, state legal relationship/authority)

Date: _____/_____/_____