AgilusHEALTH

Patient Information Sheet

Date: _____

Patient Name: _____
LAST FIRST MI

Street Address: _____

_____
CITY STATE ZIP

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we CALL or TEXT you for Appointment Reminders & Occasional Promotions? ☐ YES / ☐ NO

Social Security #: _____ Sex: ☐ M / ☐ F Birthday: _____

Payment Method ☐ Worker's Comp ☐ Ins ☐ Medicare ☐ Attorney ☐ Self ☐ Other

Date of Injury: _____ Type: MVA ☐ WC ☐ Other ☐ Referring DR: _____

Last Doctor's Appt: _____ Next Doctor's Appt: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient's Employer: _____

Spouse or Guardian's Name: _____ Phone: _____

Person Responsible for Bill: _____

Name of Primary Insurance / Attorney: _____

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARDS*

Have you received any Home Health Services in the past 60 days? YES ☐ NO ☐

If yes, what Home Health Agency Provided these Services?: _____

How did you hear about us? (*If referred by a patient, please provide their FIRST & LAST name*):

_____

Emergency Contact Name: _____ Phone: _____

I acknowledge that the information I have provided is true and correct. I also understand that **Agilus Health, Inc.** will make every reasonable effort to collect on this account; however, if my account must be turned over for collection, I will be responsible for any fees associated with the collection process.

Signature: _____ Date: _____

AgilusHEALTH

Patient Consent for Future Correspondence, Updates and News

If you would like to receive future correspondence regarding updates, promotions, news, etc, please provide us with the following information and your preferred point of contact.

**Your information will NEVER be given to a third party, nor will you be spammed. This information is for our office use only.

Your Name: _____
First Last

Birthday: _____

Address: _____
Street City

State:_____ Zip: _____ ☐HOME ☐BUSINESS ☐OTHER

Cell Phone Number: _____ Carrier: _____

Email Address: _____

Preferred method of contact: ☐TEXT ☐EMAIL ☐MAIL ☐ALL ☐ANY

Signature: _____ Date: _____

Agilus HEALTH

Photography/Video Consent Form

At Agilus Health, Inc, we are moving toward a very digital world. We take great importance in capturing as many moments throughout our clinic as possible. Most of these captured, digital moments are promoted online via Facebook, Instagram and other social media platforms, as well as on television. Unless we have additional consent from you individually, we will never show your face any any of our photographs/videos that are publicly displayed and/or promoted in some other way for marketing purposes. But this agreement is to inform you that you MIGHT be photographed or videotaped during your treatment, or any other activity within the clinic, but your face will **NOT BE SHOWN** unless otherwise agreed to.

You do have the right to completely decline even the "blurred" image of yourself to be publicly posted, so please provide the appropriate information below if it pertains to you.

I, _____, hereby authorize Agilus Health, Inc to photograph/videotape me for the purpose of identification (patient chart), evaluation, progress documentation, educational marketing, and/or demonstration or treatment and/or progression or treatment or public and/or non public education.

☐ YES, you can take photo/video of me, and use it for educational, marketing or documentation purposes WITH my face or other identifiable markings BLURRED/HIDDEN.

☐ YES, you can take photo/video of me, and use it for educational, marketing or documentation purposes WITH my face or other identifiable markings NOT BLURRED/NOT HIDDEN.

☐ YES, you can take photo/video of me, but DO NOT use it for educational, marketing or documentation purposes.

Patient Signature: _____ Date: _____

Witness Signature: _____

AgilusHEALTH

Patient Medical History

Patient Name: _____ Date: _____

1. Date of injury onset: _____

2. Check which apply to your symptoms:

- ☐ work related injury
- ☐ motor vehicle accident
- ☐ cause unknown
- ☐ other: _____
- ☐ recurrence of previous injury
- ☐ injury related to lifting
- ☐ athletic / recreational injury

3. Have you had a related surgery? ☐ YES ☐ NO

4. Do you have or have you had any of the following:

Are you pregnant?	☐ YES	☐ NO	Bowel/Bladder abnormalities	☐ YES	☐ NO
Diabetic	☐ YES	☐ NO	Skin Abnormalities	☐ YES	☐ NO
Chest pain/Angina	☐ YES	☐ NO	Nausea/Vomiting	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Ringing in your ears	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO	Rheumatoid arthritis	☐ YES	☐ NO
Pacemaker	☐ YES	☐ NO	Hernia	☐ YES	☐ NO
Headaches	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
Metal Implants	☐ YES	☐ NO	Dizziness/Fainting	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Recent Fractures	☐ YES	☐ NO

If yes on any of the above, please briefly explain and give approximate dates where applicable:

_____

_____

Do you have any allergies or any medications you cannot take? If yes, please specify:

_____

_____

Please list all previous surgeries with approximate dates:

_____

_____

Are you currently taking any medications? ☐ YES ☐ NO IF yes, please list below:

_____

_____

Do you smoke? ☐ YES ☐ NO If so, how much? _____

Do you drink? ☐ YES ☐ NO If so, how much? _____

Do you take drugs? ☐ YES ☐ NO If so, how much? _____

Do you have a rehab nurse or counselor assigned to your case? ☐ YES ☐ NO

Name: _____

Signature: _____ Date: _____

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Patient Insurance Information

