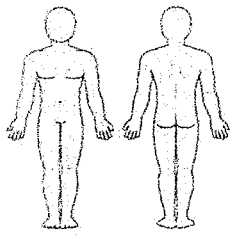
DOCTORS
FLYNN · MANCEAUX · ARCEMENT · PIZZOLATO
CHIROPRACTIC & PHYSICAL THERAPY CLINIC, INC.

Patient Last_____ First_____ Middle_____
Home Phone_____ Cell_____ Circle: Male/Female
Mailing Address _____ City_____ State_____ Zip_____
S.S. #_____ Birthday _____Age_____
Circle One: Minor Single Married Divorced Widowed Separated
Patient's or Parent's Employer _____Occupation _____
Business Address _____Phone #_____
Name of Spouse _____DOB _____
Spouse's Employer _____Phone #_____
Emergency Contact_____ Personal Email_____
Who is responsible for this account? _____
Whom may we thank for referring you? _____
Female: Are you pregnant? □ Yes □ No
Reason for Visit _____
When did your symptoms appear? _____
Is this condition progressively getting worse? Yes_____ No_____ Unknown _____
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning
□ Tingling □ Cramps □ Stiffness □ Swelling □ Other
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation
Activities or movements that are painful to perform
□ Sitting □ Standing □ Walking □ Bending □ Lying down
What other health care have you received for this problem? □ Medication □ Surgery □Physical Therapy
□ Chiropractic Services □ None □ Other_____
Other doctor(s) who have treated you for this condition_____

Please place an X on the picture where you
Continue to have pain, numbness or tingling:



Is this condition due to an accident? □ Yes □ No Date: _____
Type of accident: □ Auto □ Work □ Home □ Sports □ Other
To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Workers Comp. □ Other
Attorney name (if applicable) _____
Have you lost time from work? _____ Dates _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. This consent will end when my current treatment plan is complete or five years from the date signed below.

Signature _____ **Date**_____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Rays _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had or currently have any of the following:

AIDS/HIV	□ Yes □ No	Goiter	□ Yes □ No	Parkinson's disease	□ Yes □ No
Alcoholism	□ Yes □ No	Gonorrhea	□ Yes □ No	Pinched Nerve	□ Yes □ No
Allergy Shots	□ Yes □ No	Gout	□ Yes □ No	Pneumonia	□ Yes □ No
Anemia	□ Yes □ No	Heart Disease	□ Yes □ No	Polio	□ Yes □ No
Anorexia	□ Yes □ No	Hepatitis	□ Yes □ No	Prostate Problem	□ Yes □ No
Appendicitis	□ Yes □ No	Hernia	□ Yes □ No	Prosthesis	□ Yes □ No
Arthritis	□ Yes □ No	Herniated Disc	□ Yes □ No	Psychiatric Care	□ Yes □ No
Asthma	□ Yes □ No	Herpes	□ Yes □ No	Rheumatoid Arthrosis	□ Yes □ No
Bleeding Disorder	□ Yes □ No	High Blood Pressure	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Breast Lump	□ Yes □ No	High Cholesterol	□ Yes □ No	Scarlet Fever	□ Yes □ No
Bronchitis	□ Yes □ No	Kidney Disease	□ Yes □ No	STD	□ Yes □ No
Bulimia	□ Yes □ No	Liver Disease	□ Yes □ No	Stroke	□ Yes □ No
Cancer	□ Yes □ No	Measles	□ Yes □ No	Suicide Attempt	□ Yes □ No
Cataracts	□ Yes □ No	Migraine Headaches	□ Yes □ No	Thyroid Problems	□ Yes □ No
Chemical Dependency	□ Yes □ No	Miscarriage	□ Yes □ No	Tonsillitis	□ Yes □ No
Chicken Pox	□ Yes □ No	Mononucleosis	□ Yes □ No	Tuberculosis	□ Yes □ No
Diabetes	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Tumors, Growth	□ Yes □ No
Emphysema	□ Yes □ No	Mumps	□ Yes □ No	Typhoid Fever	□ Yes □ No
Epilepsy	□ Yes □ No	Osteoporosis	□ Yes □ No	Ulcers	□ Yes □ No
Fracture	□ Yes □ No	Pacemaker	□ Yes □ No	Vaginal Infections	□ Yes □ No
Glaucoma	□ Yes □ No			Whooping Cough	□ Yes □ No

