

**Kenner Clinic**  
 1301 West Esplanade Avenue  
 Kenner, LA 70065  
 Phone: 504-461-2222  
 Fax: 504-461-2233  
 Email: brien504@brienchiro.com

**Luling Clinic**  
 12501 Highway 90  
 Luling, LA 70070  
 Phone: 985-331-8007  
 Fax: 985-331-8003  
 Email: brien985@brienchiro.com

**Kenner/Luling Mailing Address: P.O. BOX 698, Luling, LA 70070**

## New Patient Registration for Insurance

How were you referred to this office? \_\_\_\_\_

If referred by an Attorney, please specify which attorney: \_\_\_\_\_

**Personal History**

Name: \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: Male or Female

Social Security #: \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Separated

Business/Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

In case of an emergency, who should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell Phone# \_\_\_\_\_

**Current Health Condition**

**Major Complaints:** \_\_\_\_\_

Your complaint is due to an: Auto Accident Work Injury Other Accident  
 Unknown Causes Other: \_\_\_\_\_

Have you had this problem before in the past? Yes or No If Yes, how long ago? \_\_\_\_\_

Date of Accident/Injury or Date your pain/problem began: \_\_\_\_\_

If disabled from work, please give dates: \_\_\_\_\_

Is your pain: Improving Getting Worse About the Same Comes & Goes

Circle any activity that aggravates your condition: Standing Sitting Walking Bending

Twisting Coughing Lying Lifting Other: \_\_\_\_\_

When is the pain/problem worse: Morning Noon Night

Does your pain awaken you at night? Yes or No

Have you been seen by another Doctor for this condition: Yes or No

If Yes Doctor's Name: \_\_\_\_\_

Last date consulted/examined/treated: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Medication(s) you are taking presently: Nerve Pills Pain Meds Muscle Relaxers Insulin

Blood Pressure Pills Aspirin Tylenol Advil Vitamins Supplements

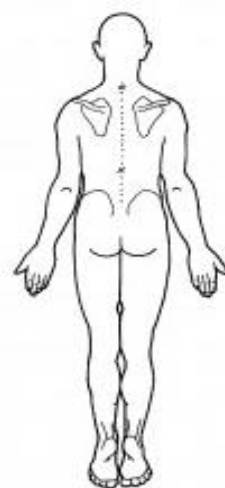
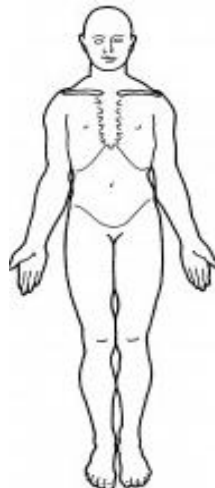
Other \_\_\_\_\_

Name of Medical Provider: \_\_\_\_\_

Using the scale 0-10, with 0 being no pain and 10 being the worst possible pain, please indicate your present pain level: \_\_\_\_\_

Please mark your area(s) of pain discomfort on the Diagram to the right using the appropriate letter(s):

