Riverbend Family Chiropractic

1972 Ormond Blvd., Suites A-C Destrehan, LA 70047
Ph 985.307.0977 Fax 985.307.0984

Personal Information:

Date _____
Patient Name _____Home Phone_____ Cell Phone _____E-Mail_____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Age _____ Social Security # _____
Driver's License # _____ Sex M / F (Circle One) Single Married Widowed Separated Divorced
Employer _____ Occupation _____
Employer Address _____ Work Phone _____
Level of Education _____ Name and age of children__ _____
Emergency contact name & number _____ Relationship _____
Who can we thank for referring you? _____ Phone Number _____

Have you had previous chiropractic care? (Check one) ☐Yes ☐ No If yes, please list who, where and when
_____

Who is responsible for your bill? (Check one)

☐ You and/or spouse ☐ Insurance ☐ Medicare ☐ Worker's Compensation ☐ Auto Insurance

Spouse information:

Spouse name _____ Date of Birth _____ Social Security # _____
Employer _____ Occupation _____
Employer Address _____ Work Phone _____

Current Health Conditions:

Please describe the principle health concern for which you came to this office
_____
_____

Is this condition related to an accident or injury? (Check one) ☐Yes ☐ No Please explain
_____
_____

When did symptoms appear? _____ Is your condition getting worse? (Check one) ☐Yes ☐ No

Have you been treated for this condition before today? (Check one) ☐Yes ☐ No
Please explain. (List who treated you, their diagnosis and treatment you received)
_____
_____

Please list **current medications**:
_____

Please list any **allergies** and the **symptoms** of a reaction (please include foods, latex and medications):_____
_____

Please list all prior illnesses and injuries you have sustained _____
_____

Have you received any surgeries? If so please describe the type of surgery, date, reason, result and current status:
_____

Tobacco, Alcohol & Other Substance Use:

Have you used __ cigarettes ___ cigars ___ pipe __ chewing tobacco __ snuff (check all that apply)
How much do / did you use per day? ____ Number of years? ____ Are you still using? Y / N If No When did you stop? _____
Have you been exposed to secondhand smoke at home or work? Y / N
Has alcohol ever interfered with your personal/ professional life? _____
Did you, or do you, use marijuana, cocaine, heroin or other illegal substances? _____

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Family History:

Please include only blood relatives do not include adopted, foster or step family members. Please list current age or age at time of death. (Heath condition examples cancer, cardiovascular disease, kidney failure, and diabetes)

Relative	Age	Alive		List of Health Conditions
Mother		Y	N	
Father				
Brother				
Brother				
Sister				
Sister				
Grandparent				
Grandparent				
Grandparent				
Grandparent				

Systems Review:

Please check "Yes" or "No" box to indicate if you have any of the following symptoms.

	Yes	No		Yes	No
General			***Musculoskeletal***		
Fevers			Joint Pain		
Night Sweats			Joint Swelling		
Chills			Injuries or Joint Fractures		
Recent Weight Change			Back Pain		
If yes, _____lbs.			Neck Pain		
Eyes			***Skin***		
Eye disease or injury			Hives		
Do you wear glasses or contacts			Eczema		
Change in vision			Rash		
Ears, Nose & Throat			Abnormal pigmentation		
Change in hearing			***Neurological***		
Voice change			Fainting spells		
Sore throat			Convulsions		
Repiratory			Paralysis		
Shortness of breath			Headaches		
Cough			***Psychiatric***		
Wheezing			Depression		
Cardiovascular			Anxiety		
Chest Pain			Memory Loss or Confusion		
Shortness of breath while walking or lying down			Insomnia		
Difficulty walking two blocks			Endocrine		
Swelling of hands, feet or ankles			Excessive thirst		
Heart Murmur			Intolerance to heat / cold		
Irregualr heart beat			***Hematologic***		
Gastrointestional			Anemia		
Bleeding with bowel movements			Have you had abnormal bruising or bleeding		
Black stool			Swollen glands		
Recent change in bowel habits			Immunology / Allergy		
Frequent diarrhea			Allergies to animals or plants		
Heartburn or indigestion			Runny nose		
Constipation			Itchy Eyes		
Genitourinary					
Frequent urination					
Night time urination					
Buring or painful urination					
Blood in urine					
Sexual Difficulty					
Incontinence					

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Insurance disclaimer – Verification of benefits is not a guarantee of payment. Benefits and payments are not determined until claim is received.

I, the undersigned (or my dependent) has insurance with _____ and assign directly to Dr. Adam Roussel all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Roussel to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Roussel or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

MEDICARE PATIENTS:

MEDICARE will only pay 80% of the allowed cost of your chiropractic adjustments, **if** the adjustments are within the number allowed for your condition and **not** deemed maintenance care. Secondary insurance will only cover services the primary insurance will cover. Any Exams, X Rays or Therapy/Modality services will be the responsibility of the patient.

Patient's Signature _____ Date_____

(This section intentionally left blank)

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Oswestry Index Questionnaire

This questionnaire is designed to help us better understand how your pain affects your ability to manage everyday – life activities. Please mark each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present – day situation.

Patients Name_____ Date _____ Score_____

Section 1 – Pain Intensity

- My pain is mild to moderate. I do not need pain killers.
- The pain is bad, but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers have no effect on the pain.

