GLOBAL MEDICAL CENTER
REGENERATIVE MEDICINE OF LOUISIANA

Dr. Dennis Peyroux, DC
Dr. Kyle Smith, DC
Donna Turgeau, FNP-C

Today's Date: _____/_____/_____

Name: _____ Age_____ Date of Birth_____

Local Address_____ City_____ State____ Zip_____

Out of Town Address_____ City_____ State____ Zip_____

Marital Status_____ Sex_____ S.S.# _____ Home Phone _____ Cell. Phone_____

Email Address: _____ Employer _____

Occupation _____ Address/Phone _____ Spouse _____

Emergency Contact_____Phone_____Relationship_____

How did you hear about our office?

☐ Yellow Pages ☐ Drive By ☐ Walk-In ☐ Internet ☐ Referral (Please tell us who) _____ ☐ Other: _____

Health Insurance Information

Primary Insurance _____ Policy Holder's Name _____ DOB _____

Policy Holder's Relationship to Patient _____ Policy Holder's Employer _____

Accident Information (SKIP this section if you were not involved in an accident)

Is your condition due to an: ☐ ***Auto Injury*** ☐ ***Work Injury*** ☐ ***Slip and Fall*** ☐ ***Other Accident (describe below)***

Date of Accident_____ Place (City/State) _____

Auto/Work Insurance Company_____ Insured's Name and DOB_____

If Auto Injury, have you reported the accident to your insurance company? ☐ No ☐ Yes Claim #_____

If Work Injury, have you reported the accident to your supervisor/boss? ☐ No ☐ Yes Claim #_____

If Slip and Fall or Other Type of Injury, please describe: _____

*Do you have an **Attorney** for your Auto or Work Comp. injury* ☐ Yes ☐ No?

Please provide Attorney Name, address and phone # _____

Current complaint

I. Please list your **worst** complaint: _____ How long have you had it: _____

How did it start: _____ ***A) Is it*** ☐ *Improving* ☐ *Worsening* ☐ *Staying the Same* ***B) Is it:*** ☐ *Mild* ☐ *Moderate*

☐ *Severe* ***C) What worsens it:*** ☐ *General activity* ☐ *Moving wrong* ☐ *Bending* ☐ *Lifting* ☐ *Walking* ☐ *Sports* ☐ *Getting up from a chair*

☐ *Using a computer/desk work* ☐ *Other:*_____ ***D) What makes it better:*** ☐ *Rest* ☐ *General activity* ☐ *Ice packs*

☐ *Heating pad* ☐ *OTC Meds* ☐ *RX Meds* ☐ *Massage* ☐ *Chiropractic* ☐ *Other:*_____ ***E) Is it worse in the:*** ☐ *AM* ☐ *PM*

☐ *After the day wears on* ☐ *Steady* ☐ *Off and on* ***F) Is the symptom:*** ☐ *Dull and Achy* ☐ *Tight and stiff* ☐ *Sharp and stabbing*

☐ *Numb and tingly* ☐ *Shooting* ☐ *Burning* ☐ *Cramping*

II. Please list your **2nd worst** complaint: _____ How long have you had it: _____

How did it start: _____ ***A) Is it*** ☐ *Improving* ☐ *Worsening* ☐ *Staying the Same* ***B) Is it:*** ☐ *Mild* ☐ *Moderate*

☐ *Severe* ***C) What worsens it:*** ☐ *General activity* ☐ *Moving wrong* ☐ *Bending* ☐ *Lifting* ☐ *Walking* ☐ *Sports* ☐ *Getting up from a chair*

☐ *Using a computer/desk work* ☐ *Other:*_____ ***D) What makes it better:*** ☐ *Rest* ☐ *General activity* ☐ *Ice packs*

☐ *Heating pad* ☐ *OTC Meds* ☐ *RX Meds* ☐ *Massage* ☐ *Chiropractic* ☐ *Other:*_____ ***E) Is it worse in the:*** ☐ *AM* ☐ *PM*

☐ *After the day wears on* ☐ *Steady* ☐ *Off and on* ***F) Is the symptom:*** ☐ *Dull and Achy* ☐ *Tight and stiff* ☐ *Sharp and stabbing*

☐ *Numb and tingly* ☐ *Shooting* ☐ *Burning* ☐ *Cramping*

MEDICARE PATIENTS (check one): Would you like to be able to ☐ *Bend and lift with no pain* ☐ *Get up from sitting with no pain* ☐ *Get a good night's sleep with no pain* ☐ *Read with no pain* ☐ *Work at a computer with no pain* ☐ *Do your housework with no pain* ☐ *Do your yard work with no pain* ☐ *Play sporting activities with no pain*

CURRENT HEALTH

- Name and phone number of family doctor: _____
- **CHIEF COMPLAINT** (Why are you here to see the doctor): _____

MEDICAL HISTORY

Please indicate whether you have had or currently have any of the following illnesses.

