MOSS BLUFF
PHYSICAL THERAPY

867 Sam Houston Jones Pkwy. 337-855-2600
Lake Charles, LA 70611 Fax: 337-855-0015

Patient Information

First Name: _____ MI:_____ Last Name:_____
Date of Birth:_____ SS#_____-_____-_____ Sex: Male _____ Female_____
Address:_____ City:_____ State:___ Zip:_____
Home#:_____ Cell#:_____ Work#:_____
Patient Employment Status: ____Employed _____Unemployed _____Retired _____ Student
Employer:_____ Employer phone number:_____
Spouse's Name:_____ Spouse's Contact number:_____
Emergency Contact: Name:_____ Number:_____ Relation:_____
Referring Physician:_____ Primary Physician:_____

Are you receiving Home Health?____Yes ____No Last visit with Home Health?_____
Have you ever had physical therapy for this condition before? _____Yes _____No

Did you sustain this injury at work?___Yes ___No
If Yes,have you filed a claim with employer?___Yes ___No

INSURANCE/ ATTORNEY INFORMATION

Please provide the following information on who is insured or responsible for services.

Primary Insurance:
Name of Insurance:_____ Policy Number:_____ Group#:_____
Policy Holder Name: _____ DOB:_____ Relationship to Patient:_____

Secondary Insurance:
Name of Insurance:_____ Policy Number:_____ Group#:_____
Policy holder Name: _____ DOB:_____ Relationship to Patient:_____

Attorney:
Name of Firm:_____ Attorney's Name:_____
Point of Contact:_____ Phone Number:_____

Worker's Compensation/Liability Company:
Name of Company:_____ Adjustor's Name:_____
Claim#:_____ Phone Number:_____

Medical History

Height:_____ Weight:_____ Body site of injury: _____
Date Condition began:_____ Date of Surgery: _____ Type of Surgery:_____
Are you currently working:_____Yes _____No Please give occupation and describe work activities:_____
Have you had X-Rays? _____Yes _____No If yes, when? _____
Have you had an MRI? _____Yes _____No If yes, when? _____
Have you had any other test performed due to this condition? _____Yes _____No
If yes, please state the test and date performed?_____

Pain Scale:
Please rate your pain for last 24 hours with the scale below:

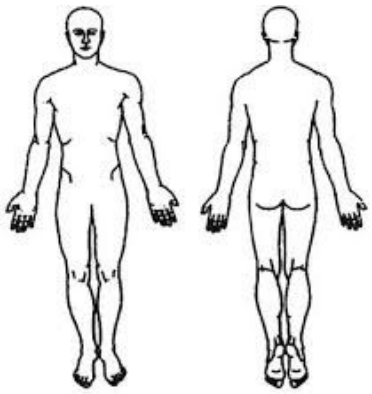
Best ___ / Worst ___/ Current ___

0 1 2 3 4 5 6 7 8 9 10
| |--------| |---------| |------------|
None Mild Moderate Severe

What positions make your pain better or worse?
_____

Which of these words best describes your pain:
___ACHING ___SHARP ___BURNING ___TINGLING ___DEEP ___STIFF

Please indicate areas of pain:



Medical Conditions:
(Please circle yes or no)

Anemia	YES	NO		Leg Injury/Surgery	YES	NO
Arthritis	YES	NO		Neck Injury/Surgery	YES	NO
Asthma / Emphysema	YES	NO		Osteoporosis	YES	NO
Back Injury/Surgery	YES	NO		Pacemaker	YES	NO
Blood Clot	YES	NO		Pins or Metal Implants	YES	NO
Cancer/Chemotherapy	YES	NO		Pregnant	YES	NO
Coronary Heart Disease	YES	NO		Respiratory Problems	YES	NO
Diabetes	YES	NO		Rheumatoid Arthritis	YES	NO
Dizziness/ Vertigo	YES	NO		Seizures	YES	NO
Elbow/Hand Injury	YES	NO		Shoulder Injury/Surgery	YES	NO
Heart Attack/Surgery	YES	NO		Shortness of Breath or chest pains	YES	NO
Hernia	YES	NO		Smoker	YES	NO
High Blood Pressure	YES	NO		Stroke----Year:	YES	NO
Hip Injury/Surgery	YES	NO		Urinary Incontinence	YES	NO
History of Falls	YES	NO		Varicose Veins	YES	NO
Infectious Disease	YES	NO		Vision or Hearing Problems	YES	NO

