TODAY'S Date:
PT #

GULF COAST BRAIN SPORT & SPINE, LLC
DR. BEAU BAGLEY
1331 OCHSNER BLVD SUITE 100
COVINGTON, LA 70433
PHONE: 985-234-0490
FAX: 985-590-3787

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Address *(Street,City, State, Zip)*	**Phone:** **Cell:** **Home:**
Preferred Method of Contact:	**Email:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Primary Care: **Referred by:**	**Date of last physical exam:**

Emergency Contact #________________________________ Name & Relationship______________________________________

Pharmacy Location__________________________________ Pharmacy Phone Number___________________________________

PERSONAL HEALTH HISTORY

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the drug	Strength	Frequency Taken

Allergies to medications

Name of the drug	Reaction you had

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Allergies to Medication		
Please check any medical problems you have.	**☐Glaucoma** **☐Diabetes** **☐Hypertension** **☐Heart Disease** **☐Stroke** **☐Arthritis** **☐Neurologic Disorder**	**☐ Gastrointestinal Disorder** **☐Cancer** **☐Infection** **☐MRSA** **☐Lung Developmental Disease** **☐Mood Disorder** **☐Genetic Disorder** **☐GERD**	**Please list dates of when the medical illness started.** ➔
List any medical problems other than the named above.			

Surgeries		
Year	Reason	Hospital

*Injury or complaint for today:*____

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?		☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?		☐ Yes	☐ No
	# of meals you eat in an average day?			
	Rank salt intake	☐ Hi	☐ Med	☐ Low
	Rank fat intake	☐ Hi	☐ Med	☐ Low
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?		☐ Yes	☐ No

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

Include but not limited to

☐ DIABETES ☐ HYPERTENTION ☐ STROKE ☐ HEART DISEASE ☐ CANCER ☐ EARLY DEATH ☐ ARTHIRITIS ☐ GENEDIC DISORDER

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

General	ENT	Musculoskeletal	Neurologic
☐ Weight Change	☐ Vision Change	☐ Joint Pain	☐ Seizure
☐ Fever	☐ Hearing Change	☐ Morning stiffness more than 1 hour ☐ Morning stiffness less than 1 hour	☐ Memory loss
☐ Chills	☐ Ringing In Ears	☐ Joint swelling	☐ Difficulty concentration
☐ Bleeding	☐ Bleeding Gums	☐ Joint redness	☐ Slowed thinking
☐ Lumps	☐ Sensitivity to Light	☐ Back pain	☐ Fatigue
☐ Mass	☐ Sensitivity to Noise	☐ Hand pain	☐ Insomnia
☐ Cancer History	☐ Change in smell	☐ Hip pain	☐ Headaches
☐ Rash, Itching	☐ Change in taste	☐ Knee pain ☐ Elbow pain	☐ Loss of balance ☐ Numbness
Cardiovascular	**Respiratory**	**Endocrine**	**Gastrointestinal**
☐ Fainting	☐ Coughing	☐ Cold intolerance	☐ Abdominal pain
☐ Chest pains	☐ Wheezing	☐ Heat intolerance	☐ Reflux
☐ High blood pressure	☐ Snoring	☐ Excess sweating	☐ Nausea
☐ Swelling	☐ Short of breath	☐ Excess thirst ☐ excess hunger	☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Blood in stool ☐ Incontinence

Skin	Gynecologic/Genitourinary	Psychological
☐ Rash	☐ Blood in urine	☐ Depression
☐ Scars	☐ Poor urinary flow	☐ Anxiety
	☐ Pregnancy	☐ Frustration
	☐ Menses	☐ Stress
	☐ Abdominal bleeding	☐ Suicidal
	☐ Pelvic pain	☐ Plan to hurt others
		☐ Plan to hurt self

Do you have a living will? ____________

X____ ___________________________

Patient, Parent or Authorized Representative **Today's Date**

X____ ___________________________

Physician **Today's Date**

PATIENT INFORMATION
HISTORY

Consent to Medical Treatment and Financial Agreement

Consent to Medical Treatment: The undersigned has been informed of the treatment procedures considered necessary for the patient and that treatment/procedures will be directed by a physician and performed by employees of Gulf Coast Brain Sport & Spine, LLC ("provider"). The undersigned understands that there is no guarantee and no assurance has been made of the results that may be obtained from treatment. Consent is hereby granted for treatment.

Refusal of Treatment: I, the undersigned, am responsible now and forever, for my actions if I decide to refuse treatment or not follow the provider's instructions.

***Provision of Information*:** I, the undersigned, will provide to the best of my knowledge accurate and complete information about the patient's present complaints, past illness, hospitalizations, medication and other matters related to the patient's healthcare.

***Assignment of Insurance or Healthcare Benefits*:** In the event the undersigned is entitled to benefits of any kind arising out of any policy of insurance or healthcare coverage insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Gulf Coast Brain Sport & Spine, LLC for application on the patient's bill. The undersigned, and/or patient agrees to be responsible for charges not covered by the assignment, including- deductibles and co-payments. Undersigned agrees to provide all necessary insurance or healthcare coverage documents including eligibility, identification card, and authorization. Undersigned agrees to notify our office of any changes in insurance or healthcare coverage when they occur. Government issued photo identification will be required when providing insurance or healthcare coverage information.

