AVALA PHYSICIAN NETWORK

Patient Medical History

Name: _____ **Date:** _____

Birthdate: _____ Height: _____ Weight: _____

Referring Physician: _____ Past PCP: _____

Date of last menstrual cycle *(female only)* _____ Last Mammogram? (Female only) _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Have you had treatment for this problem before? ☐ Yes ☐ No

Date symptoms began? _____

Is this problem the result of (check all that apply)

☐ Car Accident ☐ Work Accident ☐ Other: (please specify) _____

Are you/could you be pregnant? ☐ Yes ☐ No

PAST MEDICAL HISTORY: (Please Check Any/All of the Following that Apply)

☐ Anemia	☐ Depression	☐ High Blood Pressure	☐ Peripheral Vascular Disease
☐ Arthritis Type _____	☐ Diabetes	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Asthma	☐ DVT/Blood Clots	☐ Irritable Bowel Syndrome	☐ Stroke/TIA
☐ Bladder Problems	☐ Epilepsy	☐ Kidney Issues	☐ Tuberculosis
☐ Bleeding/Bruising	☐ Gout	☐ Liver Disease	☐ Thyroid Problem
☐ Cancer Type _____	☐ Heart Disease	☐ Lung Problems	
☐ Congestive Heart Disease	☐ Hepatitis	☐ MRSA/Staph Infection	
☐ COPD/Emphysema	☐ HIV/AIDS	☐ Osteoporosis	

☐ **Other:** _____

Medication History List the names of ALL medications that you take with or without a prescription:

Pharmacy Name: _____ Phone Number: _____

Name of Medication	Dosage	Reason for Taking

ALLERGIES

Please describe any current or past allergic reactions

Drug Allergy	Reaction

☐ I have no allergies

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Past Surgical History

Procedure	Hospital	Year

☐ I have not had surgery or been hospitalized

Social History

Do you smoke/vape? ☐Yes ☐No Have you smoked/vaped in the past? ☐ Yes ☐No

How long? _____ # Packs a day/brand: _____

Do you drink alcohol? ☐Yes ☐No How many drinks a month? _____

Do you have a history of drug/alcohol abuse? ☐ Yes ☐No

Family History

Please check the box of all of the following problems your blood relatives (i.e. parents, sibling, grandparent) have had:

	Mother	Father	Sibling	(M)Grandmother	(M)Grandfather	(P)Grandmother	(P)Grandfather
Alzheimer's							
Arthritis							
Cancer							
Diabetes							
Gout							
Heart Disease							
Osteoporosis							
Stroke							
Sudden Death							
Other							

REVIEW OF SYSTEMS

Please check any/all you have experienced in the past month. Be sure to notify your doctor if you have experienced any of the following.

General
- ☐ Fever/Chills
- ☐ Weight Change
- ☐ Hormone problems
- ☐ Other

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing
- ☐ Other

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Tendency to Bruise
- ☐ Clotting Disorder
- ☐ Swollen Lymph Nodes
- ☐ Other

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Heartburn/Acid Relief
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Other

Neurological
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Weakness
- ☐ Other

Eyes
- ☐ Glasses/Contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other

ENT/Mouth
- ☐ Difficulty Swallowing
- ☐ Ear Pain
- ☐ Nasal Congestion
- ☐ Hard of Hearing
- ☐ Sore Throat
- ☐ Other

Skin
- ☐ Rashes
- ☐ Lumps
- ☐ Itching/Puritis
- ☐ Other

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Fluid/Swelling in Extremities
- ☐ Syncope
- ☐ Other

Endocrine
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Other

Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Mood Swings
- ☐ Other

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PATIENT INFORMATION

Patient Name	**Home Telephone #** _____
Social Security Number	**Cell Telephone #** _____
Address	**Patient Sex**
City, State & Zip Code	**Date of Birth**
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No	**Emergency Contact Name & Phone** **Relationship to Patient:**
Email Address (please print):	
Ethnicity of Patient: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Unknown ☐ Declined to Answer **Patient's preferred language:** ☐ English ☐ Spanish ☐ Other:	**Race of Patient:** ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White ☐ Unknown ☐ Declined to answer ☐ Single ☐ Married ☐ Other
In compliance with the American Recovery and Reinvestment Act of 2009 **(ARRA)** to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.	

Financially Responsible Person (if different from above)

Full Name	Social Security Number _____
Address	Home Telephone# _____
City, State & Zip Code	Work Telephone# _____
Date of Birth	Cell Telephone# _____
Employer Name	Relationship to the patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Date Reviewed _____ Initials _____

Insurance Company Information

Primary Insurance Company Name	**Secondary Insurance Company Name**
Policy Number **Group Number**	**Policy Number** **Group Number**

AVALA PHYSICIAN NETWORK

Patient Name: _____ **Date of Birth:** _____

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to AVALA, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery, and this does not relieve me of my primary obligation to pay.

Signature: _____ Date: _____

Medicare Patients

If you are covered by Medicare, please read, and sign the following:

In Medicare cases, AVALA, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, co-insurance, and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature: _____ Date: _____

Heath Information Exchange: We may share your information for treatment, payment, and healthcare operations purposes through health information exchange in which we participate for participants to efficiently access and use your pertinent medical information necessary for treatment and other lawful purposes. I give consent to AVALA to share my information for treatment, payment, and healthcare operations purposes through health information exchange in which we participate for participants to efficiently access and use your pertinent medical information necessary for treatment and other lawful purposes. **Initial** _____

Appointment Reminders and Other Information: We may use your protected health information to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you. For example, we may send you a newsletter about our medical practice or the medical services that we offer to patients. **Initial**_____

Photographs: We may use photography or other means of image recording to capture pictures and imaging in an effort to offer better patient identification for workforce members, security purposes and billing procedures.