- (B) Burning
- (C) Cramping
- (D) Dull
- (N) Numb
- (S) Stabbing
- (T) Tingling



## Past Health History

Major Accidents or Falls: \_\_\_\_\_

Major Surgeries/Operations: Heart Back Neck Leg Arm Hip Appendix Tonsils Hernia

Other: \_\_\_\_\_

Hospitalization(s) other than above: \_\_\_\_\_

Have you been treated for any other health condition in the last year? Yes or No

If Yes, please explain: \_\_\_\_\_

Does anyone in your family suffer from the same problem? Yes or No

If Yes, please list the relation: \_\_\_\_\_

**Check any of the following diseases / conditions you have currently or had:**

- |   |   |                                     |                                       |
|---|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Bed Wetting            | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Gout         |
| <input type="checkbox"/> Bladder Trouble        | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hepatitis    |
| <input type="checkbox"/> Bleeding Disorders     | <input type="checkbox"/> Painful Urination    | <input type="checkbox"/> Anemia     | <input type="checkbox"/> Hernia       |
| <input type="checkbox"/> Bowel Trouble          | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Anorexia   | <input type="checkbox"/> Herpes       |
| <input type="checkbox"/> Breast Pain            | <input type="checkbox"/> Pinched Nerves       | <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Asthma     | <input type="checkbox"/> Measles      |
| <input type="checkbox"/> Chicken Pox            | <input type="checkbox"/> Prostate Dysfunction | <input type="checkbox"/> Bulimia    | <input type="checkbox"/> Migraines    |
| <input type="checkbox"/> Discolored Urine       | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Cancer     | <input type="checkbox"/> Mumps        |
| <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Cataracts  | <input type="checkbox"/> Pacemaker    |
| <input type="checkbox"/> Herniated Disc         | <input type="checkbox"/> Scarlet Fever        | <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep Loss   |
| <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Sexual Dysfunction   | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Stress       |
| <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Suicide Attempt      | <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Stroke       |
| <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Typhoid Fever        | <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Thyroid      |
| <input type="checkbox"/> Menstrual Cramps       | <input type="checkbox"/> Vaginal Infection    | <input type="checkbox"/> Fractures  | <input type="checkbox"/> Tonsillitis  |
| <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Venereal Disease     | <input type="checkbox"/> Glaucoma   | <input type="checkbox"/> Tumors       |
| <input type="checkbox"/> Mononucleosis          | <input type="checkbox"/> Whooping Cough       | <input type="checkbox"/> Gonorrhea  | <input type="checkbox"/> Ulcers       |

**Females Only:** Are you pregnant? Yes or No If Yes, what is your due date: \_\_\_\_\_

If No, when was your last menstrual cycle? From \_\_\_\_\_ to \_\_\_\_\_

Do you Exercise: Yes or No

If yes, which would best describe your exercise intensity: Mild Moderate Strenuous

Do you smoke: Yes or No If Yes, how often? \_\_\_\_\_

Do you drink alcohol? Yes or No If Yes, how many drinks per week? \_\_\_\_\_

What does your work activity mainly consist of? Sitting Standing Light Labor Heavy Labor

**I CERTIFY THAT THIS INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Office Policy

Patient Name: \_\_\_\_\_

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered part of your treatment. The following statements refer to our office policies, which we require you read, accept, sign and date before any treatment can begin.

- Every new patient is required to fill out forms concerning his/her history and general information prior to being examined.
- Each insurance company or group has specific guidelines that we must follow to warrant payments for our services. As a courtesy to you, we file all claims to your insurance company or group. Please remember that YOU have to contract with the insurance company or group and YOU are ultimately responsible for payment. We cannot accept responsibility for collecting from your insurance company or group, nor negotiating a settlement on a dispute of a claim. If you need assistance with your insurance, please see our office manager, who will readily assist you.
- Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary of our area. Please understand that you are responsible for payment in full regardless of an insurance company's arbitrary determination of usual and customary rates.
- Open accounts with no ACCEPTABLE payment activity for 60 days will be considered past due. A billing charge may be assessed to the account balance along with a finance charge of 1.5% per month. You will be responsible for the original past due balance along with these additional charges. ACCEPTABLE payment activity will be determined on an individual basis. Please speak with our office manager to avoid any misunderstandings.
- Open accounts with no ACCEPTABLE payment activity for 120 days will automatically be placed with our collection agency. You will be responsible for payment of the original balance plus any billing charges, finance charges, collection fees and attorney fees assessed to your account.

The adult accompanying a minor is responsible for full payment. The adult (i.e. parent or legal guardian) must be present with the minor and sign the treatment consent form before any services can be administered.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I authorize Brien Chiropractic Clinic to release medical records, radiographs and reports to any physicians, other health care providers, or insurance companies/groups that may be consulted or who need direct access to these records for health care.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Informed Consent Form

Every type of health care is associated with some risk of potential problems. Health care providers including chiropractors are required by law to tell you the nature of your condition, the general nature of the treatment, and the risks involved. In keeping with the Louisiana Law of Informed Consent, you are being asked to sign and date this form which confirms our discussion of these matters.

