PATIENT REGISTRATION

NeuroMuscular MEDICAL ASSOCIATES

PATIENT INFORMATION

Patient Name	*Date of Birth*	*Sex (circle one)* Male Female

Patient's SSN	*Marital Status (circle one)* Divorce Married Single Widowed Unknown	*Driver's License State / License Number*

Home Address

Mailing Address (if different)	*Email address*

Home Number	*Cell Number*	*Work Number*

Best time to call for reminders **Morning ☐ Afternoon ☐ Evening ☐**	*Number to Call for Reminders* (circle one) Home / Cell / Work	*Reminder call type*: ☐ Voice ☐ Text/SMS

Current Employment Status: (circle one) Full Time Part Time Not Employed Self Employed Retired Disabled	*Employer Name/Phone: (If applies)*

Race ☐ White ☐ Black / African Am. ☐ Hispanic ☐ Unreported/Refuse to Report ☐ Other	***Ethnicity*** ☐ Hispanic or Latino ☐ Not Hispanic ☐ Refuse to report	***Language*** ☐ English ☐ Indian ☐ Spanish ☐ Other ☐ Russian

How did you hear about us? ☐☐*Physician Referred* ☐☐*Family or Friend* ☐ *Television Ad* ☐ *Website/Internet*

EMERGENCY CONTACT	Name	Relationship	Day phone number

Primary Care Physician	Referring Physician

ACCIDENT RELATED?

Is Reason for Visit Accident Related	**Yes ☐ No ☐**	**Date of Accident:**
Were you injured on the job?	**Yes ☐ No ☐**	**Worker's Compensation Carrier:**
Date of Injury?	**Date last worked?**	**Claim #:**

Who is to be billed? ☐ **Private Pay** ☐ **Health Insurance** ☐ **Worker Comp** ☐ **Your Attorney**

(Note: If "Your Attorney" is selected, the Attorney must execute our Continuing Guaranty before services can be rendered and any bills will be issued.)

INSURANCE INFORMATION

PRIMARY	Insurance Company	Insurance Group No	Phone Number
	Subscriber's Name	Subscriber's Date of Birth	Subscriber's ID Number
SECONDARY	Insurance Company	Insurance Group No	Phone Number
	Subscriber's Name	Subscriber's Date of Birth	Subscriber's ID Number

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR FEES	Name	Telephone Number

I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly by the doctor.

Patient Signature: ***Date:***

ATTORNEY INFORMATION

Have you engaged the services of an attorney in connection with your present illness / injury/reason for this visit? **Yes ☐ No ☐**	If you answered YES, the Continuing Guaranty must be received before services can be rendered. (See above)

Provide Name and contact # of attorney (If applies):

If NO, do you anticipate retaining an attorney?	**Yes ☐ No ☐**	**(Rev 2/2019)**

PAIN MANAGEMENT QUESTIONNAIRE

NeuroMuscular MEDICAL ASSOCIATES

Patient Name: _____ Today's Date: _____

Date of Birth: _____ SSN: _____

1) When did the pain begin? (Give specific date; if related to accident, please describe)

_____

2) Is your pain Work Related? ☐Yes ☐No *If Yes, name/phone# of Worker's Comp Co?* _____

3) Are you involved in a lawsuit because of your pain? ☐Yes ☐No *If Yes, name/Phone # of your Attorney*
   a) If Yes, was this related to an Auto Accident? ☐Yes ☐No _____

4) Have you had any surgery for Pain?
☐Yes ☐No *If Yes, list surgeries and dates:*

