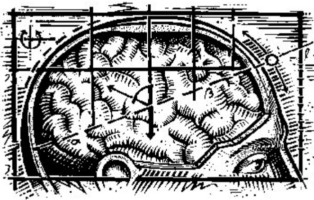


155 Hospital Drive
Suite 100
Lafayette LA 70503
Phone: 337 235 7743
Fax: 337 769 0892

Alan J. Appley, M.D.

Neurological Surgery

Please Print. The following information becomes part of your confidential medical record.

Patient Name:____________________________________ Date:_____________________
Address:____
City:______________________________ State:____________ Zip Code:___________________
SSN:_______-______-_______ Date of birth:_____/_____/______ Age:__________
☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other Primary Language:__________________
Home Phone:_____-_____-_____ Work Phone:____-_____-_____ ext._____ Cell: ___-____-_______
E-mail address: ____ Employer: _____________________
Emergency Contact:_______________Relationship: ______________ Phone:______-______-_______

Spouse /Parent Information

Name:____ Date of birth: ___________________
SSN #: _______-_____-______________ Employer: ____

Confidential Channel Communication Request

As required by the health Information Portability and Accountability Act (HIPAA) of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels.

I hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supercedes any prior request for confidential channel communications I may have made.

1. May we discuss our Personal Health Information with anyone else? (You must fill in the name and phone number if okay)
   Spouse ____
   Parent ____
   Child or Children ____
   ____
   Other ____
2. May we leave a detailed verbal message or send written correspondence to:
   _____Home Number _____Work Number ______Cell Phone _______Fax ______Home Address

   *Yes* Billing Address _____Text Msgs ______Email :________________________________

If no one is listed we will leave a message with ONLY a call back number

____ ___________________________

Patient or Responsible Persons Signature Date

Please complete if you are Group Health, Medicare or Medicaid:

Primary Insurance Carrier: ____
Address: ______________________City: _________ State: ________ Zip: ____________
Phone: ________________________ Fax #: ________________________
Name of Policy Holder: ____
SS# for Policy Holder: ______________DOB for Policy Holder: ________________
Policy Number: ____________________ Group Number: ________________
Employer (if group Policy) ____
[ ] I would like a copy of my clinic note sent to this insurance carrier.

Secondary Insurance Carrier: ____
Address: ______________________City: _________ State: ________ Zip: ____________
Phone: ________________________ Fax #: ________________________
Name of Policy Holder: ____
SS# for Policy Holder: ______________DOB for Policy Holder: ________________
Policy Number: ____________________ Group Number: ________________
Employer (if group Policy) ____
[ ] I would like a copy of my clinic note sent to insurance carrier.

Referring Physician: ____
Address: ____________________ City: __________ State: _________ Zip: _________
Phone: ________________________ Fax Number: ____________________
[ ] I would like a copy of my clinic note sent to this doctor.

Attorney: ____
Address: ____________________ City: __________ State: _________ Zip: _________
Phone: ________________________ Fax Number: ____________________
[ ] I would like my attorney to receive a copy of my clinic note.

Please list any other physician's that your have seen in the past for this problem or similar problem:

Physician Name: ____
Address: ____________________ City: __________ State: _________ Zip: _________
Phone: ________________________ Fax Number: ____________________
[ ] I would like a copy of my clinic note sent to this doctor.

Physician Name: ____
Address: ____________________ City: __________ State: _________ Zip: _________
Phone: ________________________ Fax Number: ____________________
[ ] I would like a copy of my clinic note sent to this doctor.

Physician Name: ____
Address: ____________________ City: __________ State: _________ Zip: _________
Phone: ________________________ Fax Number: ____________________
[ ] I would like a copy of my clinic note sent to this doctor.

All the above information is true and correct to the best of my knowledge.

______________________________________ ______________________

Signature: Date:

Chief Complaint:

Please describe your chief complaint in detail and include the duration of the symptoms (onset of problem, location of pain numbness, tingling, rate your pain level, etc…)

____
____
____
____
____

If this is the result of an accident please give date of accident: (month date year) ______________________

☐ Motor Vehicle Accident ☐ Work Related Injury ☐ Slip & Fall ☐ No apparent cause
☐ Altercation ☐ Assault ☐ other: ______________________________

Please give date (month/day/year): ____

The onset of your symptoms has been:

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Fall ☐ Bending ☐ Pulling ☐ Insidious
☐ Twisting (☐ right ☐ left) ☐ Other: _____________________________________

What makes the pain worse?

