TRITON HEALTHCARE INC.

8128 Florida Blvd
Denham Springs, LA 70726
Ph. (225)791-8666
FAX (225)791-2891

Patient Information

Please Print
Patient Name:_____ Date of Birth:_____ Age:_____

Responsible Party if Minor:_____

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

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

Social Security#:_____ Email Address:_____

Employer:_____ Address:_____

Occupation:_____ Dr. Referred By:_____

Primary Insurance to Be Billed:_____
Card Holder Name:_____ ID#:_____
Group ID:_____ Customer Service#:_____

Secondary Insurance to Be Billed:_____
Card Holder Name:_____ ID#:_____
Group ID:_____ Customer Service#:_____

Is This Worker's Comp Claim:_____ YES_____NO Injury Date:_____
Was this injury reported:_____YES _____NO Claim#:_____
Contact Person:_____ Telephone#:_____
Car Accident:_____YES_____NO Injury Date:_____
Was this injury reported?_____YES_____NO Claim#:_____
Contact Person:_____ Telephone #:_____
Litigation:_____YES_____NO_ If YES Attorney's Name:_____
Address:_____

Have you had Physical Therapy Before?_____YES_____NO If so, Where?_____
Have you had any Home Health in the last 60 days for any reason? _____YES_____NO

I hereby give my consent for treatment and authorize Triton Healthcare, Inc. to furnish and receive my information related to this illness or accident to/from my insurance carrier, attorney, or other medical personnel.

Signature:_____ **Date:**_____

Patient Information:

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Are you on a work restriction from your doctor? Y N Are you receiving Home Health? Y N
Occupation, including activities that comprise your workday: _____

Health Habits:
Smoking Currently: ☐ Yes ☐ No Alcohol: ☐ Current ☐ Past ☐ Never
Do you exercise beyond normal, daily activities and chores? ☐ Yes ☐ No
Hobbies/Leisure Activities: _____

Do you have pacemaker/defibrillator? Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
List anything you are allergic to (medications, latex, etc) : _____

Medical/Surgical Information:

Have you RECENTLY (past 3 months) had any of the following symptoms (check all that apply)?

- ☐ fatigue
- ☐ fever/chills/sweats
- ☐ nausea/vomiting
- ☐ weight loss/gain
- ☐ difficulty walking
- ☐ changes in bowel or bladder function (including but not limited to color, frequency)
- ☐ chest pain
- ☐ vision changes
- ☐ difficulty swallowing
- ☐ muscle weakness
- ☐ dizziness/lightheadedness
- ☐ heartburn/indigestion
- ☐ cough
- ☐ coordination problems
- ☐ pain at night
- ☐ constipation/diarrhea
- ☐ loss of appetite
- ☐ shortness of breath
- ☐ fainting
- ☐ falls
- ☐ headaches
- ☐ joint pain/swelling

Please check if you've EVER had any of the following conditions (check all that apply)?

- ☐ cancer
- ☐ heart problems
- ☐ chest pain/angina
- ☐ high blood pressure
- ☐ circulation problems
- ☐ blood clots
- ☐ stroke
- ☐ anemia
- ☐ bone or joint infection
- ☐ chemical dependency (i.e., alcoholism)
- ☐ Fibromyalgia
- ☐ depression
- ☐ lung problems
- ☐ tuberculosis
- ☐ asthma
- ☐ rheumatoid arthritis
- ☐ other arthritic condition
- ☐ bladder/urinary tract infection
- ☐ kidney problem/infection
- ☐ sexually transmitted disease/HIV
- ☐ pelvic inflammatory disease
- ☐ broken bones
- ☐ thyroid problems
- ☐ diabetes
- ☐ osteoporosis
- ☐ multiple sclerosis
- ☐ epilepsy/seisure
- ☐ eye problem/infection
- ☐ ulcers
- ☐ liver problems
- ☐ hepatitis
- ☐ pneumonia
- ☐ other _____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ cancer
- ☐ heart problems
- ☐ high blood pressure
- ☐ diabetes
- ☐ stroke
- ☐ depression
- ☐ tuberculosis
- ☐ thyroid problems
- ☐ blood clots

