Superior Healthcare, L.L.C.
3501 Severn Avenue , Suite 8
Metairie, Louisiana 70002

PATIENT APPLICATION

PLEASE PRINT. All requested information must be completed. If any question does not apply, please enter the term "N/A."

Last Name_____First Name_____M.I._____Date of Birth_____Age_____

Home Address_____
Street/City/State/Zip Code

Nickname : _____ Race / Ethnicity: _____ Gender: MALE / FEMALE _____

Social Security #_____Home Phone_(____)_____Cell Phone_(____)_____Work Phone_(____)_____

Employer_____Occupation_____May we contact you at work? Y/ N Home? Y/ N

Marital Status □ S □ M □ D □ W Spouse's Last Name_____First Name_____M.I._____

Responsible Party □ Self □ Spouse □ Other If "Other," relationship to you?_____Responsible Party Phone_(____)_____

Responsible Party Information: If "Self," state "Same." Last Name_____First Name_____DOB._____

Do we have permission to discuss your condition with or provide information from your chart to your spouse or other named individual? Y / N

Last Name_____First Name_____M.I._____Relationship to you_____

Primary Care Physician_____Phone_(____)_____

Who may we thank for this referral? _____ Your email address:_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Superior Healthcare, LLC to furnish medical/chiropractic/physical rehab and treatment that is considered necessary and proper in diagnosing or treating my/their physical condition and have received the Patient Rights and Responsibilities.

Patient Initial Here: **_____**

EMERGENCY CONTACT INFORMATION

Last Name_____First Name_____M.I._____Relationship to you_____

TWO Emergency Contact Phone Numbers Home Phone_(____)_____Cell Phone_(____)_____Work Phone_(____)_____

INSURANCE INFORMATION and FINANCIAL POLICY STATEMENT

Primary Ins._____Contract #_____Group #_____Effective Date_____Copay_____

Name and of Policy Holder (If other than "Self") Last Name_____First Name_____M.I._____

Policy Holder's / Insured's Social Security #_____Policy Holder's / Insured's Date of Birth_____

Secondary Ins._____Contract #_____Group #_____Effective Date_____

Name and of Policy Holder (If other than "Self") Last Name_____First Name_____M.I._____

Policy Holder's / Insured's Social Security #_____Policy Holder's / Insured's Date of Birth_____

It is our policy to bill your insurance carrier(s) as a courtesy to you, although you are responsible for the entire bill when the services are rendered. You are required to authorize the release of any medical information necessary to process claims. We require that payment of any copay per visit be made at the time of your visit. If your insurance carrier(s) do no remit payment within 90 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier(s) in excess of the balance of your account, we will promptly refund the credit. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit to this office. The policy does not apply to individuals who have contracted a Care Plan Financial Agreement with Superior Healthcare, Inc. unless and until such agreement expires, and/or there is coinsurance due per your insurance company; nor does it apply to Worker's Compensation or Personal Injury patients. However, Worker's Compensation or Personal Injury patients should be advised that you may be held responsible for your charges in the event your claim is converted. I have read the above information and fully understand my responsibility for the payment of my account.

Patient / Guardian Signature_____ Date_____

Superior Healthcare, L.L.C

Health History

Patient Name _____DOB: _____ Today's Date _____
Date of last physical examination _____
Reason for visit:
_____
_____

Symptoms

Check symptoms you currently experience or have experienced in the past year.

GENERAL
☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of Sleep
☐ Loss of Weight
☐ Nervousness
☐ Sweats
☐ Low Energy/Fatigue

SKIN
☐ Bruise Easily
☐ Hives
☐ Itching
☐ Change in Moles
☐ Rash
☐ Scars
☐ Sores that will not heal

HEENT
EYE, EAR, NOSE, THROAT
☐ Blurred Vision
☐ Double Vision
☐ Vision – Flashes
☐ Vision - Halos
☐ Crossed Eyes
☐ Earache
☐ Ear Discharge
☐ Ringing in Ears
☐ Sinus Problems
☐ Nosebleeds
☐ Allergies
☐ Hay Fever
☐ TMJ/Pain/Clicking
☐ Teeth Grinding
☐ Bleeding Gums
☐ Difficulty Swallowing
☐ Hoarseness