☐ Nothing ☐ During exercise ☐ After exercise ☐ Prolonged sitting –length _________
☐ Prolong standing - length ________ ☐ Walking length __________ ☐ Bending forward
☐ Bending backward ☐ Pushing ☐ Pulling ☐ Squatting ☐ Night pain
☐ Changing Position ☐ Laying down ☐ Other: _____________________

What makes the pain better?

☐ Nothing ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Medication
☐ Shifting/changing position ☐ Exercising ☐ Other: ______________________

Please check off which of the following you have had done:

☐ X-ray Where _______ ☐ MRI Where ______ ☐ Discography Where ______ ☐ CT Scan Where _______ ☐ EMG/NCS (electrical studies) Where ___________
☐ Myelogram/CT Where______ ☐ Bone Scan Where_____ ☐ Other (Please Specify):_________________________

What treatments have you had for this problem? (Check all that apply)

☐ Nothing ☐ Chiropractic Care ☐ Injections
☐ Physical Therapy
  ☐ Stretching ☐ Strengthening ☐ Traction ☐ Tens ☐ Pool Therapy
  ☐ Massage ☐ Ultrasound ☐ Heat/Ice
☐ Medications
  ☐ Muscle Relaxants ☐ Pain Medications ☐ Anti-Inflammatory (Prescription)
  ☐ Anti-Inflammatory – Over the Counter (Aspirin, Tylenol, Advil, etc)
  ☐ Other: (please specify): ____
  If so, did you get relief? ☐ No ☐ Slight ☐ Marked ☐ Moderate

Course or Progression of Symptoms?

☐ Improving ☐ Unchanged ☐ Worsening

Patient Name:

Do you have any mobility needs?
☐ Cane ☐ Wheelchair ☐ Crutches ☐ Walker

Have you had other episodes of pain or injuries to your neck or back?
- ☐ No, never
- ☐ Yes, Once When? ____________ (year)
- ☐ Yes, more than once
  - The first episode or injury was in _____________(year)
  - The last episode or injury was in ______________ (year)
  - Total number of episodes or injuries: _______________ (year)
  - Frequency of these episodes or injuries: ______________(year)

Patient is ________ right handed _________ left handed

Occupation ______________________________________
Current work status?

- ☐ Regular Employment – No Restriction
- ☐ Full – Time with Restrictions
- ☐ Part – Time by choice
- ☐ Part – Time for Medical Reasons
- ☐ Retired by Choice
- ☐ Retired by Medical Reasons
- ☐ Unemployed
- ☐ Currently not working for medical reasons
- ☐ Student
- ☐ Other –Specify _____________

If no date last worked __________________

Dr. Appley has treated/or is treating a member of my family? [ ] No [ ] Yes
____

Have you ever seen a Cardiologist? [ ] Yes [ ] No If yes, who was the cardiologist that you saw?
____

Allergies

Name of Allergies	Type of Reaction

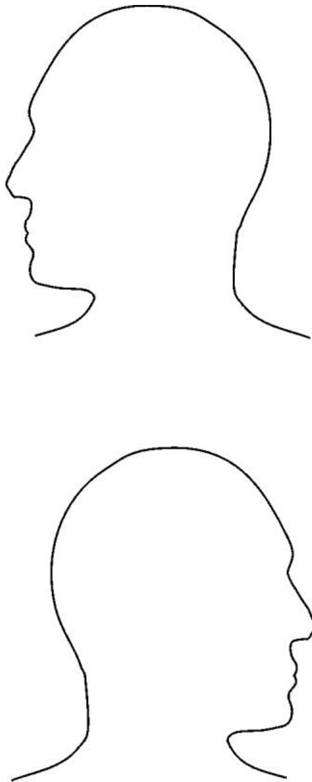
Please use a separate sheet of paper to write any additional allergies