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she will be totally responsible for all charges for services including but not limited to botulinum toxin/xeomin/dysport, synvisc, supartz, exercise prescription, and any other non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by specialists and physicians for whom Gulf Coast Brain Sport & Spine, LLC are authorized to bill. I, the undersigned, accept the fee(s) charged as legal and lawful debt. I understand the fee(s) charged are due at the time of service. Should it be necessary to forward my account for collection, I agree to pay all monies due, including a 40% collection fee, attorney fees, and/or court costs if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Louisiana and any other state. All delinquent balances shall bear interest at the legal rate. There will be a $40 service fee for returned checks. The undersigned agrees and understands that if he/she does not have insurance, proof of insurance, or participate in a plan that provider is contracted with, payment for service will be due at time of service. For patients without insurance, a deposit of $100 will be required prior to the provider's evaluation.

Medicare authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible in paying for my treatment (Section 1128 B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Medical Forms/Copies: Undersigned understands that completion of medical forms is a service separate from the clinic visit and requires time for the provider to complete. Fee for completion of forms is $25 for 2 page forms and $10 per additional page. FMLA and Disability Forms are evaluated on a case by case basis at the discretion of the provider. Independent medical evaluations are considered a distinct service and will be evaluated on a case by case at the discretion of the provider. Copy charge for records is $1.00 per page for the first 25 pages, $.50 per page for 26 to 350 pages, $.25 per page thereafter, and a handling charge not to exceed $25.00 and actual postage.

Miscellaneous provisions: I understand that I may be contacted by an automated system via telephone and/or email to be reminded of appointments or other news events. Under no circumstances will Gulf Coast Brain Sport & Spine, LLC be liable for property of patients. Undersigned agrees to be respectful and courteous of other patients and organization personnel and property of Gulf Coast Brain Sport & Spine, LLC. Undersigned agrees that Gulf Coast Brain Sport & Spine, LLC is a medical office and smoke-free facility; therefore, undersigned, visitors, and family agree not to smoke within 15 feet of the entrance of our facility.

(Patient or Authorized Representative)____________________________________ Date: ________________________

POLICY TITLE: NOTICE OF PRIVACY PRACTICES	**POLICY NO:** PRIC 002
EFFECTIVE DATE:	**REVIEWED:**

Exhibit PRIV.002-B

Acknowledgement of Receipt of HIPAA
Privacy Policies and Procedures

I, ____, have received and reviewed a copy of

Gulf Coast Brain Sport and Spine, LLC’s Notice of Privacy Practices.

Patient Name ____

If Personal Representative, Relationship to Patient ____

Signature ____

Date ____

GULF COAST BRAIN SPORT & SPINE, LLC
PATIENT GUIDELINE POLICY

1. Given the nature of healthcare today, more people are seeking care for more limited appointment times. If your appointment needs to be cancelled, please call 24 hours in advance or sooner in order to allow for scheduling of other patients that request an appointment. After the second instance of not canceling your appointment within 24 hours, your account will be placed in "**No Show**" status and there will be a $25 dollar no show fee for missed clinic appointments or a $75 fee for missed procedure appointments. The appropriate no show fee will be collected before scheduling any further appointments. After the fourth no show instance, it will be discussed that you may consider another provider with different clinic hours.
2. If there are issues that arise that will cause you to be late to your scheduled appointment time, please call to inform the staff of your status. The staff will check provider's schedule at that time to see if you can be worked in. There is no guarantee that you will be seen by provider that day if you are more than 30 minutes late to your scheduled appointment. After the second instance of being more than 30 minutes late to your scheduled appointment, your account will be placed in "**No Show**" status and the same fees as stated in the previous paragraph and policy as stated applies.
3. Gulf Coast Brain Sport & Spine, LLC is *Not* a Pain Clinic. The philosophy of Gulf Coast Brain Sport & Spine, LLC is to address injury or developmental disorder without narcotic medication. Because of potential for addiction, misuse, and diversion of medication, **narcotics will not be a part of the treatment plan provided through this clinic.** Narcotic medications include but are not limited to morphine, hydrocodone, oxycodone, oxycontin, Percocet, Lortab, methadone, fentanyl, duragesic, etc.
4. Refills will only be called in during regular business hours and may take up to 3 business days to complete. Because medical issues or medication lists change, refills after a 3 month period will only be provided in association with an office visit. When refilling medication, new medications, allergies, and diagnoses need to be brought to the provider's attention in order to treat the patient appropriately. It's the patient's responsibility to call in advance when medication is running out.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING POLICY, IS THE PATIENT OR GUARDIAN, OR IS AUTHORIZED BY THE PATIENT AND ACCEPTS THE TERMS THEREOF.

PRINT NAME

SIGNATURE OF PATIENT, PARENT OR REPRESENTATIVE **DATE**