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications/supplements you are currently taking (INCLUDING pills, injections, skin patches, and/or over the counter medications/supplements/vitamins)(mark any that are new):

_____

_____

Have you ever taken steroid medications for any medical conditions? **YES** **NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES** **NO**

Please list any surgeries/conditions for which you have been hospitalized, including dates:

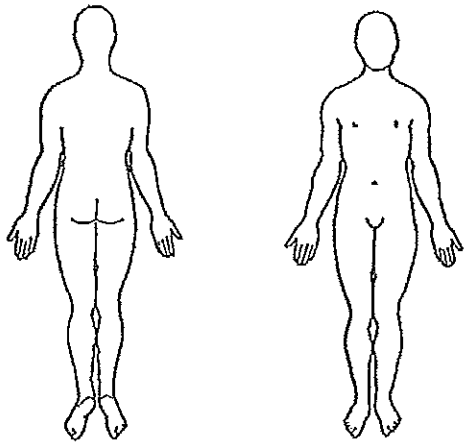
_____

Current condition/chief complaint

Roughly, when did your symptoms start? _____
What caused your symptoms? _____
My symptoms are currently: _____
Treatment received so far for this problem (chiropractic, injections, etc): _____
Please list special tests performed for this problem (x-ray, MRI, labs, etc): _____
What are your goals for Physical therapy? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right:



My symptoms currently: ☐ Come and go ☐ Constant
☐ Are constant, but change with activity
☐ Wake me up at night

Describe your sleeping habits:
☐ No difficulty ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

Symptoms are worst: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise
Symptoms are best: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey: _____ The best your pain has been over the past week: _____ The worst your pain has been over the past week: _____

Using the 0 to 10 the scale, with 0 being *"complete function"* and 10 being the *"unable to do anything"* please describe:

0 1 2 3 4 5 6 7 8 9 10

Dry Needling Consent Form

Dry needling is a valuable adjunct treatment for chronic pain or stiffness, and it can be used to deactivate myofascial trigger points. Like any medical procedure, there are possible complications.

While these complications are uncommon, they do sometimes occur and must be considered prior to giving consent to the procedure. With the dry needling technique, a fine, flexible and sterile needle is used. We practice standard precautions during treatment. The purpose of the needling is to release shortened bands of muscle caused by abnormal functioning of the nervous system. A local inflammatory process is stared to encourage healing. No medications are injected.

Dry needling may cause an increase in pain for one to three days followed by an expected improvement in the overall pain state. The increase pain is related to a local chemical response and an overactive shortened muscle bands that have not been released and to the soreness caused by the "twitching" of the muscle.

Any time a needle is used there is a risk of infection. However, we are using new, disposable and sterile needles, and infections are extremely rare. A needle may be placed inadvertently in an artery or vein. If an artery or vein is punctured with the needle, a hematoma (or bruise) will develop. If a nerve is touched, it may cause paresthesia (a prickling sensation) which is usually brief, but it may continue for a couple of days. When a needle is placed close to the chest wall, there is a rare possibility of a pneumothorax (air in the chest cavity). Fortunately, all these complications are not fatal and are readily reversible.

Patients are requested to inform practitioners about conditions such as pregnancy, pacemakers, and the use of blood thinners or issues with blood pressure, or immunosuppressant medications prior to the treatment.

I have read or had read to me the above; I understand the risks involved with dry needling. I have had the opportunity to ask questions I had and all of my questions have been answered. I consent to examination and treatment at Triton Healthcare Inc., including dry needling.

Signature:_____ Date:_____

Print name:_____

Witness:_____

ASSIGNMENT AND RELEASE

We agree to submit a claim to your insurance company and/or attorney based on the information you have provided to us.

You agree to accept responsibility for co-payments, deductibles, co-insurances, medical care and other services that are provided to you which are not specifically covered by your healthcare for any reason, i.e. a failure on your part to obtain necessary authorizations or appropriate referrals. Other examples include refusals by your insurance company to pay benefits because of circumstances which preclude coverage, i.e. injuries on the job (worker's compensation), and injuries sustained by motor vehicles (no-fault) or pre-existing conditions.

