

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

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

Present Employer: _____ **Occupation:** _____

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

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:

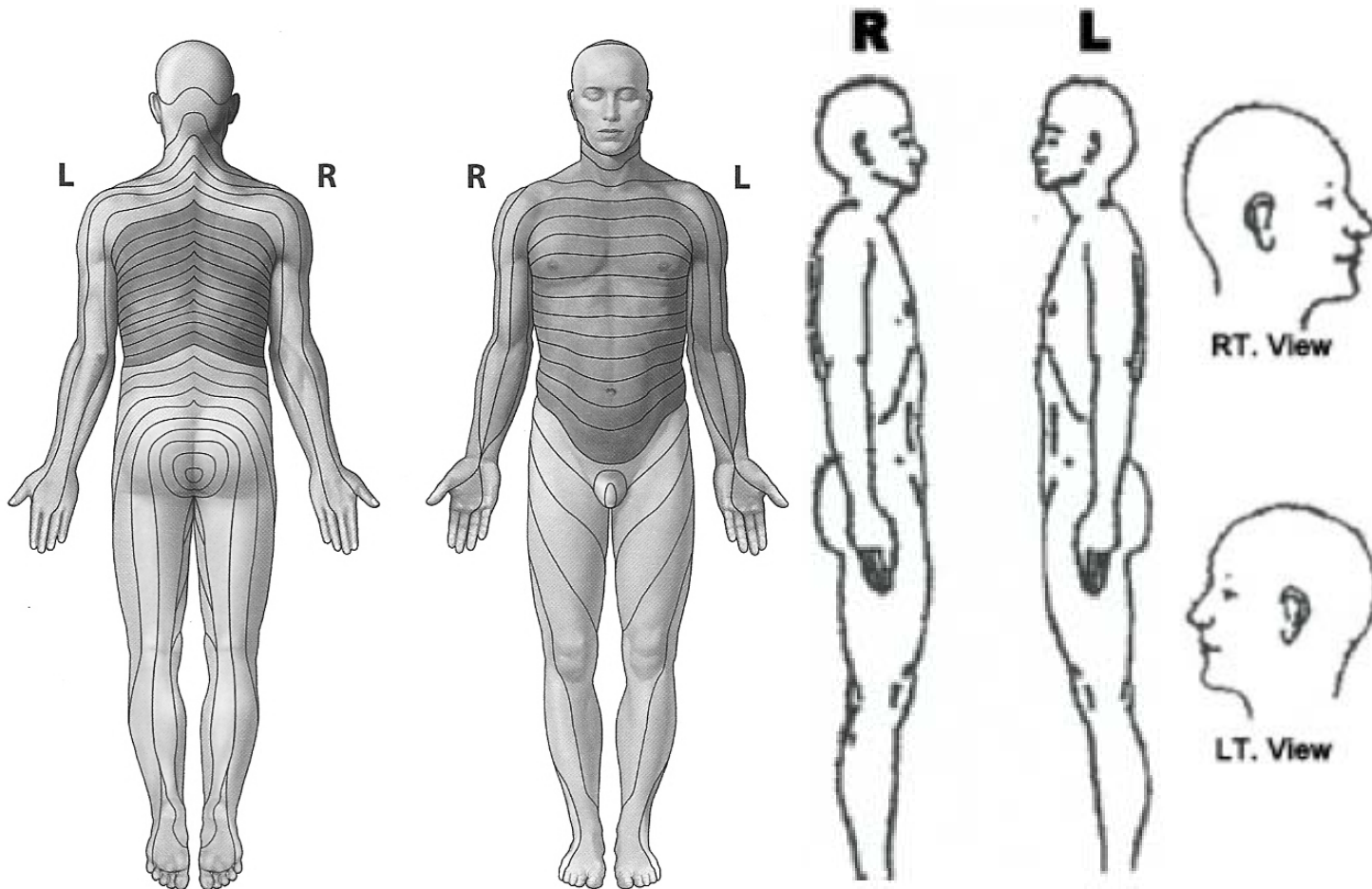
- | | | |
|---|--|--|
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> NUMBNESS | <input type="checkbox"/> SHOOTING |
| <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> TINGLING | <input type="checkbox"/> CRAMPING |
| <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> 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"/> BOWEL ABNORMALITIES |

OTHER Explain : _____

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			MENTAL PROBLEMS		
DIFFICULT SWALLOWING			LOSS OF BALANCE		
ABDOMINAL PAIN			MUSCLE WEAKNESS		
CONSTIPATION			NUMBNESS		
BLOODY STOOL			TINGLING		
HEART PROBLEMS			ALLERGIES		
BLEEDING DISORDER			DIABETES		
			THYROID PROBLEMS		

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			ARTHRITIS		
HEART FAILURE			HEPATITIS B		
HIGH BLOOD PRESSURE			HEPATITIS C		
HIV			OTHER		

COMMENTS: _____

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

NAME: _____ BIRTHDATE: _____

SOCIAL SECURITY #: _____

**PRIVACY NOTICE
Effective Date May 15, 2007**

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: Haydel Spine & Pain Specialty Care Center, A Louisiana Professional Medical Corporation 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 Haydel Spine & Pain Specialty Care Center. 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. Haydel Spine & Pain Specialty Care Center may also use personal health information to carry out Haydel Spine & Pain Specialty Care Center's day to day operations such as scheduling and quality review.

2. Required Authorizations: Haydel Spine & Pain Specialty Care Center 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"), Haydel Spine & Pain Specialty Care Center has adopted privacy policies regarding usage of patients' personal health information. Haydel Spine & Pain Specialty Care Center is 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 Haydel Spine & Pain Specialty Care Center's privacy policy or for a copy of this notice, please contact our Privacy Officer. Haydel Spine & Pain Specialty Care Center reserves the right to change this Notice and to make the revised and changes notice effective for medical information that Haydel Spine & Pain Specialty Care Center already has about you, as well as any information Haydel Spine & Pain Specialty Care Center received in the future. We will post a copy of the current notice in Haydel Spine & Pain Specialty Care Center. 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 Date



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

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

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

FINANCIAL POLICY/CONSENT

Thank you for choosing us as your health care provider. 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.

Regarding Insurance:

You should be aware that 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. We cannot bill your insurance company unless you give us your insurance information and an original claim form. 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

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. You should be aware that there will be a \$30.00 charge for all NSF checks.

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 and Houma Medical Imaging. You have the right to choose where to receive services.

Thank you for understanding our policy. Please let us know if you have questions or concerns. I have read the Policy. I understand and agree to this Policy:

X _____
Signature of Patient or Responsible Party

X _____
Print Name

X _____
Date



A Professional Medical Corporation

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

- Abstract/Pertinent, Consult, Physical Orders, Lab, Radiology reports, History & Physical, Operative Report, Nurses Notes, X-ray / Radiology Report, Other, Discharge Summary, Progress Notes, ER Report, entire Chart

Purpose for Release: MEDICAL TREATMENT

I hereby acknowledge, and hereby consent to such, that the released information may 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: ____/____/____