MUSCLE/JOINT/BONE
Pain, Weakness, Numbness
☐ Arms
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulders

CERVICAL – THORACIC – LUMBAR SPINE
☐ Neck Pain
☐ Radiating Pain Shoulder
☐ Radiating Pain Arms/Hands
☐ Weakness in Grip
☐ Coldness in Hands
☐ Numb/Tingling Arms/Hands
☐ Pain on Deep Breathing
☐ Mid Back Pain
☐ Pain into Ribs/Chest
☐ Pain into Hips/Legs/Feet
☐ Numbness/Tingling Legs/Feet
☐ Coldness Legs/Feet
☐ Muscle Cramps Legs/Feet
☐ Lower Back Pain

CARDIOVASCULAR
☐ Chest Pain
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Irregular Heartbeat
☐ Poor Circulation
☐ Rapid Heartbeat
☐ Swelling of Ankles
☐ Varicose Veins
☐ Excessive Water Retention

LUNGS
☐ Difficulty Breathing
☐ Persistent Cough
☐ Bloody Mucus
☐ Bloody Sputum

☐ Recurrent Colds or Flu

GASTROINTESTINAL
☐ Bloating
☐ Bowel Changes
☐ Constipation
☐ Diarrhea
☐ Excessive Hunger
☐ Excessive Thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion/Heartburn/Reflux
☐ Nausea
☐ Rectal Bleeding
☐ Stomach Pain
☐ Vomiting
☐ Vomiting Blood

GENITO-URINARY
☐ Blood in Urine
☐ Frequent Urination
☐ Loss of Bladder Control
☐ Painful Urination

MEN ONLY
☐ Breast Lump(s)
☐ Erectile Dysfunction
☐ Lump(s) in Testicle
☐ Discharge from Penis
☐ Sore(s) on Genitalia
☐ Other

WOMEN ONLY
☐ Abnormal Pap Smear
☐ Bleeding Between Periods
☐ Breast Lump(s)
☐ Extreme Menstrual Pain
☐ Hot Flashes
☐ Nipple Discharge
☐ Painful Intercourse
☐ Vaginal Discharge
☐ Sexual Dysfunction
☐ Other
Last Menstrual Period _____
Last Pap Smear _____
Last Mammogram _____
Are you pregnant? ☐ Yes ☐ No
Number of Children _____

Conditions

Check conditions you currently experience or have experienced in the past year.

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Chicken Pox
☐ Chronic Fatigue
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herpes
☐ High Cholesterol
☐ HIV Positive
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headaches
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Psychiatric Care
☐ Restless Leg Syndrome
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Scarlet Fever
☐ Stroke
☐ Suicide Attempt
☐ Systemic Lupus
☐ Thyroid Problem
☐ Tonsillitis
☐ Tuberculosis
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infections
☐ Venereal Disease

NAME: DOB: DATE:

Current Medications

Pharmacy Name Phone

Allergies

Family History

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had/have any of the following.	
					Disease	Relationship to you
Father					☐ Arthritis/Gout	
Mother					☐ Asthma/Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ SLE/CFS/Other Rheumatoid	
					☐ Tuberculosis	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Serious Illnesses/Injuries

Appx. Date	Type of Serious Illness/Injury and Outcome

Pregnancies

Year	Sex	Complications if Any

Health Habits

Check and describe how much you use or do below:

- ☐ Alcohol
- ☐ Caffeine
- ☐ Illegal Drugs
- ☐ Tobacco
- ☐ Exercise

Occupational

Check if your work exposes you to the following:

- ☐ Hazardous Substances
- ☐ Heavy Lifting
- ☐ Stress
- ☐ Other
- ☐ Other
- ☐ Other

I certify that the above information is correct to the best of my knowledge. I will not hold my physician or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____

Date:_____

Health Questionnaire

Name: _____

E-mail Address: _____

Check off any of the following symptoms you have experienced in the past 6 months:

☐ Mid Back Pain
☐ Low Back Pain
☐ Pain between Shoulder Blades
☐ Neck Pain
☐ Tension/Headaches/migraine
☐ Fibromyalgia
☐ Dizziness
☐ Cramping in Arms, Hands, Legs, Feet
☐ Weakness in Arms, Hands (Grip), Hips, Knees, Feet, Shoulder
☐ Unexplained Weight Gain/ Loss
☐ Tension Across Top of Shoulders
☐ Numbing/Tingling in Arms/Hands
☐ Numbing/Tingling in Legs/Feet
☐ Pain in the legs
☐ Pain in the Feet
☐ Pain in Knees, Shoulder, Elbow, Hands
☐ TMJ
☐ Difficulty Losing Weight
☐ Tired/Fatigued
☐ Difficulty Sleeping
☐ Allergies/Asthma/ Respiratory Problems
☐ Digestive Problems
☐ Carpal Tunnel
☐ Coldness in Feet, Hands

OTHER (explain) _____

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like ?(describe) _____

What have you done that has helped this problem? _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:
☐ Moody
☐ Irritable
☐ Interrupt sleep
☐ Restricted in your daily activities

Does this affect your work:
☐ Decision making
☐ Poor attitude
☐ Decreased productivity
Exhausted at the end of the day
☐ Unable to work long hours

Does this affect your life:
☐ Lose patience with spouse/children
☐ Restricted household duties
☐ Hinders ability to exercise or sports
☐ Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

◆ Medications…Helped: Little Some Much
◆ Physical Therapy…Helped: Little Some Much
◆ Chiropractic…Helped: Little Some Much
◆ Exercise…Helped: Little Some Much
◆ Nutrition…Helped: Little Some Much
◆ Stretching…Helped: Little Some Much

Signature: _____ Date: _____/_____/_____

`Neurological / MRI/ Vascular Patient Questionnaire

Name Date

For any YES answer, please explain under comment and notify the doctor:

1. Do you suffer from neck pain in your shoulder, arms or hands? NO YES
Comment:

2. Do you have weakness, numbness or burning in your shoulder arms, or hands? NO YES
Comment:

3. Do your hands or arms fall asleep regularly? NO YES
Comment:

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
Comment:

5. Do you suffer from a loss of handgrip strength? NO YES
Comment:

6. Do you suffer with back pain with pain in your buttocks, legs, or feet? NO YES
Comment:

7. Do you have weakness, numbness or burning in your buttocks, legs, or feet? NO YES
Comment:

8. Do your legs or feet fall asleep regularly? NO YES
Comment:

9. Do you have reduced feeling (sensation) or swelling in your legs or feet? NO YES
Comment:

10. Do you suffer from cold hands or feet? NO YES
Comment:

11. Have you tried any medications such as anti-inflammatory? NO YES
If yes, what kind of medication?

12. Have you tried any physical therapy or Chiropractic treatments before? NO YES
If yes: When? For how long? What kind?

13. Have you had an MRI? NO YES
If yes: When? Who ordered it? What was it ordered for?

14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
If yes: When? What kind? Who ordered it?

15. If you have tried any treatment or medications, did this make your problem better? NO YES
Comment:

Note: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

Superior Healthcare

3501 Severn Avenue, Suite 8
Metairie, LA 70002
(504) 835-0565

MEDICATION REFILL POLICY

THE FOLLOWING APPLIES TO ANY AND ALL PATIENTS RECEIVING SCRIPTS

1. It is your responsibility to notify the office in a timely manner when refills are necessary.
2. Approval of your refill may take up to three business days. So please be courteous and do not wait to call.
3. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.
4. Medication refills will only be addressed during regular office hours (Monday – Thursday 8-12, 2-6 Friday 8-12). Please notify your provider the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.
5. Refills can only be authorized on medications that have been prescribed by providers in our office. We will not refill medications prescribed by other providers. In order to get a medication in need of refill prescribed by another facility you will have to come into the office for an office visit and get a new prescription written.
6. Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy will be notified of the approval status. Neither the pharmacy nor the provider can guaranty that your insurance will approve the medication. Please check with your pharmacy or your insurance company for updates.
7. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in denial of refills. All prescriptions require a follow up appointment every 3-6 months.
8. If you have any questions regarding your medications please discuss these questions during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact the office immediately and make an appointment to discuss this.
9. New symptoms or events require an appointment. Your provider will not diagnose or treat over the phone. If it is an emergency or the office is closed go to the ER.
10. It is the policy of the office not to prescribe narcotics. You will need to see pain management or go to the ER for narcotics.
11. If your prescription and or medications are lost, stolen, destroyed or in some other way damaged, the medication and prescriptions will not be re-written for you or refilled. You will have to wait till the next month when the next refill is available.