This agreement is not intended to conflict with or circumvent the provisions of contracts and governmental regulations.

This agreement is not intended to conflict with any grievance procedure that maybe available to you.

I hereby authorize payment directly to Triton Healthcare, Inc.

Signature:_____ Date _____

HIPAA Notice
for Patients of
Triton Healthcare, Inc.

NOTICE OF PRIVACY PRACTICES
Effective Date: April 14, 2003
Last Revision Date: None

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.

This Notice serves as a joint notice for Triton Healthcare, Inc. (collectively referred to herein as "we" or "our"). We have designated ourselves as an organized health care arrangement under the Health Insurance Portability and Accountability Act of 1996. We will follow the terms of this Notice and may share health information with each other for purposes of treatment, payment and health care operations as described in this Notice. Since we maintain health information separately, we will respond separately to your questions, requests and complaints concerning your health information.

OUR DUTIES REGARDING YOUR HEALTH INFORMATION

We respect the confidentiality of your health information and recognize that information about your health is personal. We are committed to protecting your health information and to informing you of your rights regarding such information. We are also required by law to protect the privacy of your protected health information and to provide you with notice of these legal duties. This Notice explains how, when and why we typically use and disclose health information and your privacy rights regarding your health information. In our Notice, we refer to our uses and disclosures of health information as our "Privacy Practices." Protected health information generally includes information that we create or receive that identifies you and your past, present or future health status or care or the provision of or payment for that health care. We are obligated to abide by these Privacy Practices as of the effective date listed above.

We may, however, change our Privacy Practices in the future and specifically reserve our right to change the terms of this Notice and our Privacy Practices. We will communicate any change in our Notice and Privacy Practices as described at the end of this Notice. Any changes that we make in our Privacy Practices will affect any protected health information that we maintain.

Generally, our Privacy Practices strive:

To make sure that health information that identifies you is kept private; To give you this Notice of our Privacy Practices and legal duties with respect to protected health information; To follow the terms of the Notice that is currently in effect; and to make a good faith effort to obtain from you a written acknowledgement that you have received or been given an opportunity to receive this notice.

HEALTH-CARE PROVIDERS INCLUDED IN THIS NOTICE

Our Notice does not address the privacy practices that your personal doctor may will not affect the medical decisions they make in your care and treatment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We use and disclose your protected health information in a variety of circumstances and for different reasons. Many of these uses and disclosures require your prior authorization. There are situations, however, in which we may use and disclose your health information without your authorization. Many of these uses and disclosures will occur with your treatment, for payment of health services or for our health-care operations. There are additional situations, however, where the law permits or requires us to use and disclose your health information without your authorization. These situations will also be described in this section of the Notice. Specifically, we may use and disclose your protected health information as follows:

For Treatment, Payment and Health Care Operations

1. For Your Treatment. We may use and/or disclose your protected health information to physicians, nurses, dietitians, technicians, residents, medical or other health professional students, physical therapists or other health-care personnel who are involved in your care and who will provide you with medical treatment or services.

2. For Payment of Health Services That You Receive. We may use and/or disclose your protected health information to bill and receive payment for the health services that you receive from us. For example, we may provide your health information to our billing or claims department to prepare a bill or statement to send to your insurance company, including Medicare or Medicaid, or another group or individual that may be responsible for payment for your health services.

3. For Our Health-Care Operations. We perform many activities to help assess and improve the services that we provide. Such activities include, among others, participating in our client facilities medical or nursing training programs or education, performing quality reviews, conducting patient opinion surveys, developing clinical guidelines and protocols, engaging in case management and care coordination, business management, insurance or legal compliance reviews or participating in accreditation surveys such as the Joint Commission for the Accreditation of Healthcare Organizations or required regulatory surveys. These activities are referred to as "health-care operations." We may use and/or disclose health information for purposes of any of these health-care operations.

