

GULF COAST BRAIN SPORT & SPINE, LLC

DR. BEAU BAGLEY
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TODAY'S Date:

PT #

EMG/NCS HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name (<i>Last, First, M.I.</i>):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Address (<i>Street, City, State, Zip</i>)		Phone:	
Preferred Method of Contact:		Cell:	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Home:	
Primary Care:		Email:	
Referred by:		Date of last physical exam:	
		Social Security #	

Emergency Contact # _____ Name & Relationship _____

Pharmacy Location _____ Pharmacy Phone Number _____

PERSONAL HEALTH HISTORY

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the drug	Strength	Frequency Taken

Allergies to medications

Name of the drug:	Reaction you had:

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio <input type="checkbox"/> Allergies to Medication			
Please check any medical problems you have.	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Gastrointestinal Disorder	Please list dates of when the medical illness started. ➔
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	
	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Infection	
	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> MRSA	
	<input type="checkbox"/> Stroke	<input type="checkbox"/> Lung Developmental Disease	
	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mood Disorder	
	<input type="checkbox"/> Neurologic Disorder	<input type="checkbox"/> Genetic Disorder	
		<input type="checkbox"/> GERD	
List any medical problems other than the named above.			
Surgeries			
Year	Reason	Hospital	

Injury or complaint for today: _____

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<u>General</u>	<u>ENT</u>	<u>Musculoskeletal</u>	<u>Neurologic</u>
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Vision Change	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Seizure
<input type="checkbox"/> Fever	<input type="checkbox"/> Hearing Change	<input type="checkbox"/> Morning stiffness more than 1 hour <input type="checkbox"/> Morning stiffness less than 1 hour	<input type="checkbox"/> Memory loss
<input type="checkbox"/> Chills	<input type="checkbox"/> Ringing In Ears	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Difficulty concentration
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Joint redness	<input type="checkbox"/> Slowed thinking
<input type="checkbox"/> Lumps	<input type="checkbox"/> Sensitivity to Light	<input type="checkbox"/> Back pain	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Mass	<input type="checkbox"/> Sensitivity to Noise	<input type="checkbox"/> Hand pain	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Cancer History	<input type="checkbox"/> Change in smell	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Headaches
<input type="checkbox"/> Rash, Itching	<input type="checkbox"/> Change in taste	<input type="checkbox"/> Knee pain <input type="checkbox"/> Elbow pain	<input type="checkbox"/> Loss of balance <input type="checkbox"/> Numbness
<u>Cardiovascular</u>	<u>Respiratory</u>	<u>Endocrine</u>	<u>Gastrointestinal</u>
<input type="checkbox"/> Fainting	<input type="checkbox"/> Coughing	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Chest pains	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Reflux
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Snoring	<input type="checkbox"/> Excess sweating	<input type="checkbox"/> Nausea
<input type="checkbox"/> Swelling	<input type="checkbox"/> Short of breath	<input type="checkbox"/> Excess thirst <input type="checkbox"/> excess hunger	

Skin	Gynecologic/Genitourinary	Psychological
<input type="checkbox"/> Rash	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Depression
<input type="checkbox"/> Scars	<input type="checkbox"/> Poor urinary flow	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Frustration
	<input type="checkbox"/> Menses	<input type="checkbox"/> Stress
	<input type="checkbox"/> Abdominal bleeding	<input type="checkbox"/> Suicidal
	<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Plan to hurt others
		<input type="checkbox"/> Plan to hurt self

Do you use tobacco? YES NO

Packs Per Day _____

Number of years? _____

Do you have a living will? YES NO

X _____
Patient, Parent or Authorized Representative

Today's Date

X _____
Physician

Today's Date

Consent to Medical Treatment and Financial Agreement

Consent to Medical Treatment: The undersigned has been informed of the treatment procedures considered necessary for the patient and that treatment/procedures will be directed by a physician and performed by employees of Gulf Coast Brain Sport & Spine, LLC (“provider”). The undersigned understands that there is no guarantee and no assurance has been made of the results that may be obtained from treatment. Consent is hereby granted for treatment.

Refusal of Treatment: I, the undersigned, am responsible now and forever, for my actions if I decide to refuse treatment or not follow the provider’s instructions.

Provision of Information: I, the undersigned, will provide to the best of my knowledge accurate and complete information about the patient’s present complaints, past illness, hospitalizations, medication and other matters related to the patient’s healthcare.

Assignment of Insurance or Healthcare Benefits: In the event the undersigned is entitled to benefits of any kind arising out of any policy of insurance or healthcare coverage insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Gulf Coast Brain Sport & Spine, LLC for application on the patient’s bill. The undersigned, and/or patient agrees to be responsible for charges not covered by the assignment, including- deductibles and co-payments. Undersigned agrees to provide all necessary insurance or healthcare coverage documents including eligibility, identification card, and authorization. Undersigned agrees to notify our office of any changes in insurance or healthcare coverage when they occur. Government issued photo identification will be required when providing insurance or healthcare coverage information.