PRIMARY INSURANCE

Insurance Company: _____ Co-Pay: _____

Group #: _____ Subscriber #: _____

Insured First Name: _____ Last Name: _____

Social Security #: _____ DOB: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Ext: _____

Advanced Directive? ☐ YES ☐ NO Where is it filed? _____ (medical facility)

Insured Employed By: _____ Business Address: _____

City: _____ State: _____ Zip: _____ Business Phone: _____

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? ☐ YES ☐ NO

Insurance Company: _____ Co-Pay: _____

Group #: _____ Subscriber #: _____

Insured First Name: _____ Last Name: _____

Social Security #: _____ DOB: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Ext: _____

Advanced Directive? ☐ YES ☐ NO Where is it filed? _____ (medical facility)

Insured Employed By: _____ Business Address: _____

City: _____ State: _____ Zip: _____ Business Phone: _____

EMPLOYMENT STATUS

☐ EMPLOYED ☐ UNEMPLOYED ☐ FULL TIME STUDENT ☐ PART TIME STUDENT ☐ RETIRED

Last Degree Earned: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

Occupation: _____ Business Name: _____

Business Phone: _____ Business City: _____

Driver's License #: _____ State Issued: _____ Exp. Date: _____

Is this visit for an accident? ☐ YES ☐ NO

Date of injury: _____ Is this a MOTOR VEHICLE ACCIDENT: _____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

AgilusHEALTH

Patient's Extended Signature Authorization

"I request that payment of authorized insurance benefits be made to Agilus Health, Inc. I authorize any medical information about myself needed to determine these benefits or the benefits payable for related services to be released to the insurance company and it's agents."

Signature of Patient (Legal Guardian) _____ Date Signed _____

****We file your INSURANCE as a courtesy to you. Your insurance coverage is ultimately a contract between you and your insurance company. If for some reason, whether it is pre-existing, failure to receive claim, etc, they do not pay the claim, it is necessary that you understand that you are responsible for the balance and will pay for all services rendered to you by our clinicians through our office.**

Signature of Responsible Party _____ Date Signed _____

Acknowledgement of Notice of Privacy Practices

Agilus Health, Inc. reserves the right to modify the privacy practices outlined in the notice.

☐ I have received a copy of the notice of privacy practices for **Agilus Health, Inc.**

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature or Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

AgilusHEALTH

Patient Consent for Future Correspondence, Updates and News

I hereby give my consent for Agilus Health, Inc to use and disclose Protected Health Information (PHI) about me to carryout treatment Payment and Healthcare Operations (TPO). (Agilus Health, Inc Notice of Privacy Practices provides a more complete description as such uses and disclosures.)

I receieved a copy of the Notice of Privacy Practices and understand it is my responsibility to read the form prior to signing this consent. Agilus Health, Inc reserves the right to revise its' notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Agilus Health, Inc at 1305 Texas Ave, Alexandria, LA 71301.

With this consent, Agilus Health, Inc may call my home, text my cell phone, or contact any alternative location and leave a message on voicemail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. Agilus Health, Inc may also contact me at my home or other alternate locations and leave a voicemail or in person concerning my account.

With this consent, Agilus Health, Inc may mail to my one or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Agilus Health, Inc restrict how it uses or discloses my PHI to carryout TPO. However, the practice is not required to agree to my personally requested restrictions, but if it does, it is bound by this agreement.

I also give my consent to be treated in the gym in front of other patients the may be attending therapy.

By signing this form, I am consenting to Agilus Health, Inc use and disclosure my PHI to carryout TPO. I may revoke my consent in writing except to the extent that the practice already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Agilus Health, Inc may decline to provide treatment to me.

_____ _____

Signature of Patient (Legal Guardian) Date Signed

_____

Patient's Name

_____

Print Name of Patient or Legal Guardian

Acknowledgement of Notice of Privacy Practices

Agilus Health, Inc. reserves the right to modify the privacy practices outlined in the notice.

☐ I have received a copy of the notice of privacy practices for **Agilus Health, Inc.**

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature or Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

☐ Complete Records	☐ History & Physical	☐ Progressive Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Record	☐ Other (please specify below)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated with my medical care:

Name: **AGILUS HEALTH, INC.**

Address: **1305 TEXAS AVENUE**

City, State, Zip: **ALEXANDRIA, LA 71301**

Phone: **318-443-5278** Fax: **318-443-1906**

The purpose/reason for this release of information is as follows:

_____

Signature:

_____ _____

Patient Name | Signature of Patient or Personal Representative

_____ _____

Patient Date of Birth or Social Security Number | Printed Name of Patient or Personal Representative

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED ANY DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other heath care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used a necessary to support the day-to-day activities and management of **Agilus Health, Inc**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of

your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting.

We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Agilus Health, Inc. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outline in their notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit.

The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Receptionist** or **Office Manager**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager,
Agilus Health, Inc.
1305 Texas Ave.
Alexandria, LA 71301

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise related against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is:

Jenny Smith, CFO
Agilus Health, Inc.
1305 Texas Ave.
Alexandria, LA 71301
(318) 443-5278

This notice is effective on or after **September 5, 2013**