For example, we may use health information to assess the scope of our services or to determine if additional health services are needed. In determining what services are needed, we may disclose health information to physicians, medical or other health or business professionals for review, consultation, comparison and planning. If we use or disclose health information in this manner, we may try to remove any information that identifies you to further protect your health information. Additionally, we may disclose health information to auditors, accountants, attorneys, government regulators, or other consultants to assess and/or ensure our compliance with laws or to represent us before regulatory or other governing authorities or judicial bodies.

4. For Another Provider's Treatment, Payment or Health-Care Operations. The law also permits us to disclose your protected health information to another health-care provider involved with your treatment to enable that provider to treat you and get paid for those services as well as for that provider's health-care operation activities involving quality reviews, assessments or compliance audits.

5. Special Circumstances When We May Disclose Your Health Information Related to Treatment, Payment or Health-Care Operations. After removing direct identifying information (such as your name, address, and social security number) from the health information, we may use your health information for research, public health activities or other health-care operations (such as business planning). While only limited identifying information will be used, we will also obtain certain assurances from the recipient of such health information that they will safeguard the information and only use and disclose the information for limited purposes.

Additionally, we may disclose health information to outside organizations or providers in order for them to provide services to you on our behalf. We will also seek written assurances from these providers to safeguard the health information that they receive.

For Permitted or Required by Law Activities

There are situations where we may use and/or disclose your health information without first obtaining your written authorization for purposes other than for treatment, payment or health-care operations. Except for the specific situations where the law requires us to use and disclose information (such as reports of births to the health department or reports of abuse or neglect to social services), we have listed all these permitted uses and disclosures in this section.

1. For Public Health Activities. We may use or disclose health information to a public health authority that is authorized by law to collect or receive information in order to report, among other things, communicable diseases and child abuse, or to the FDA to report medical device or product related events. In certain limited situations, we may also disclose health information to notify a person exposed to a communicable disease.

2. For Health Oversight Activities. We may disclose health information to a health oversight agency that includes, among others, an agency of the federal or state government that is authorized by law to monitor the health-care system.

3. For Law Enforcement Activities. We may disclose limited health information in response to a law enforcement official's request for information to identify or locate a victim, a suspect, a fugitive, a material witness or a missing person (including individuals who have died) or for reporting a crime that has occurred on our premises or that may have caused a need for emergency services.

4. For Judicial and Administrative Proceedings. We may disclose health information in response to a subpoena, or order of a court or administrative tribunal.

5. To Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner to identify a deceased person or to determine the cause of death.

6. For Purposes of Organ Donation. We may disclose health information to an organ procurement organization or other facility that participates in the procurement, banking or transplantation of organs or tissues.

7. For Purposes of Research. We may conduct and participate in medical, social, psychological and other types of research. Most research projects are subject to a special approval process to evaluate the proposed research project and its use of health information before we use or disclose health information. In certain circumstances, however, we may disclose health information to people preparing to conduct a research project to help them determine whether a research project can be carried out or will be useful, so long as the health information they review does not leave our premises.

8. To Avoid Harm to a Person or for Public Safety. We may use and disclose health information if we believe that the disclosure is necessary to prevent or lessen a serious threat or harm to the public, or the health or safety of another person.

9. For Specialized Government Functions. We may use and disclose health information of certain military individuals, for specific governmental security needs, or as needed by correctional institutions.

10. For Workers' Compensation Purposes. We may disclose your health

information to comply with the workers' compensation laws or other similar programs.

11. For Appointment Reminders and to Inform You of Health Related Products or Services. We may use or disclose your health information to contact you for medical appointments or other scheduled services, or to provide you with information about treatment alternatives or other health-related products and services.

When your preferences will guide our use or disclosure

While the law permits certain uses and disclosures without your authorization, the law also provides you with an opportunity to inform us of your preference, in certain limited situations, concerning the use or disclosure of your health information. For these limited uses and disclosures, we may simply ask and you may simply tell us your preference concerning the use or disclosure of your health information. These limited situations include:

1. The information, if any, given to family or friends. Unless you tell us otherwise prior to a discussion or if your situation appears to permit us; we may disclose to a family member, other relative or a close personal friend health information concerning your care, including information concerning the payment for your care.