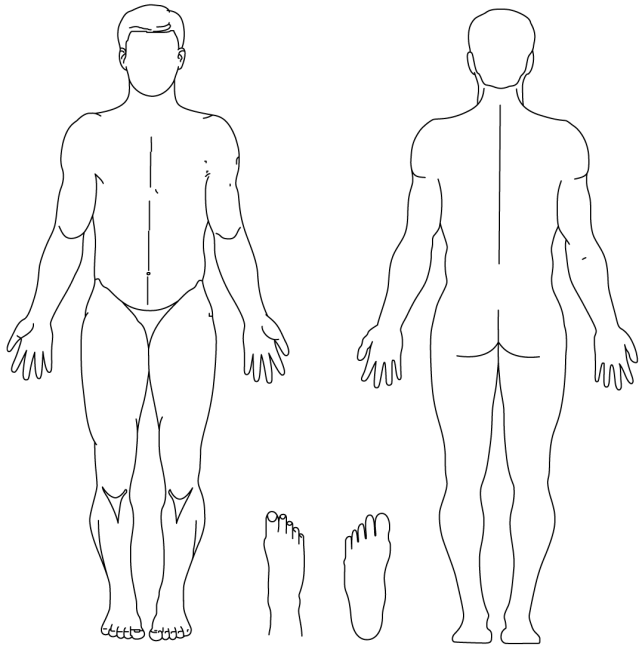
_____

_____

_____

5) For the physician to properly monitor your pain, indicate on the diagram the location of your pain using the following symbols:

a) Entire painful area (xxxx)
b) Single most painful spot (x)
c) Numbness (ooooo)
d) Tingling area(s) (------)



6) Does the pain move from one area to another?
☐Yes ☐No
If Yes, please describe:

_____

_____

7) PAIN SCALE (Use this scale to rate your pain)

0	1-2	3-4	5-6	7-8	9	10
No Pain	Minimal	Mild	Moderate	Severe	Excruciating	Unbearable

Using this scale, rate the pain:
Now _____ Best Times _____ Worst Times _____

Patient Name: _____ Date: _____

8) List ALL of your medication you are taking now:.

Medication/ Strength		
1)	2)	3)
4)	5)	6)
7)	8)	9)
10)	11)	12)

Do you drink alcohol for pain relief? ☐Yes ☐No If Yes, type and amount of alcohol _____

9) Circle all physical and/or occupation therapies you have experienced for pain treatment current and in the past:

Hot Packs	Cold Packs	Paraffin	Laser
Exercises	Massage	Fluidotherapy	TENS
Ultrasound	Whirlpool	Neuroprobe	Biofeedback
	Other _____		

Place a check-mark by those that gave you most relief.

10) Use (X) for pain decreases, (O) for pain increases for each of the following:
_____ fatigue _____ tension _____ alcohol _____ medications

11) In a 24-hour period, indicate the hours you spend:

In pain	_____	Reclining because of pain	_____
Reclining for other reasons	_____	Sleeping	_____

12) Circle the numbers indicating your pain limitations in each activity listed

Activity	None	Normal	Mildly Limited	Moderately Limited	Severely Limited
Walking	0	1	2	3	4
Running	0	1	2	3	4
Bending	0	1	2	3	4
Lifting	0	1	2	3	4
Sitting	0	1	2	3	4
Stair climbing	0	1	2	3	4
Resting	0	1	2	3	4
Sexual activities	0	1	2	3	4
Working	0	1	2	3	4
Hobbies	0	1	2	3	4
Standing	0	1	2	3	4
Reclining	0	1	2	3	4
Sleeping	0	1	2	3	4
Exercise	0	1	2	3	4
House cleaning/maintenance	0	1	2	3	4
Bowel movements	0	1	2	3	4

13) Were pain not a problem, what you like to do that you cannot do now?

_____

_____

14) ***Are you actively employed?*** ☐Yes ☐No
If not employed, When did you last work your regular job? ***Give Date:*** _____
Are you on Disability? ☐Yes ☐No

REVIEW OF SYSTEMS

NeuroMuscular MEDICAL ASSOCIATES

Patient's Name: _____ Today's Date: _____

Chief Complaint: _____

YOUR HEALTH HISTORY +++ CHECK ALL THAT APPLY

This would apply to your past as well as your current Health History/Conditions

Constitutional:
- ☐ Insomnia
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Weight gain
- ☐ Weight loss
- ☐ Chills/sweats
- ☐ Fever

Musculoskeletal:
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Prior joint surgery
- ☐ Joint swelling
- ☐ Cramps/spasms
- ☐ Gout

Neurology:
- ☐ Bowel incontinence
- ☐ Bladder incontinence
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Nerve damage
- ☐ Tremors
- ☐ Dizziness