Other _____
_____

Exercise
□ None
□ Moderate
□ Daily
□ Heavy

Work Activity
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

Habits
□ Smoking — Packs/Day _____
□ Alcohol — Drinks/ Week _____
□ Coffee/ Caffeine Drinks — Cups/Day _____
□ High Stress Level — Reason _____

Are you pregnant? □ Yes □ No Due Date _____

Injuries/Surgeries you have had	**Description**	**Date**
Falls		
Head/ Injuries Falls		
Broken Bones		
Dislocations		
Surgeries		

Medications	**Allergies**	**Vitamins/Herbs/Minerals**
Pharmacy Name _____		
Pharmacy Phone (___) _____		

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Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgement to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgement. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I about to receive.

I have read or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

_____	_____	_____
Patient's Name (Print)	Patient's Signature	Date

_____	_____
Relationship or authority if not signed by patient	Witness

6902 West Main Street Houma, Louisiana 70360-2897 • Telephone (985) 868-3136 • Fax (985) 868-4040
970 South Acadia Road • Thibodaux, Louisiana 70301Telephone (985) 446-2403 • Fax (985) 446-9954

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INSURANCE

We welcome you as a new patient and want you to be clear on your financial responsibility for care at our clinic.

If you have health insurance, we will call and verify your coverage. This will be explained to you and the terms of your coverage will be in your chart. You will be responsible for any non-covered expenses such as ice packs, vitamins, back braces, pillows, etc. You are also responsible for any and all costs associated with your deductible and co-payments. You can pay this on each visit or on a monthly basis.

Patient signature required: I have read the above and understand and agree that I am responsible for any and all charges that are not reimbursed by my health insurance.

For questions, please contact the billing office.

Patient's Name (Print)	Patient's Signature	Date

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Acknowledgement or Receipt of Notice or Privacy Practices

This form will be retained in your medical record

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice or Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ Date of Birth:_____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of

DRS. FLYNN-MANCEAUX-ARCEMENT-PIZZOLATO-THOMPSON

I understand that the Notice describes the uses and disclosures of my protected health information by FMAP and informs me of my rights with respect to my health information.

_____

Patient's Signature or that of Legal Representative ●Printed Name or that of Legal Representative

_____

Today's Date If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgment
- ☐ Communications barriers prohitibted obtaining the acknowledgement
- ☐ Other (please specify): _____

Employee Name_____Today's Date_____

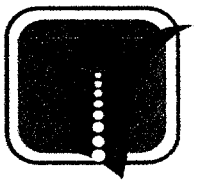
IMPORTANT NOTICE

As a courtesy, this office will provide you with your insurance benefits and will file all insurance claims. Please note that you will either have a copay or will be required to pay towards your deductible at each visit. If your deductible has been met, most insurance companies will cover a percentage of treatment billed. Once you have met your out of pocket maximum, most insurance companies will cover one hundred percent or all eligible expenses for the remainder of the calendar year. At the beginning of each month, statements are mailed and at times insurance claims are still pending. If there is a question about your personal balance, please feel free to contact our insurance department at your convenience at 985-868-3136. Please note that this may be done by telephone, or feel free to do this at this time of one of your therapy sessions.

Please sign and date this letter stating hat you are aware of your insurance benefits and that you know that you will be required to pay all co-pays, unmet individual deductibles and out of pocket maximums at the time that services are rendered.

Patient Signature:_____

Date:_____



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SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice or Privacy Practices. Our full length Notice is available upon requests.

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the Notice of Privacy Practices):

For medical treatment
To obtain payment for our services
In emergency situations
For appointment and patient recall reminders
To run our Practice more efficiently and ensure all our patients received quality care
For research
To advert a serious threat to health or safety
For organ and tissue donation
For workers' compensation programs
In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

The right to inspect and copy
The right to request restrictions
The right to amend
The right to a paper copy of this notice
The right to an accounting of disclosures
The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that is available upon request.