We want to give each patient the best possible care with the least possible risk of complications. To accomplish this, we format treatment plans to suit the distinctive needs of each patient. The following paragraphs describe the most severe risks associated with chiropractic care which are extremely rare in occurrence:

- **STROKE:** Stroke is the most serious problem associated with spinal manipulation. The consequences can be temporary or permanent dysfunction of the brain with very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery which runs on each side of your neck. This problem occurs so rarely that there is no conclusive data that specifies quantity of probability.
- **DISC HERNIATION AGGRAVATION:** Disc herniations that create pressure on the spinal nerve and/or spinal cord are successfully treated by chiropractors on a daily basis. Chiropractic manipulation can aggregate an existing disc herniation resulting in an increase of symptoms which may last for a few days but seldom for longer periods of time.
- **SOFT TISSUE INJURY:** Soft tissue primary refers to muscles and ligaments. Muscles move bone, and ligaments limit bone movement. Rarely, chiropractic manipulation can result in minor damage to a particular soft tissue. This may cause a temporary increase in pain and necessary treatments for resolution, but there are no long term effects to the patient.
- **RIB FRACTURES:** The rib cage is found in the thoracic spine or middle back area. Rarely does chiropractic manipulation cause a fracture of a rib to occur. Patients who have weakened bones (Osteopenia or Osteoporosis) have a higher risk of rib fractures because their bones are weaker than normal. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.
- **OTHER POSSIBLE COMPLICATIONS:** There are many other side effects and/or complications that may also rarely occur due to spinal manipulation. These possible complications include, but are not limited to the following: headaches, skin burns, dizziness, radiating pains into the arms and/or legs, exacerbation of pain/problem, soreness, etc.

I hereby authorize, Mitchell P. Brien, D.C. and/or Matthew D. Ellender, D.C. to provide chiropractic treatments including examination/diagnostic, spinal manipulation/adjustments, and various modes of physical therapy that may be deemed necessary or responsible. My treatment plan will be explained to me and I have read and I understand all information set forth in this document, including any attachments. I acknowledge that I will have the opportunity to ask any questions about the contemplated procedure and that my questions will be answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Print Patient's Name : \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that I have provided and explained the information set forth herein, including any attachments and have answered all questions concerning proposed treatment to the best of my knowledge and ability.

\_\_\_\_\_  
Mitchell P. Brien, D.C. or Matthew D. Ellender, D.C.

\_\_\_\_\_  
Date

## Notice of Privacy Practices for Protected Health Information Page 1

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### **Uses and Disclosures**

Here are some examples of how we might have to use or disclose your health care information:

- Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
- Our insurance or billing staff may have to disclose your examination and treatment records and your billing records to another party, such as insurance carrier, and HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
- Our chiropractor and members of the practice staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
- Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520 (b) (1) (iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

### **Our Privacy Pledge**

We have and always will respect your privacy. Other than the uses and disclosures we described above, **we will not sell or provide any of your health information to any outside marketing organization.**

### **Permitted Uses and Disclosures Without Your Consent or Authorization**

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
- We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
- We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
- We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
- We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

### **Your Right to Revoke Your Authorization**

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

- If we have already released your health information before we received your request to revoke your authorization 164.508(b)(5)(i).
- If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at:

Brien Chiropractic Clinic  
P.O. Box 698  
Luling, La. 70070

### **Your Right to Limit Uses or Disclosures**

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know in writing what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

### **Your Right to Receive Confidential Communication Regarding Your Health Information**

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to our needs, please make any request in writing.

**Notice of Privacy Practices for Protected Health Information Page 2**

***Your Right to Inspect and Copy Your Health Information***

You have the right to inspect and/or copy your health information for six years from the date that the record was created or as long as the information remains in our files.