Section 2 – Personal Care

- I can look after myself normally without causing extra pain
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself, and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help most days in most aspects of self – care.
- I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting

- I can lift heavy weights without causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking

- I can walk as far as I wish.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can walk only if I use a cane or crutches.
- I am in bed or in a chair for most of every day.

Section 5 – Sitting

- I can sit in any chair for as long as I like.
- I can sit in my favorite chair only, but for as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want, but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing more than ½ hour.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- Pain does not prevent me from sleeping well.
- I sleep well but only when taking medications.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

Section 8 - Social Life

- Social life is normal and causes me no extra pain.
- Social life is normal, but increases the degree of pain.
- Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, ect.
- Pain has restricted my social life, and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

Section 9 – Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.

Section 10 – Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere, but it gives me extra pain.
- Pain is bad, but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to necessary journeys under ½ hour.
- Pain prevents traveling except to the doctor / hospital .

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	*palpation*	*vital signs*
range of motion testing	*orthopedic testing*	*basic neurological testing*
muscle strength testing	*postural analysis EMS*	*intersegmental traction*
ultrasound	*hot/cold therapy*	*neuro re-education/massage chair*
radiographic studies	*ION cleanse*	*laser treatment*

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the next have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustment. The other complications are also generally described as rare.

Your odds of an adverse effects are less than the odds of you being struck by lightning

The availability and nature of other treatment options.

Other treatment options for your condition may include: Self-administered, over-the-counter analgesics and rest. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers. Hospitalization and/or surgery.

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Roussel and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____	_____	_____
Sign	Print	Date

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NOTICE OF PRIVACY PRACTICES SUMMARY

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy practices.

Uses and Disclosure of Health Information

We use health information about you for treatment, to obtain payment information for treatment, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you chose to sign an authorization to disclose information, you can later revoke that authorization to stop any further uses and disclosures.

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 in 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.

Your Rights

Although your health record is the physical property of the healthcare practitioner/facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of privacy upon request
- Inspect and obtain a copy of your health record as provided in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain and accounting of disclosures of your health as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to 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 can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact: Riverbend Family Chiropractic Office Administrator, 1972 Ormond Blvd., Suites A-C, Destrehan, LA 70047 or phone 985.307.0977.

WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

_____ _____
Signature of Patient or Legal Representative Witness

_____ _____
Date Date

I have been offered / given a copy of the HIPPA information.
Signature:_____ Date:_____

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Authority to Release Medical Reports and Information

Re: _____ (patient's name)

To: Medical and Benefit Providers

Date: _____

I, _____, hereby authorize you or any member or employee of your office or association, as well as any hospital in which I have been a patient, to release complete and legible copies of any and all information concerning my physical or psychiatric condition, both past and present to:

Riverbend Family Chiropractic
Dr. Adam Roussel
1972 Ormond Blvd., Suites A-C Destrehan, LA 70047
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or their duly authorized agents.

This authorization to release written or verbal information includes, but is not limited to medical reports, clinical notes, nurse's notes, patient's history of injury, subjective and objective complaints, x-rays, test results, interpretation of x-rays or other tests (including a copy of the report), diagnosis and prognosis: if applicable, any hospital operational logs, emergency logs, tissue committee reports, psychiatric reports and records, physical therapy records, all out-patient records, hospital bills, bills for services you have rendered, payments received, statements of earnings and benefits, and any other relevant and material information in your possession.

I hereby expressly waive any laws, regulations and rules of ethics which might prevent any hospital, doctor or other person who has treated or provided benefits in a professional capacity or otherwise from releasing said information.

A photostatic copy of this authorization, which contains my signature, shall be considered as effective as the original and shall be honored by those to whom it is sent or provided.

_____
Signature

_____
Date of Birth

_____
Social Security #

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LETTER OF PROTECTION
And
FINANCIAL AGREEMENT

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I authorize Dr. Adam Roussel to furnish my attorney/and or insurance company with a full report of their examination, diagnosis, etc., regarding the accident in which I was involved.

I further authorize and direct my attorney/and or insurance company to pay directly to Dr. Adam Roussel, such sums I now or hereafter owe then out of the proceeds of any settlement, judgment, or verdict of my case, or payment from an insurance company obligated to reimburse me for charges made for their services. Further give a lien on my case to Dr. Roussel against any and all proceeds of any settlement, judgment or verdict for treatment from injuries in connection therewith.

I understand that I am directly and fully responsible to Dr. Roussel for all professional bills submitted by them for services rendered to me and that this agreement is made solely for their additional protection. I also understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover, and that this corporation's agreement to wait of my charges is given in exchange for my agreement to give up or waive the right to demand an offset for attorney's fee and costs expended in obtaining a recovery.

In the event that settlement, judgment or verdicts are insufficient to make full payment for my medical costs, **I agree that Dr. Roussel is under no obligation to reduce their charges**. I further acknowledge that any insufficient or payment from the settlement, judgment or verdict will be paid by the undersigned personally so that the total amount due for medical bills and costs is paid in full.

I also understand that I may be responsible for interest, up to 18%, on my account(s) on balances that are outstanding when the case settles.

If Applicable:

Interest begins _____ 20__ Interest Rate _____%

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_____ _____ _____
Sign Print Date

RELEASE PERMISSION FORM

I, the undersigned, do hereby give my permission for Riverbend Family Chiropractic to display my photo, x-ray images, and any written comments for educational purposes.

Patient Name: _____

Patient Signature: _____

Date: _____