Please list any previous surgeries and the year they were performed:

Surgery	Date or Year

Please list ALL CURRENT MEDICATIONS

Name of Medication	Dose of Medication (MG)	Frequency	Route of Administration

Please list any known allergies:_____

I,_____, authorize Moss Bluff Physical Therapy to provide physical, occupational, and speech therapy as needed. I authorize the release of all medical records to my insurance company, attorney, referring physician, rehab nurse or worker's compensation insurance. I understand that I am responsible to inform this office of any changes that occur. I authorize the rlease of payments for services rendered to be made directly to Moss Bluff Physical Therapy regardless of participation in or out-of network. I do hereby acknowledge my debt with Moss Bluff Physical Therapy and that I am ultimately responsible for that debt. Lastly, I declare that all the above medical information is true and correct to the best of my knowledge.

_____ _____

Signature of Patient or Guardian Date

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INOFRMATION. PLEASE REVIEW IT CAREFULLY.

Moss Bluff Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herin.

USES AND DISCLOSURES OF HEALTH INFORMATION

Moss Bluff Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrativen activities and evaluating the quality of care that we provide.

For example, Moss Bluff Physical Therapy may use your personal health information to contact you to provide appointment reminders, inforamtion about treatment alternatives or other health related benefits that could be of interest to you.

Moss Bluff Physical Therapy may also use or disclose your personal health information without prior authorization for auditing purposes and for emergencies. We also provide information when required by law.

In any other situation, Moss Bluff Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason you may later revoke that authorization to stop future disclosures at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review and obtain a copy of your personal health inforamtion at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Moss Bluff Physical Therapy will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Moss Bluff Physical Therapy may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact your practice manager at the information listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Moss Bluff Physical Therapy's Health Information Practices or if you have any further questions, please contact the following:

Moss Bluff Physical Therapy

337-855-2600

867 Sam Houston Jones Pkwy

Lake Charles, LA 70611

NOTICE OF INFORMATION DISCLOSURE CONSENT FORM

I have read and fully understand Moss Bluff Physical Therapy's Notice of Information Disclosure. I understand that Moss Bluff Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operation related to treatment and payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand Moss Bluff Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.I hereby consent to the use and disclosure of my personal health information for purposes as noted in Moss Bluff Physical Therapy's Notice of Information Disclosure. I understand that I retain the right to revoke this consent by notifying the practice in writing any time.

_____ _____

Patient's Name Date

_____ _____

Patient's Signature Signature of Patient Representative

_____

Relationship to Patient

WellRx Questionnaire

DOB_____ Male___ Female___

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

   ___ Yes ___No

2. Are you homeless or worried that you might be in the future?

   ___Yes ___No

3. Do you have trouble paying for your utilities (gas, electricity, phone)?

   ___Yes ___No

4. Do you have trouble finding or paying for a ride?

   ___Yes ___No

5. Do you need daycare, or better daycare, for your kids?

   ___Yes ___No

6. Are you unemployed or without regular income?

   ___Yes ___No

7. Do you need help finding a better job?

   ___Yes ___No

8. Do you need help getting more education?

   ___Yes ___No

9. Are you concerned about someone in your home using drugs or alcohol?

   ___Yes ___No

10. Do you feel unsafe in your daily life?

    ___Yes ___No

11. Is anyone in your home threatening or abusing you?

    ___Yes ___No