***Your Right to Amend Your Health Information***

You have the right to request that we amend your health information for six years from the date that the record was created or as long as the information remains in the files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

***Your Right to Receive an Accounting of the Disclosures we Have Made of Your Records***

Louisiana law requires that we furnish you, upon your request, a copy of any information related in any way to you which we have transmitted to any company, or public or private agency, or any person.

We may charge reasonable copying charges for this service which are set forth in the statutes as well as a handling charge an actual postage.

We may deny access to a record if we are reasonable conclude that knowledge of the information contained in the record would be injurious to the health or welfare of the patient or could reasonably be expected to endanger the life or safety of any other person.

***Your Right to Obtain a Paper Copy of This Notice***

If you have agreed to receive privacy notices by email, you may request a paper copy of this notice at any time.

***Our Duties***

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

***Re-disclosure***

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

***Your Right to Complain***

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violate your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

**Brien Chiropractic Clinic  
P. O. Box 698  
Luling, LA 70070**

If you would like further information about our privacy policies and practices please contact:

**Dr. Mitchell P. Brien  
P.O. Box 698  
Luling, LA 70070  
985-331-8007**

This notice is effective as of APRIL 1, 2003. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Dr. Mitchell P. Brien  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of Personal Representative's Authority to act for the Patient

## Authorization For Release of Records

Date:

Brien Chiropractic Clinic  
12501 Highway 90  
Luling, La 70070

Phone #: 1-985-331-8007  
Fax #: 1-985-331-8003

To:

Patient:  
Date of Birth:  
Social Security #:

Our clinic is requesting all medical records on your patient, who is now receiving chiropractic care. We are thanking you in advance for your cooperation in this matter.

Please include the following:

Medical Records                       CT Scan Reports  
 X-ray Reports                             Lab Reports  
 MRI Reports                               Other

Brien Chiropractic Clinic

Patient  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Billing and Payment

\_\_\_\_\_ **Self-pay:** If you have no available insurance coverage you will be billed directly for services provided at the time services are rendered.

\_\_\_\_\_ **Health Insurance:** We will bill your health insurance provider if, at the time of service, we are a contracted provider with the insurance company. However, you must remit all payments due as a result of any deductible, co-insurance, and/or co-payments per the insurance plan. These payments as well as payments for services not covered under the plan are due at the time each service is rendered.

\_\_\_\_\_ **Third Party Fault:** In the event that a third-party is at fault for your injury and you wish for us to bill that third-party or your auto insurance medical payments carrier instead of your health insurer, then we will attempt to collect from the third-party at the full cost of our services. However, in the event that the third-party recovery is unsuccessful, then you will be responsible for the full amount of the outstanding medical bill.

Patient's printed name: \_\_\_\_\_

Patient's signature: \_\_\_\_\_

Patient's representative (if minor): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Date: \_\_\_\_\_

Name of attorney if represented: \_\_\_\_\_



## Credit Card Policy

Brien Chiropractic Clinic has implemented a credit card policy. You will be asked for your credit card number at the time you check in and the information will be held SECURELY until your insurance have paid their portion and notified us of the amount your share. At that time, any remaining balance owed by you that is \$100 or less will be charged to your credit card and a copy of the charge will be mailed to you.

This will be an advantage to you since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance companies' determination of payment.

Co-pays, coinsurance and deductibles will still be due at the time of service.

If you have any questions about this payment method, do not hesitate to ask.

I AUTHORIZE BRIEN CHIROPRACTIC CLINIC TO CHARGE OUTSTANDING BALANCES ON MY ACCOUNT TO THE FOLLOWING CREDIT CARD OR DEBIT CARD:

VISA / MASTERCARD / DISCOVER (CIRCLE ONE)

Name on Card \_\_\_\_\_

Card number \_\_\_\_\_

Expiration date \_\_\_\_\_

Cvv \_\_\_\_\_

Zip code \_\_\_\_\_