Psychology:
- ☐ Nervous/depressed
- ☐ Sleep disturbance

General:
- ☐ Cold hands/feet
- ☐ Easily fatigued
- ☐ Bruises easily
- ☐ Skin rash

Cardiology
- ☐ Chest pain
- ☐ Swelling of legs
- ☐ High blood pressure

HEENT:
- ☐ Vision problems
- ☐ Trouble swallowing

Gastroenterology:
- ☐ Abdominal pain
- ☐ Changes in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Allergy:
- ☐ Nasal congestion
- ☐ Allergic to:_____
- ☐ _____
- ☐ _____

Endocrinology:
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Diabetes
- ☐ Thyroid disease

Hematology/Lymph:
- ☐ Bleeding disorder
- ☐ Blood thinner used

Other:
- ☐ Smoke: packs daily_____
- ☐ Alcohol: type_____ frequency_____
- ☐ Cancer: type_____
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV Positive
- ☐ Pacemaker
- ☐ Defibrillator Implant

- ☐ **Prior pain management:**_____
  Who?_____
  Where?_____
  Injections?_____

18212 E. Petroleum Dr. Bldg 6A Baton Rouge, Louisiana 70809 P: 225 224 8096 F: 225 408 3741
42078 Veteran Avenue, Suite G Hammond, Louisiana 70403 P: 985 542 7177 F: 985 340 7078
3001 19th Street Metairie, Louisiana 70002 P: 504 469 9642 F: 504 469 9642

NeuroMuscular
MEDICAL ASSOCIATES

Fred DeFrancesch, MD
Robert Nicholson, MD
William Lee, MD
Physical Medicine and Rehabilitation

Pain Management Agreement

Patient Name:_____ DOB:_____

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help you and your doctor comply with the law regarding controlled medications.
I understand that this AGREEMENT is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on the agreement**. I understand that if I break any part of this agreement, my doctor may stop prescribing pain control medication and I may be discharged from this clinic.** In such case, my doctor may taper off the medicines over a period of several days, if necessary, to avoid withdrawal symptoms. A drug-dependence treatment program may be recommended. Also, NeuroMuscular Medical Associates LLC does not treat any medical LEGAL related conditions.

I WILL:

- **Communicate fully and honestly with my doctor about the character and intensity of pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.**
- **Safeguard my pain medication from loss or theft. *Lost or stolen medication WILL NOT BE REPLACED.***
- **Submit to blood, urine, saliva, hair sample tests or Random PILL COUNT visits if requested by my doctor to determine my compliance with my program of pain control medication.**
- **Use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time. Bring all unused pain medication to EVERY office visit.**

I WILL NOT:

- **Use my medication at a rate greater than the prescribed rate.**
- **Use any illegal controlled substances; Share, sell or trade my medication with anyone.**
- **Attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medicines from any other doctor.**

I HAVE BEEN INFORMED OF/THAT:

- **The limited evidence in regard to the benefits of opioids.**
- **The potential risks and benefits of opioid treatment, including the risk for addiction, abuse and misuse.**
- **The potential side effects, including respiratory depression, cognitive impairment or impaired motor skills.**
- **The risk for a potentially fatal overdose as a result of accidental exposure.**
- **The potential for interactions with other medications and/or alcohol.**
- **For woman who are pregnant or of childbearing age, the risk for neonatal exposure to opioids, including risk for neonatal withdrawal**

Patients are seen by APPOINTMENT ONLY. If any patient or family member creates a disturbance in any NMA office while attempting to be seen without an appointment, I understand that I or my family member may be escorted out of the office by NMA staff or local authorities, if necessary. If I have an emergency, I will obtain services at an emergency department, not at NeuroMuscular Medical Associates. *I agree that refills of my prescriptions of pain medications will be made at the time of an office visit.* .

I agree to use _____ pharmacy, located at _____,

Telephone number _____, for filling my prescriptions of pain medications.

