



Patient Information Sheet

Date: _____

Patient Name: _____
LAST FIRST MI

Street Address: _____

CITY STATE ZIP

Social Security #: _____ Birthdate: _____ Sex: M / F

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____ Cell Carrier: _____

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

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

Marital Status: Single Married Divorced Widowed

Spouse or Guardian's Name: _____ Phone: _____

Patient's Employer: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Are you currently on Home Health? Yes / No

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: _____

Patient Medical History

Patient Name: _____ Date: _____

1. Date of injury/illness onset: _____

2. Check which apply to your symptoms:

- | | |
|---|---|
| <input type="checkbox"/> work related injury | <input type="checkbox"/> recurrence of previous injury |
| <input type="checkbox"/> motor vehicle accident | <input type="checkbox"/> injury related to lifting |
| <input type="checkbox"/> cause unknown | <input type="checkbox"/> athletic / recreational injury |
| <input type="checkbox"/> other: _____ | |

3. Have you had a related surgery? YES NO

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

- | | | | |
|---------------------|--|-----------------------------|--|
| Are you pregnant? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Bowel/Bladder abnormalities | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetic | <input type="checkbox"/> YES <input type="checkbox"/> NO | Skin Abnormalities | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chest pain/Angina | <input type="checkbox"/> YES <input type="checkbox"/> NO | Nausea/Vomiting | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO | Ringing in your ears | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Rheumatoid arthritis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Pacemaker | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hernia | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Headaches | <input type="checkbox"/> YES <input type="checkbox"/> NO | Seizures | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Metal Implants | <input type="checkbox"/> YES <input type="checkbox"/> NO | Dizziness/Fainting | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cancer | <input type="checkbox"/> YES <input type="checkbox"/> NO | Recent Fractures | <input type="checkbox"/> YES <input type="checkbox"/> 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? If yes, please list below: YES NO

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: _____



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:

| | | |
|--|---|---|
| <input type="checkbox"/> Complete Records | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progressive Notes |
| <input type="checkbox"/> Care Plan | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Treatment Record | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Hospital Reports | <input type="checkbox"/> Medication Record | <input type="checkbox"/> 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's Extended Signature
Authorization**

****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.**

"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



Photography/Video Consent Form

Here 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: _____

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