All Other Uses and Disclosures Require Your Prior Written Authorization

For situations not generally described in our Notice, we will ask for your written authorization before we use or disclose your health information. You may revoke that authorization, in writing, at any time to stop future disclosures of your information. Information previously disclosed, however, will not be requested to be returned, nor will your revocation affect any action that we have already taken. In addition, if we collected the information in connection with a research study, we are permitted to use and disclose that information to the extent it is necessary to protect the integrity of the research study.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

This portion of our Notice describes your individual privacy rights regarding your health information and how you may exercise those rights.

Requesting Restrictions of Certain Uses and Disclosures of Health Information

You may request, in writing, a restriction on how we use or disclose your protected health information for your treatment, for payment of your health-care services, or for activities related to our health-care operations. You may also request a restriction on what health information we may disclose to someone who is involved in your care, such as a family member or friend. To make a request to Triton Healthcare, Inc., please contact the individual listed in the Contact Section of this Notice.

We are not required to agree to your request. Additionally, any

restriction that we may approve will not affect any use or disclosure that we are legally required or permitted to make under the law, including our facility directory.

Requesting Confidential Communications

You may request and receive reasonable changes in the manner or the location where we may contact you for appointment reminders or other related information. You must make your request in writing and specify the alternate method or location where you wish to be contacted and how you will handle payment for your health services. To make a request to Triton Healthcare, Inc., please contact the individual listed in the Contact Section of this Notice.

We will accommodate your reasonable request but in determining whether your request is reasonable, we may consider the administrative difficulty it may impose on us.

Inspecting and Obtaining Copies of Your Health Information

You may ask to look at and obtain a copy of your health information. You must make your request in writing. For Triton Healthcare, Inc., please submit your request to the individual listed in the Contact Section of this Notice.

We may charge a fee for copying or preparing a summary of requested health information. We will respond to your request for health information within 30 days of receiving your request, unless your health information is not readily accessible, or the information is maintained in an off-site storage location.

Requesting a Change in Your Health Information

You may request, in writing, a change or addition to your health information. To make a request to Triton Healthcare, Inc., please submit your request to the individual listed in the Contact Section of this Notice. The law limits your ability to change or add to your health information. These limitations include whether we created or include the health information within our medical records or if we believe that the health information is accurate and complete without any changes. Under no circumstances will we erase or otherwise delete original documentation in your health information.

Requesting an Accounting of Disclosures of Your Health Information

You may ask, in writing, for an accounting of certain types of disclosures of your health information. The law excludes from an accounting many of the typical disclosures, such as those made to care for you, to pay for your health services, or where you provided your written authorization to the disclosure.

To make a request for an accounting for Triton Healthcare, Inc., please submit your request to the individual listed in the Contact Section of this Notice. Generally, we will respond to your request within 60 days of receiving your request unless we need additional time.

Obtaining a Notice of Our Privacy Practices

We provide you with our Notice to explain and inform you of our Privacy Practices. You may also take a copy of this Notice with you. Even if you have requested this Notice electronically, you may request a paper copy at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice concerning our Privacy Practices affecting all the health information that we now maintain, as well as information that we may receive in the future. We will provide you with the revised Notice by making it available to you upon request and by posting it at our service sites.

COMPLAINTS

We welcome an opportunity to address any concerns that you may have regarding the privacy of your health information. If you believe that the privacy of your health information has been violated, you may file a complaint with the individual(s) listed in Section VII of this Notice. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized or retaliated against for filing a complaint.

CONTACT PERSONS

For questions, concerns, requests or complaints concerning Triton Healthcare, Inc., you may contact the Privacy Officer at the telephone number or address listed below. To look at or obtain a copy of your health information from Triton Healthcare, you may contact the Triton Healthcare, Inc. Privacy Officer at the telephone number or address listed here.

Triton Healthcare, Inc.
Attn: Byron Nichols, Privacy Officer
8128 Florida Blvd.
Denham Springs LA 70726

Phone (local): 791-8666
(Toll-free): 1-888-762-8668
Fax: 1-225-791-2891
Email: triton1@eatel.net

Patient Signature: _____ Date: _____