Initial _____

After Hours: I understand that AVALA Care does not have an On Call physician. I understand that any message sent to AVALA Care via patient portal or voicemail left for physician after hours will not be seen until the following business day. I understand that in the event of a medical emergency after hours, I should go to the nearest emergency room. **Initial** _____

AVALA PHYSICIAN NETWORK

Patient Name:_____ Date of Birth:_____

Covered Benefits: As a courtesy, we will verify and file your claim with your insurance carrier, however we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/coinsurance, and any non-covered services as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim or if you or your physician elect to continue therapy past your allowed/approved visits, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. It is not a guarantee of payment. Please contact your insurance carrier directly to confirm your individual benefits for Physical Therapy services.

Co-Payments: Co-payments and Co-insurance amounts must be paid at each visit according to your insurance contract. Please plan accordingly. We accept cash, checks and credit cards (Visa or Master Card).

Attendance Policy: Your physician allocates a specific amount of time for your appointment to meet the needs of your rehabilitation program. We understand that there are times when you must miss an appointment, but request that you give us 24-hour notice. Please schedule a make-up appointment as soon as possible to help meet your rehabilitation goals. So that we may provide attentive care to each of our patients, please be aware that if you arrive more than 15 minutes later than your scheduled time, you may be asked to reschedule your appointment.

I have read the above statements. It is my understanding that I am financially responsible to **AVALA** for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to **AVALA**. I agree to pay the full amount of all charges incurred by the above-named patient that are not covered by my insurance provider.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. When an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five-dollar ($25) fee; this will not be covered by your insurance company.

_____ _____

Patient Signature Date

_____ _____

Guarantor's Signature Date

Medical Release: I hereby authorize **AVALA** to release my medical records to physicians, insurance companies, and other social agencies as necessary. I also authorize AVALA to obtain any portion of my medical record from another institution that is deemed medically necessary during my treatment. **Initial**_____

Consent to Provide Treatment: I hereby authorize **AVALA** through its appropriate personnel to perform upon me or the above-named patient appropriate physical therapy assessment and treatment procedures relating to my diagnosis. **Initial**_____

AVALA PHYSICIAN NETWORK

Patient Name: _____ **Date of Birth:** _____

ePrescribing

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

The benefit to you:

> Less confusion over handwritten prescriptions or unclear phone calls

> Reduced possibility of medical errors

> Less chance of adverse drug reactions

> Fewer trips to drop off at the pharmacy

> A safer, faster, easier way to get your prescription filled

Patient Consent

I agree that AVALA may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_____ _____

Patient's Signature Date

AVALA PHYSICIAN NETWORK

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: Required for all Authorization for Release of PHI or Right of Access

Patient Name:	Birth Date:
Patients Address:	Social Security # (optional)
PHI Recipient Name: AVALA Care	Fax Number: 985-338-2621
PHI Sender Name:	Fax Number:

This Authorization will expire on the following: (Fill in the Date or Event, but not both)

Dates: _____ Event:_____

Please check which of the following you would like to be requested

☐ ALL PHI in record	☐ Physician Orders	☐ Demographics
☐ History and Physical	☐ Laboratory	☐ Rehabilitation Services
☐ Consult Report	☐ Imaging/Radiology	☐ Special Test/Therapy
☐ Operative Report	☐ Nursing Notes	☐ Itemized Bill/Claims
☐ Progress Note	☐ Medication Record	☐ Other

I acknowledge and herby consent to such, that the release information may contain alcohol, drug abuse, psychiatric. HIV testing, HIV results or AIDS information._____(Initial) If not applicable, check here .
I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures
I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

Please mail medical records to AVALA Care at 7039 Highway 190 E. Service Road, Covington, LA, 70433 or fax records to 985-338-2621

AVALA PHYSICIAN NETWORK

DESIGNATION OF INDIVIDUAL INVOLVED IN MY CARE

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have the right to authorize the release of your protected health information, including medical and billing records, to an individual(s) you designate. Please complete this form in its entirety designating the individual(s) with whom you would like AVALA to share your information.

Patient Name: _____ **Date of Birth:** _____

Designation of Individual(s) Involved in My Care:

At my request, I hereby identify the following individual(s):

_____

_____.

(Collectively, the "Designated Individual") as an individual(s) involved in my care and I hereby authorize AVALA to release any and all protected health information about me, including billing and medical records, to the Designated Individual. This authorization permits the disclosure of paper records, electronic records and verbal communications. Additionally, to the extent my medical or billing records contain information related to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, HIV/AIDS, and/or other sensitive information, I hereby agree to its release

Termination/Revocation of Designation: Unless terminated sooner in writing by me, this authorization will terminate three (3) years after my last date of treatment by AVALA. I understand that I may revoke this authorization and cancel this designation by sending a written Revocation of Designation Form to AVALA. I understand and acknowledge that the revocation or cancellation of this designation shall not apply to information that has already been released prior to the revocation/cancellation date.

Re-Disclosure: I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer by protected by HIPAA.

No Obligation to Sign: I understand that I do not have to sign this authorization and treatment of me will not be denied if I do not sign this form. I hereby release and discharge AVALA, its employees, agents and owners of any liability and will hold them harmless or complying with this authorization

Signature: _____ Date: _____

AVALA PHYSICIAN NETWORK

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices of **AVALA.**

_____ _____

Signature Date

_____ _____

Print Name Date of Birth

If not signed by the patient, please indicate relationship:

___Parent or guardian of minor patient;

___Power of Attorney, Tutrix, Curator or Designated Personal Representative

_____

(NAME OF PATIENT)

___ACKNOWLEDGMENT REFUSED:

Efforts to obtain:

_____

_____

Reason for refusal:

_____

_____