☐ Heart Disease	☐ Chronic Lung Disease	☐ Diabetes	☐ Cancer
☐ High Blood Pressure	☐ Eye Disease	☐ Hepatitis	☐ Asthma
☐ Stomach Problems	☐ Kidney Problems	☐ Bleeding Problems	☐ Anemia
☐ Excessive Scarring	☐ Other	Please Explain: _____	

_____

Current or previous serious illnesses or injuries: _____

Previous surgeries: _____

Epidural: ☐ Yes ☐ No Date: _____

MEDICATIONS

MEDICATION	DOSAGE	QTY	FREQ	MEDICATION	DOSAGE	QTY	FREQ
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

- Please list any medications you are allergic to: _____
- Please indicate your height and weight _____What is your usual blood pressure_____/_____

Any current loss of bowel or bladder control: ☐ Yes ☐ No Any current seizures, paralysis, speech, vision problems: ☐ Yes ☐ No

Any unexplained recent weight loss: ☐ Yes ☐ No Current fever: ☐ Yes ☐ No Current nutritional problems: ☐ Yes ☐ No

- Have you had spinal X-Rays within the past 5 years? If yes, when and where _____
- **Do you have a pacemaker? ☐ Yes ☐ No If yes, please ALERT our doctor and/or assistant**
- Do you have any blood/lymph disorders? ☐ Yes ☐ No If yes, please list _____
- Do you have osteoporosis or rheumatoid arthritis? ☐ Yes ☐ No
- Please list any other electrical device that you currently wear_____
- Please select one: ☐ I have never smoked ☐ Former smoker ☐ Current smoker, if so how much: ____ pk./day ____ pk./wk.
- Please select one: ☐ I don't drink alcohol ☐ Rarely drink ☐ Social drinker ☐ Heavy drinker (_____ oz. per day/week)
- Have you ever had chiropractic care ☐ Yes ☐ No If yes, last date of treatment_____ By whom: _____

Similar or difference condition: _____ Results: _____

What are your overall expectations from your treatment with our doctor: _____

_____

FAMILY HISTORY

	MOTHER:	FATHER:	SIBLING:	GRANDPARENT:	CHILDREN:
Arthritis					
Cancer					
Diabetes					
Heart Problems					
High Blood Pressure					
High Cholesterol					
Stroke					
Thyroid Problems					
Obesity					
Liver Problems					
Kidney Problems					
Depression/Anxiety					
Blood Disorders					

- ***WOMEN ONLY*** *I hereby declare that to the best of my knowledge* ☐ ***I am*** ☐ ***I am not pregnant****. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.*

I, the undersigned, voluntarily give my consent for to receive medical and health care services by the doctor and/or nurse practitioner to examine and treat my condition as he/she deems appropriate through the use of chiropractic care and/or medical care. I also give my consent for the doctor to take x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate.

Patient Signature_____

(Parent/Guardian signature if under 18 years of age)

NOTICE OF PRIVACY PRACTICES

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We use your Patient Health Information We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and *administrative proceedings:* We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials. *Deaths:* We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes. *Workers Compensation:* We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights. *Request Restrictions:* You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices We may change our policies at any time.
Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:
Global Medical Center
436 Old Spanish Trail
Slidell, LA 70458
(985) 641-4898

Effective Date: April 14, 2003

I,

_____

hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:

_____

Date:

_____

If not signed, reason why acknowledgement was not obtained:

GLOBAL MEDICAL CENTER
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Dr. Kyle Smith, DC
Donna Turgeau, FNP-C

GENERAL/FINANCIAL POLICY

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current. All self-pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, American Express or Care Credit.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. **We must emphasize that as medical providers, our relationship is with you, not your insurance company.** Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below, you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- If you are a **MEDICARE PATIENT**, please be advised that Medicare **only covers** Spinal Adjustments in a Chiropractor's office. All services outside of the Spinal Adjustment in our office will be your financial responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **WE ARE HERE TO HELP YOU.**

I understand that I will be solely responsible for payment of services rendered by Dr. Dennis Peyroux, DC, Dr. Kyle Smith, DC, Dr. Michael Isabelle, MD and Lauren Born, FNP-C that are NOT reimbursed by insurance and for services that the office does not provide or fill out forms for insurance purposes.

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

_____ _____ _____
Printed Name Signature of Patient/Legal Guardian Date

CONSENT TO RELEASE INFORMATION: In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below, I hereby give my consent for Global Medical Center, LLC to release my medical records to:

_____ _____ _____
Name of Family Member/Friend Signature of Patient/Parent/Legal guardian Date

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for Dr. Peyroux, Dr. Smith, Dr. Isabelle and L. Born, FNP-C to examine, and if needed, treat my minor child _____.
Print child's name here

_____ _____ _____
Printed Name Signature of Patient/Legal Guardian Date