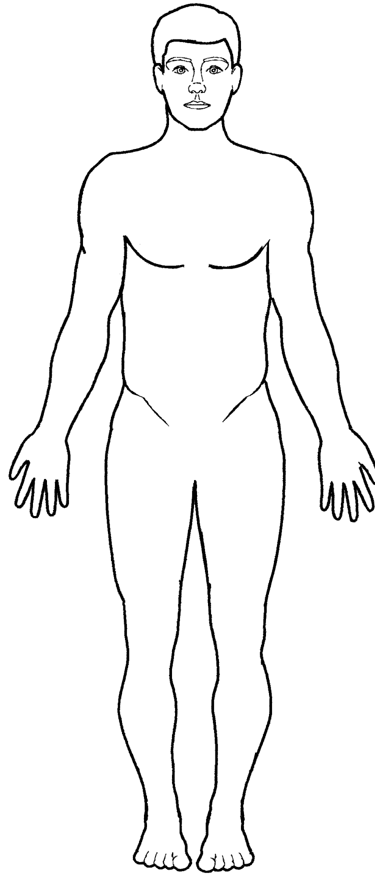
Do you have any allergies to iodine? [ ] No [ ] Yes
If yes, describe the nature of the reaction: ____

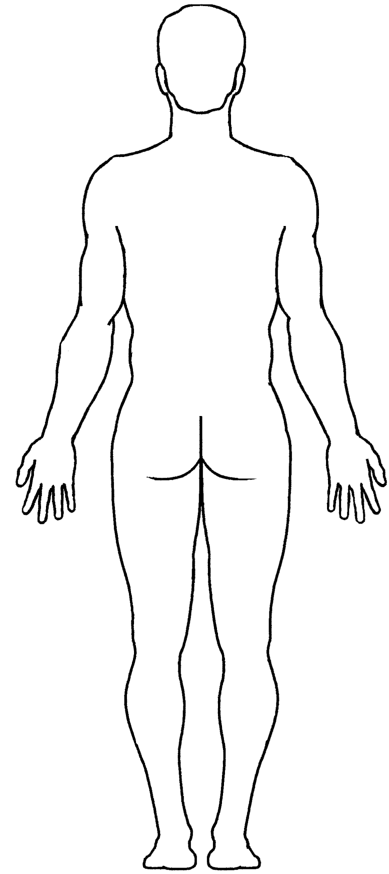
Patient Name:

Mark the areas of your body where you feel pain and/or sensations below, using the appropriate symbol

Aching/Pain	Numbness	Pins & Needles	Burning	Stabbing
^^^^^^	------	000000	XXX	//////////







Pain Scale:

This is a pain scale from "0" (no pain) to "10" (torture pain). Please choose a number that best fits your pain complaints for your "AVERAGE pain and your "WORST" pain in whatever area(s) hurt.

0	2	4	6	8	10
None	Mild	Discomforting	Distressing	Horrible	Excruciating

Worst pain you've ever had		0	1	2	3	4	5	6	7	8	9	10
Current neck pain	Average	0	1	2	3	4	5	6	7	8	9	10
	Worst	0	1	2	3	4	5	6	7	8	9	10
Current arm Pain	Average	0	1	2	3	4	5	6	7	8	9	10
	Worst	0	1	2	3	4	5	6	7	8	9	10
Current Mid Back Pain	Average	0	1	2	3	4	5	6	7	8	9	10
	Worst	0	1	2	3	4	5	6	7	8	9	10
Current low Back pain	Average	0	1	2	3	4	5	6	7	8	9	10
	Worst	0	1	2	3	4	5	6	7	8	9	10
Current leg Pain	Average	0	1	2	3	4	5	6	7	8	9	10
	Worst	0	1	2	3	4	5	6	7	8	9	10

Alan J. Appley, MD, FACS
Consent for Treatment and Financial Authorization

Patient Name: ____ Date: ____________________

I hereby give consent to Alan J. Appley, MD to provide whatever treatment he may deem necessary to the patient listed above.

I understand my responsibility for payment of services provide to me. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Alan J. Appley, MD for Professional Physician's fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by the insurance policy.

In the matter of balances remaining unpaid, it is the policy of our office to refer such outstanding debts to either a collection agency or an attorney for further action. Accounts referred to either an attorney or collection agency are subject to a late fee of 35% of the unpaid amount.

I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made either to me or on my behalf to Alan J. Appley, MD for any medical services furnished to me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If item 9 of HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I hereby authorize the release of my medical records to Alan J. Appley, MD. I release you from all legal responsibility or liability that may arise from this authorization. You have my permission to fax my medical records whenever medically necessary.

