204 Boots Drive Farmerville, LA 71241
Phone: (318) 620-0075
Fax: (318)-620-0070

2601 Cypress Street West Monroe, LA 71291
Phone: (318) 582-5346
Fax: (318)-582-5348

NELA REHABILITATION

PATIENT INFORMATION – ADULT

Patient Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Gender: Male Female

Social Security #: _____ D.O.B. _____

RESPONSIBLE PARTY (If not patient)

Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

D.O.B.: _____

Social Security: _____

Employer: _____

Relationship to Patient: Mother Father Guardian

INSURANCE INFORMATION

If patient is not the subscriber, please provide subscribers DOB below

Name of Insurance Company: _____

Name of Policy Holder: _____

Policy Holder Address: _____

_____

Home Phone: _____

Work Phone: _____ Cell Phone: _____

D.O.B.: _____ SS#: _____

Employer: _____

Policy Holder ID: _____

Group #: _____

Relationship to Patient: Mother Father Guardian Self

EMERGENCY/ALTERNATE CONTACT NUMBERS

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

How did you hear about us? ☐ Word of Mouth ☐ Physician Reference ☐ Advertising ☐ Search Engine ☐ Insurance Provider List

Assignment of Insurance Benefits: I hereby authorize Northeast Louisiana Rehabilitation, LLC to provide any medical care that is deemed necessary. I hereby authorize payment of benefits directly to Northeast Louisiana Rehabilitation, LLC. I hereby authorize Northeast Louisiana Rehabilitation, LLC to release any information necessary to process my claim. I acknowledge/understand that I am responsible for any charges incurred that my insurance does not pay for or cover for any reason whatsoever. I also acknowledge that if my account is turned over to a collection agency that I will be responsible for the collection fee towards my account. I also attest that the information that I have provided above is correct and truthful to the best of my knowledge.

Patient/Guardian's Signature: _____ Date: _____

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Patient Name: _____

Medical History Questionnaire

What is your main reason for needing therapy?

_____

When and how did this begin_____

_____

What imaging (i.e. X-ray, MRI, CT) have been performed? Include date and results if known_____

Are you currently working? _____ YES _____ NO Occupation? _____

In what type of recreational activities do you participate? _____

Do you smoke? _____ YES _____ NO

When is your next appointment with referring MD? _____

Any scheduled appointments with other doctors? _____

Primary Care Physician's Name and Clinic? _____

Is the reason you need therapy related to an accident? Please check which applies to you:

Work-Man's Comp ☐ **Auto Accident** ☐ **Attorney involved? YES** ☐ **NO** ☐

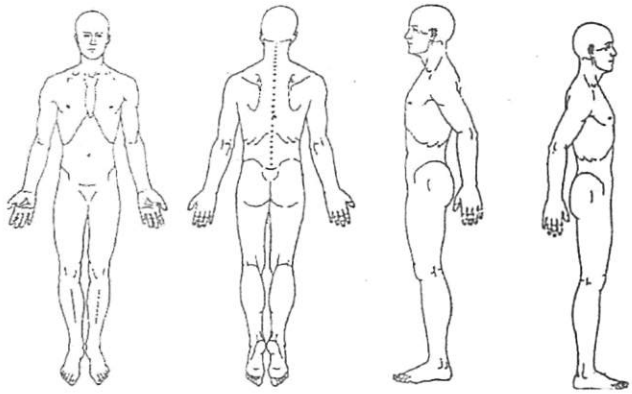
****Please Shade in Specific Areas of Pain on the Diagrams****

Rate your pain on a scale of 0-10 (0 = no pain and 10 = emergency room pain)

____/10 right now

____/10 at its worst

____/10 at its best



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Please list all Current Medications, dosages, and frequency

(or provide a list to be copied):

Name and Purpose	Dosage	Frequency	Route

Allergies/Medical Devices: If there are any known allergies (ex: nuts, dyes) or medical devices (ex: shunt) that you wish for the therapist to be aware of, please list below.

Please list all current medical conditions (i.e. Diabetes, High Blood Pressure, Heart Conditions, etc.) and all previous surgeries and dates:

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NELA REHABILITATION

PATIENT CONSENT FORM

Medical Release for Northeast Louisiana Rehabilitation to Release Records: I hereby authorize Northeast Louisiana Rehabilitation, LLC to release to healthcare providers copies of all medical reports, progress notes, physician's orders, itemized statements, and any other documents relating to any examination or treatment pertaining to the said patient. This release also authorizes verbal communication by provider to the party who is to receive medical records.

Authorization for Healthcare Provider to *Release Records to Northeast Louisiana Rehabilitation*: I hereby authorize all health care providers to release unto Northeast Louisiana Rehabilitation, LLC all medical reports, progress notes, physician's orders, itemized statements, and any other documents relating to any examination or treatment pertaining to the said patient. This release also authorizes verbal communication by provider to the party who is to receive medical records

Use and Disclosure of Your Protected Health Information: Your protected health information will be used by Northeast Louisiana Rehabilitation, LLC or disclosed to others (i.e. caregiver present at the time of treatment) for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices: You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.
_____ Initial here stating that you received a copy of the **Privacy Practices.**

Requesting a Restriction on the Use of Disclosure of Your Information: You may request a restriction on the use of disclosure of your protected health information for the purposes of treatment, payment or health care operations.

Northeast Louisiana Rehabilitation, LLC may or may not agree to restrict the use of disclosure of you protected health information.

If **Northeast Louisiana Rehabilitation, LLC** agrees to your request, the restriction will be binding on the practice. Use of disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standard.

Revocation of Consent: You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices: Northeast Louisiana Rehabilitation, LLC reserves the right to modify the privacy practices outlined in the notice.

Photograph: I hereby understand that photography, video camera, and any other form of medial may be used for treatment purposes and/or clinical in-services.
If you DO NOT consent to photograph, please sign here _____

Media Release: I hereby understand and authorize the use of photography, video camera, and any other for of media to use used for advertising such as printed publications, website, and/or social media.
If you DO NOT consent to media release, please sign here _____

Signature: I have reviewed this consent form and give my permission to Northeast Louisiana Rehabilitation, LLC to use and disclose my health information in accordance with it for the purposes of treatment, payment & health care operations. A photocopy of this authorization form shall have the same force and effects as the original thereof. Should I wish to revoke any of this authorization, I will be required to request the revocation in writing with the appropriate for obtaining from the office personnel.

_____ _____
Patient Name (Print) **Date**

_____ _____
Signature of Patient/Legal Representative/Guardian **Relationship to Patient**

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PRIVACY PRACTICES -PATIENT COPY

THIS NOTICE DESCRBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by use in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be sending medical information to the referring physician.

- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill and/or chart notes for your visit to your insurance company for payment.

- HEALTH CARE OPERATIONS include the business aspects of running out practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be sending charts to the physical therapy network for quality assurance review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, reschedule appointments, or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercises by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.