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she will be totally responsible for all charges for services including but not limited to botulinum toxin/xeomin/dysport, synvisc, supartz, exercise prescription, and any other non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by specialists and physicians for whom Gulf Coast Brain Sport & Spine, LLC are authorized to bill. I, the undersigned, accept the fee(s) charged as legal and lawful debt. I understand the fee(s) charged are due at the time of service. Should it be necessary to forward my account for collection, I agree to pay all monies due, including a 40% collection fee, attorney fees, and/or court costs if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Louisiana and any other state. All delinquent balances shall bear interest at the legal rate. There will be a \$40 service fee for returned checks. The undersigned agrees and understands that if he/she does not have insurance, proof of insurance, or participate in a plan that provider is contracted with, payment for service will be due at time of service. For patients without insurance, a deposit of \$100 will be required prior to the provider’s evaluation.

Medicare authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible in paying for my treatment (Section 1128 B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Medical Forms/Copies: Undersigned understands that completion of medical forms is a service separate from the clinic visit and requires time for the provider to complete. Fee for completion of forms is \$25 for 2 page forms and \$10 per additional page. FMLA and Disability Forms are evaluated on a case by case basis at the discretion of the provider. Independent medical evaluations are considered a distinct service and will be evaluated on a case by case at the discretion of the provider. Copy charge for records is \$1.00 per page for the first 25 pages, \$.50 per page for 26 to 350 pages, \$.25 per page thereafter, and a handling charge not to exceed \$25.00 and actual postage.

Miscellaneous provisions: I understand that I may be contacted by an automated system via telephone and/or email to be reminded of appointments or other news events. Under no circumstances will Gulf Coast Brain Sport & Spine, LLC be liable for property of patients. Undersigned agrees to be respectful and courteous of other patients and organization personnel and property of Gulf Coast Brain Sport & Spine, LLC. Undersigned agrees that Gulf Coast Brain Sport & Spine, LLC is a medical office and smoke-free facility; therefore, undersigned, visitors, and family agree not to smoke within 15 feet of the entrance of our facility.

(Patient or Authorized Representative)_____

Date: _____

POLICY TITLE: NOTICE OF PRIVACY PRACTICES	POLICY NO: PRIC 002
EFFECTIVE DATE:	REVIEWED:

Exhibit PRIV.002-B

**Acknowledgement of Receipt of HIPAA
Privacy Policies and Procedures**

I, _____, have received and reviewed a copy of
Gulf Coast Brain Sport and Spine, LLC’s Notice of Privacy Practices.

Patient Name _____

If Personal Representative, Relationship to Patient _____

Signature _____

Date _____

GULF COAST BRAIN SPORT & SPINE, LLC

PATIENT GUIDELINE POLICY

1. Given the nature of healthcare today, more people are seeking care for more limited appointment times. If your appointment needs to be cancelled, please call 24 hours in advance or sooner in order to allow for scheduling of other patients that request an appointment. After the second instance of not canceling your appointment within 24 hours, your account will be placed in “**No Show**” status and there will be a \$25 dollar no show fee for missed clinic appointments or a \$75 fee for missed procedure appointments. The appropriate no show fee will be collected before scheduling any further appointments. After the fourth no show instance, it will be discussed that you may consider another provider with different clinic hours.
2. If there are issues that arise that will cause you to be late to your scheduled appointment time, please call to inform the staff of your status. The staff will check provider’s schedule at that time to see if you can be worked in. There is no guarantee that you will be seen by provider that day if you are more than 30 minutes late to your scheduled appointment. After the second instance of being more than 30 minutes late to your scheduled appointment, your account will be placed in “**No Show**” status and the same fees as stated in the previous paragraph and policy as stated applies.
3. Gulf Coast Brain Sport & Spine, LLC is *Not* a Pain Clinic. The philosophy of Gulf Coast Brain Sport & Spine, LLC is to address injury or developmental disorder without narcotic medication. Because of potential for addiction, misuse, and diversion of medication, **narcotics will not be a part of the treatment plan provided through this clinic.** Narcotic medications include but are not limited to morphine, hydrocodone, oxycodone, oxycontin, Percocet, Lortab, methadone, fentanyl, duragesic, etc.
4. Refills will only be called in during regular business hours and may take up to 3 business days to complete. Because medical issues or medication lists change, refills after a 3 month period will only be provided in association with an office visit. When refilling medication, new medications, allergies, and diagnoses need to be brought to the provider’s attention in order to treat the patient appropriately. It’s the patient’s responsibility to call in advance when medication is running out.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING POLICY, IS THE PATIENT OR GUARDIAN, OR IS AUTHORIZED BY THE PATIENT AND ACCEPTS THE TERMS THEREOF.

PRINT NAME

SIGNATURE OF PATIENT, PARENT OR REPRESENTATIVE

DATE



VACCINE QUESTIONNAIRE

PATIENT NUMBER _____

DATE ENTERED _____

Patient Name _____

Have you received the flu vaccine between October 1, 2018 and today?

_____ Yes _____ No

If yes please give the month and year received

Month _____ Year _____

Have you ever received the Pneumonia Vaccine?

_____ Yes _____ No

If yes please give the month and year received

Month _____ Year _____

Signature _____

Date _____