ATTENTION: Effective 11/15/12 there will be a $50 **charge** for all New Patient **NO SHOWS** and a $25.00 charge for all return patients who **NO SHOW** without **24 hours notice**

Dr. Appley is proud to disclose the fact that he has financial interest in Lafayette Surgical Specialty Hospital. If you are referred to this facility and have any questions, please feel free to discuss this with Dr Appley directly.

Patient's Signature (Parent/Guardian if minor child) ____
Date ___________________________ Witness Signature ____

Lifetime Medicare B Signature Authorization (Please circle one)

1. Do you or your spouse work for a company that provides you with health insurance? YES NO
2. Are you entitled to Medicare because of a disability or End Stage Renal Disease? YES NO
3. Is this illness or injury the result of an automobile accident or injury? YES NO
4. Is this illness or injury the result of an accident or illness that occurred at work? YES NO
5. Has treatment for this accident or illness been authorized by the Veteran's Administration? YES NO
6. Are you entitled to any benefits under the Federal Black Lung Program? YES NO

Note: If you answered yes to any of the above questions, Medicare may be secondary.

MEDICARE PATIENTS ONLY: Medicare Part B Signature Authorization (Lifetime)

I certify that the information given by me in applying for payment under Tide XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Patients Name_________________________________ Patient Signature ______________________________
Medicare # _____________________________________ Date ____

Alan J. Appley, MD
Authorization to Release Health Information

***ALL ASTERISKED ITEMS MUST BE COMPLETED.**

*Patient Name: ______________________________ *** Date of Birth:** ___________________

***Patient Number:** ____________________________ *** Social Security** # ________________

***Address:** ____

***Provider authorized to release the Health Information:**
(Name of releasing entity)
____
____
____

***Entity to receive the Health Information:**
Alan J. Appley M.D.
155 Hospital Drive
Suite 100
Lafayette LA 70503
337-235-7743 Phone
337-769-0892 Fax

Dates of service of Health Information that is covered by this authorization:
Start date: ____________ End date: ____________
*Health Information related to the patient to be release under this authorization:
_______ Complete health record
_______ Immunizations
_______ Laboratory tests
_______ Radiology Report
_______ Specific Physician
_______ Specific Medical Dept.
_______ Other (Please Specify): _diagnostic studies, op notes, consultant reports, history & physical
____

The following information will be release when included in the above unless you indicate otherwise:
______ Do not release any AIDS or HIV test results
______ Do not release any records of psychiatric care
______ Do not release any records of alcohol/substance abuse treatment
______ Other: ____
*Purpose of Disclosure: Neurological Surgery Evaluation
*Authorization expiration date or event: ____________________________________

You may revoke this authorization at any time, except to the extent that we have already relied upon it in making a use of disclosure. A written request to revoke an authorization any be sent to Dr. Alan Appley Medical Records Department.
The patient has the right to refuse to sign this authorization. Dr. Alan Appley cannot condition treatment, payment, enrollment or eligibility for benefits on the patient providing this signed authorization. When the patient's health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient or any of its agents and/or employees and may no longer be protected by 45 C.F.R. Parts 160 and 164.

A photocopy/facsimile of this authorization may serve as an original.
The party receiving the medical records is responsible for payment of the copying charges.
Records will be rendered after payment and signature are received

______________________ ______________________
*Patient's Signature *Date (Expires upon death)

OR

*If patient is a minor or unable to sign for self:

By my signature below I certify that I am the ______________________ (relationship) of the above named patient.

______________________ ______________________ ______________________
Signature of Patient Representative Printed Name Date

*Verification of identity of person in to whom records are being given, Indicate method of verification:
_______ personal knowledge ______ pictured ID ________ Other: Describe: _________________

Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

You may obtain a paper copy of privacy practices upon request – Contact our Privacy Officer
If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer

This office has made me aware of my rights as a patient. I hereby acknowledge my full and complete understand of these rights.

______________________________ ______________________

Patient Signature Date

Current Medications

Please bring ALL bottles of medications that you are taking to your scheduled appointment.

HOME MEDICATIONS

MEDICATION NAME	DOSAGE	HOW MEDICATION IS TAKEN	REASON FOR TAKING	COMMENTS
Example: *Tylenol*	*325mg*	*2tabs every 4hrs*	*headaches*	