I authorize the doctor and my pharmacy to cooperate fully with any city, state and federal law enforcement agencies, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me upon signing.
This Agreement is entered into on this _____day of_____, 20___. Rev. 8/2023;db

Patient Signature-_____ Physician Signature- _____

Witness Signature-_____

NeuroMuscular
MEDICAL ASSOCIATES

Fred DeFrancesch, MD
Robert Nicholson, MD
William Lee, MD
Physical Medicine and Rehabilitation

FINANCIAL POLICY

Our Office policy is that charges are due and payable at the time service is rendered. ***NO REFUNDS.*** This applies to insurance coverage as well. Our office will provide you with an insurance claim and mail it for you. When you assign insurance benefits to us, we give you credit for the amount usually covered by insurance. You are responsible for paying the difference. NeuroMuscular Medical Associates LLC does NOT treat any medical legal related conditions.

BILLING AND CREDIT-Monthly statements are due and payable in full upon receipt. In the event that you are unable to pay the entire bill, please contact the office to make payment arrangements.

Any statement remaining unpaid without satisfactory arrangements may be turned over to a collection agency for collection. Office policy dictates the assignment of any account 90 DAYS past due to an agency for collection. Should your account be referred to an agency for collection, you will be responsible for all collection and attorney fees incurred.

If you have retained an attorney to pursue an injury or accident claim, you must notify this office immediately. If an injury or illness is determined to be caused by a third party and it is not covered by your health insurance, or if you elect to have us bill you and/or your attorney directly, you are responsible for all of our charges, in full.

NMA CASH PATIENT POLICY

The initial visit cost for a new cash paying patient is **$500**. This is a 25% discount off our usual and customary charge of $675. Any new cash patient must bring in a **$200** cash deposit to reserve or make an appointment. We will no longer take appointments for any patient that has not already paid the initial $200 deposit. Once we have received this deposit, we will schedule an appointment at the location and with the physician of your choice. At the day and time of visit, the remaining $300 will be collected. If a patient shows up for the initial visit without the $300 balance, he/she will not be seen by NMA staff. Likewise, if a patient does not show up for their scheduled appointment, the $200 deposit is non-refundable. If a patient calls 24 hours prior to scheduled appointment time to reschedule, then $200 deposit will still apply for the rescheduled visit. (Maximum two re-scheduled visits allowed for initial visit appointment; afterwards, the $200 deposit is non-refundable)
Usual follow-up appointments are **$250** *(level 4)* payable at the time of visit. One week follow-up appointments for **medication changes only are $84** *(level 2)* also payable at the time of visit.
The cost for trigger point, joint and Toradol injections administered by the PA or physician is **$60** for up to three injections. This charge will need to be paid at the time of check-out and before any prescriptions for medication are given out. For other scheduled injections performed only by the physician, the cost is **$500** for simple injections and **$750** for more complex injections. Patients will be informed in advance of these injection costs and will be required to pay for these types of procedures at check-in.

I have read the above policy and understand it completely. I acknowledge that if there is something I do not understand, I have the opportunity to ask an administrative NMA employee for clarification. If you have any questions regarding your bill, please feel free to call the office. We will honor all arrangements made regarding your financial obligation.

Thanks for choosing us for your medical needs.

Patient Name: _____

Patient Signature: _____

Date: _____

Rev 8/2023;db

NeuroMuscular
MEDICAL ASSOCIATES

HIPAA Notice of Privacy Practices

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********

It Is My Legal Duty To Safeguard Your Protected Health Information (PHI).

By law, we are required to insure that your PHI is kept private. The PHI constitutes information created or noted by us that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. We are required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how we would use and/or disclose your PHI. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice; PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this Notice.

Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to PHI already on file with us. Before we make any important changes to our policies, we will immediately change this Notice. You may also request a copy of this Notice from us, or you can view a copy of it in our office.

How We Will Use and Disclose Your PHI.

We will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below, you will find the different categories of our uses and disclosures, with some examples.

Some uses and disclosures of your PHI related to treatment, payment, or health care operations require your prior written consent, such as the following:

1. For Treatment: We may disclose your PHI to physicians, other healthcare professionals and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a physician is treating you, we may disclose your PHI to her/him in order to coordinate your care.
2. For Healthcare Operations: We may disclose your PHI to facilitate the efficient and correct operation of our practice. Examples: Quality Control - We might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. We may also provide your PHI to our attorneys, accountants, consultants, and others to make sure that we are in compliance with applicable laws.
3. To Obtain Payment for Treatment: We may use and disclose your PHI to bill and collect payment for the treatment and services we provided you. Example: We might send your PHI to your insurance company or health plan in order to get payment for the health care services that we have provided to you. We could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for our office.