Thank you for your cooperation in this matter.

I have read and fully understand the ‘Medication Refill Policy’ and agree to abide by these terms.

Patient Signature or Responsible Party Date

Superior Healthcare, LLC

Notification of Information Practices

Health **I**nsurance **P**ortability **& A**ccountability **A**ct

(HIPAA)

The purpose of the consent form is to inform you, the patient, how your personal health information is used and/or disclosed by this provider or organization. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat your health care needs, receive payment for services rendered, and allow administrative and other types of health care operations to happen, which are part of normal business activities of the provider or organization.

Your Consent

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among my diagnosis/es and other health information to my bill(s).
- A source of information for applying my diagnosis/es and other health information to my bill(s).
- A means by which my health plan or health insurance company can verify that services billed were actually provided.
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care are competent to do so.

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and disclosed by Superior Healthcare.
- I have the right to review the Notice of Information Practices prior to signing this consent.
- Superior Healthcare can change its Notice of Information Practices, but notify me of those changes before they are put into practice and will mail me a copy of the new Notice to the address that I have provided.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that Superior Healthcare is not required to agree to those restrictions.
- Any restriction to which Superior Healthcare agrees to will be respected.
- I may revoke this consent in writing at any time. Further, I am aware that Superior Healthcare can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that took place before the consent was revoked.

I request the following restrictions to the use or disclosure of my health information.

_____

_____.

For provider use only:
Restriction is:
□ Accepted □ Denied
Reason Denied:
_____
_____.
Patient Notified?
□Yes □ No

Please provide your signature below to indicate that you have read the above consent and have reviewed the Notice of Information Practices.

_____ _____

Signature of Patient or Legal Representative Date

_____

Legal Representative/ Printed Name/ Relationship/ Why the Patient Cannot Sign

_____

Effective Date

Superior Healthcare, LLC

3501 SEVERN AVENUE SUITE 8 METAIRIE, LOUISIANA 70002
504-835-0565

Patient Rights & Responsibilities

Patient Rights:

1. The patient has the right to considerate and respectful service.
2. The patient has the right to obtain service without regard to race, creed, national origin, sex, age, disability, diagnosis or religious affiliation.
3. Subject to applicable law, the patient has the right to confidentiality of all information pertaining to his/her medical care. Individuals or organizations not involved in the patient's care will not have access to the information without the patient's written consent.
4. The patient has the right to make informed decisions about his/her care.
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process; policy # CQI – 101. Upon admission to our services all patient/caregivers are informed of how complaints are reported, reviewed, and resolved. A copy of the patient rights and responsibilities, which the patient/caregiver receives, clearly states whom to call w/ complaints, or unsolved problems. All complaints will be reported to the administrator who will review the complaint and within 5 working days and resolve complaint. The information is then documented on a complaint summary and if unsolved, a written response is sent to the patient within 14 days. The Quality Improvement Team reviews complaints on a quarterly basis as a way of identifying areas for improvement. All complaint summaries will be filed in the Complaint file and kept confidential.

Patient Responsibilities:

1. The patient should promptly notify the Superior Healthcare, LLC of any changes to their address or telephone.

2. The patient should promptly notify the Superior Healthcare, LLC of any changes concerning their physician.

3. The patient should promptly notify the Superior Healthcare, LLC of any changes to their address or telephone.

4. The patient should promptly notify the Superior Healthcare, LLC of any equipment failure or damage.

5. Except where contrary to federal or state law, the patient is responsible for any equipment rental and sale charges which the patient's insurance company/companies does not pay.