Certain other uses and disclosures do not require your consent. We may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.
2. When disclosure is required by federal, state, or local law, judicial, board, or administrative proceedings; or, law enforcement. Example: We may make a disclosure to the appropriate officials when a law requires us to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
3. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
4. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
5. If disclosure is compelled by the patient or the patient's representative pursuant to federal, state or local health and safety codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

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6. To avoid harm, we may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public. If disclosure is compelled or permitted by the fact that you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
7. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger.
8. If disclosure is mandated by federal, state or local child abuse and neglect reporting laws. For example, if we have a reasonable suspicion of child abuse or neglect.
9. If disclosure is mandated by federal, state or local elder/dependent adult abuse reporting laws. For example, if we have a reasonable suspicion of elder abuse or dependent adult abuse.
10. For emergency treatment, your consent isn't required if you need emergency treatment. In the event that we try to get your consent afterwards but you are unable to communicate with us (for example, if you are unconscious or in severe pain), but we think that you would consent to such treatment if you could, we may disclose your PHI.
11. We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
12. For health oversight reasons, we may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
13. For specific governmental purposes, we may disclose PHI of military personnel and veterans under certain circumstances. Also, we may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
14. For research purposes, we may provide PHI without releasing confidential material disclosing only identities in order to conduct or support medical research.
15. For workers' compensation purposes, we may provide PHI in order to comply with workers' compensation laws.
16. We may use PHI to provide appointment reminders. We may use PHI to give you information about alternative treatment options, or other health care services or benefits we offer.
17. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
18. We are permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.
19. For treatment, healthcare operations or to obtain payment for treatment, photographs, videotapes, digital or other images may be recorded to document our care or identify you. We will retain the ownership rights to these photographs, videotapes, digital, or other images, but you will be allowed access to view them or obtain copies pursuant to this Notice. These images will be stored in a secure manner that will protect your privacy and that they will be kept for the time period required by law or outlined in our policy. Images that identify you will be released and/or used outside our practice only upon written authorization from you or your legal representative or in accordance with other section of this policy.
20. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess our compliance with HIPAA regulations.
21. If disclosure is otherwise specifically required by law.

Certain uses and disclosures require you to have the opportunity to object.
Disclosures to family, friends, or others: we may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

Other uses and disclosures require your prior written authorization.
In any other situation not described in earlier sections, we will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures of your PHI by us.

What Rights You Have Regarding Your PHI

The Right to See and get Copies of Your PHI
In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. If we do not have your PHI, but we know who does, we will advise you how you can get it. You will receive a response from us within 30 days of our receiving your written request. Under certain

NeuroMuscular
MEDICAL ASSOCIATES

circumstances, we may feel we must deny your request, but if we do, we will give you the reasons for the denial. If you ask for copies of your PHI, we will charge you a reasonable fee for copies as established by professional, state or federal guidelines. We may see fit to provide you instead with a summary or explanation of the PHI, if clinically appropriate.

The Right to Request Limits on Uses and Disclosures of Your PHI
You have the right to ask that we limit how we use and disclose your PHI. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.

The Right to Choose How We Send Your PHI to You
It is your right to ask that your PHI be sent to you at an alternate address such as, sending information to your work address rather than your home address. We are obliged to agree to your request providing that we can give you the PHI, in the format you requested, without undue inconvenience.

The Right to Get a List of the Disclosures We Have Made
You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years for adults or until one year after a child client turns 21 years old.

We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no cost, unless you make more than one request in the same year, in which case we will charge you a reasonable sum based on a set fee for each additional request.

The Right to Amend Your PHI
If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that we correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of our receipt of your request. We may deny your request, in writing, if we find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by someone other than us. Our denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and our denial be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI.

How to Complain About My Privacy Practices
If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint with our Privacy Officer listed below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about our privacy practices, we will take no retaliatory action against you.

Person to Contact for Information About This Notice or to Complain About My Privacy Practices

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact our Office Privacy Officer, at:

Privacy Officer
3001 19th Street
Metairie, LA 70002
(504) 469-9641

Effective Date of This Notice: This notice went into effect on June 10, 2002 and has been revised effective Febuary 6 2019

NeuroMuscular
MEDICAL ASSOCIATES

AUTHORIZATION TO VIEW RX HISTORY FROM EXTERNAL SOURCE

Name: _____ DOB: _____

I authorize Neuromuscular Medical Associates, LLC to view any and all available Rx History from an External Source for the above patient. I am aware that Neuromuscular Medical Associates, LLC uses a secure connection to SureScripts to send and receive prescriptions in the office. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by the providers and staff at Neuromuscular Medical Associates, LLC and this information may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____

Signature of Patient Date

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that under the Health Insurance Portability & Accountability Act of 1996, as amended (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I have been informed by you of your HIPAA Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that for treatment, healthcare operations or to obtain payment for treatment, photographs, videotapes, digital or other images may be recorded to document my care or identify me, and I consent to this. I acknowledge receipt of the HIPAA Notice of Privacy Policy and have had the right to review such HIPAA Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its HIPAA Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the HIPAA Notice to Privacy Practices.

Individuals I would like PHI released to:

_____

I understand that I may revoke this consent in writing at any time except to the extent you have taken action relying on this consent.

_____

Patient's Name (Print) Date

_____

Patient's Signature Date Rev 8/2023//db.

18212 E. Petroleum Dr. Bldg 6A Baton Rouge, Louisiana 70809 P: 225 224 8096 F: 225 408 3741
42078 Veteran Avenue, Suite G Hammond, Louisiana 70403 P: 985 542 7177 F: 985 340 7078
3001 19th Street Metairie, Louisiana 70002 P: 504 469 9641 F: 504 469 9642

NMA
NeuroMuscular
MEDICAL ASSOCIATES

Fred R. DeFrancesch, M.D.
Physical Medicine and Rehabilitation
Pain Medicine

NO SHOW / CANCEL POLICY

Procedure Policy:

Procedure appointments require us to block a large time slot to service you. We need at least 24 hours notification to attempt to fill the empty time slot.

Any no-shows or cancellations less than 24 hours from your procedure appointment time will be charged $100.00 fee.

If notice is not given within 24 hours, payment of $100.00 will be required before your next appointment can be scheduled.

I understand the importance of the above information and policy.

Patient's Name

Patient or Guardian's signature

Date

18212 E. Petroleum Dr., Bldg 6A
Baton Rouge, LA 70809
Tele 225.224.8096
Fax 225.408.3741

42078 Veterans Ave., Ste. G
Hammond, LA 70403
985.542.7177
985.340.7078

3001 19th Street
Metairie, LA 70002
504.469.9641
504.469.9642

NAME: _____ DATE: _____

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (LAST, FIRST, MIDDLE)	DOB:
ADDRESS	SSN:

CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE PHI:	ENTITY RECEIVING (REQUESTING) PHI:
	NeuroMuscular Medical Associates Fred DeFrancesch MD Robert Nicholson MD William H Lee MD ☐ 42078 Veterans Avenue Ste G Hammond LA 70403 ☐ 18212 E Petroleum Dr Bldg 6 Baton Rouge LA 70809 ☐ 3001 19th Street Metairie LA 70002 FAX: 985.340.7078 *P: 985.542.7177 225.224.8096 504.469.9641*

This authorization will expire on the follow date or even. If date or event is not indicated, authorization will expire 12 months from date signed:

Date: Event:

Purpose of this Disclosure: TREATMENT

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
☐ All PHI in the Record		
☐ Progress Notes		
☐ Laboratory Tests		
☐ Xray / US / CT / MRI Report		
☐ History and Physical Examination		
☐ Discharge Summary		
☐ Consultation Reports		
☐ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

☐ AIDS OR HIV TEST RESULTS
☐ Alcohol, drug or substance abuse treatment
☐ Psychiatric or mental care / treatment
☐ Other (specify):

I UNDERSTAND THAT:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

Signature of Patient:	Date:
Signature of Patient's Representative (If necessary):	Date:
Personal Representative's relationship to patient:	