



Today's Date _____

ACCIDENT QUESTIONNAIRE

NAME _____

Date of Accident _____

1. What kind of car were you in?

- Compact
- Mid-size
- Full size
- SUV
- Mini-van
- Pick-Up Truck
- Bus
- 18 Wheeler
- Commercial

2. What was the other vehicle?

- Compact
- Mid-size
- Full size
- SUV
- Mini-van
- Pick-Up Truck
- Bus
- 18 Wheeler
- Commercial

3. Did you hit anything else after the first impact?

- Yes No
- Another vehicle
- Other _____
- _____
- _____

4. At the time of the crash what was your vehicle doing?

- Sitting at a stop sign/stop light
- Stopped in traffic or stopped for another reason
- Moving with traffic
- Crossing an intersection
- Turning
- Other _____

5. How was your vehicle hit?

- From behind/rear impact
- From the front/front impact
- From the driver's side
- From the passenger's side
- Other _____

6. What was the weather like when your crash happened?

- Raining or recently rained
- Misting or recently misty
- Dry

7. What was the street condition?

- Wet/slick
- Dry



Today's Date _____

8. Where were you in the car?

- Driver
- Front seat passenger
- Passenger in back seat on driver's side
- Passenger in back seat on passenger's side
- Passenger in back seat in the middle
- Passenger in 3rd row of SUV or mini-van
- Passenger in car-seat - rear facing
- Passenger in car-seat - facing forward
- Passenger in booster seat

9. Were you wearing a seat belt?

- Yes No

What kind of seat belt were you wearing?

- Lap/Shoulder
- Shoulder only
- Lap only

11. What was your body position?

- Facing forward
- Turned to right or left
- Leaning forward
- Slouching in seat

10. Were you hit by an airbag?

- Yes No
- Head/face/neck
- Arm/forearm/shoulder

13. What was your head position?

- Looking forward
- Head turned up Head turned down
- Head turned right Head turned left

12. Did you go to a hospital or doctor after the crash?

- Yes No

What hospital/doctor? _____

14. Did your body strike any part of the inside of the vehicle?

- Yes No

If yes please describe.

Doctor's use only-



Today's Date _____

Symptoms

NAME _____

Date of Accident _____

INSTRUCTIONS: Check any symptom you have felt at any time since your car accident

1. HEAD INJURIES

___ I was unconscious

___ Fatigued

___ Did you strike your head on anything?

___ Appetite changed

If yes, what? _____

___ Sleeping more than usual

___ Headaches

___ Sleeping less than usual

___ Dizziness

___ Vision problems; blurry, double vision

___ Difficulty walking NOT due to back pain

___ Trouble reading or writing

___ Balance problems

___ Nausea

___ Confused

___ Vomiting

___ Sensitive to noise

___ Depressed

___ Sensitive to light

___ Mood swings

___ Trouble concentrating

___ Irritable

___ Trouble remembering

___ Trouble speaking

2. CUTS OR BRUISES

___ Head or face cut/bruise

___ Neck cut/bruise

___ Chest cut/bruise

___ Abdomen cut/bruise

___ Arms cut/bruise

___ Hands cut/bruise

___ Legs cut/bruise

___ Feet cut/bruise

___ Seat belt bruise or chest pain from
seat belt cut/bruise

___ Other cuts or bruises _____



3. JAW PROBLEMS

- Jaw pain
- Clicking
- Pain while opening and/or closing mouth
- Clicking while opening and/or closing mouth
- Pain while moving jaw from side to side

4. NECK/UPPER BACK

- Neck pain Right side Left side Both sides
- Upper back pain Right side Left side Both sides
- Pain/tingling/numbness radiating into the RIGHT shoulder, arm, forearm or hand
- Pain/tingling/numbness radiating into the LEFT shoulder, arm, forearm or hand
- Popping/clicking in neck

5. MID-BACK/LOWER BACK PAIN

- Mid-back pain Right side Left side Both sides
- Low back pain Right side Left side Both sides
- Pain/tingling/numbness into the RIGHT buttock, thigh, leg or foot
- Pain/tingling/numbness into the LEFT buttock, thigh, leg or foot

6. OTHER AREAS OF PAIN

- | | | | |
|---|---|-------------------------------------|---|
| <input type="checkbox"/> Right shoulder | <input type="checkbox"/> Right trapezius | <input type="checkbox"/> Right hip | <input type="checkbox"/> Right thigh |
| <input type="checkbox"/> Left shoulder | <input type="checkbox"/> Left trapezius | <input type="checkbox"/> Left hip | <input type="checkbox"/> Left thigh |
| <input type="checkbox"/> Right elbow | <input type="checkbox"/> Right hand/wrist | <input type="checkbox"/> Right knee | <input type="checkbox"/> Right ankle/foot |
| <input type="checkbox"/> Left elbow | <input type="checkbox"/> Left hand/wrist | <input type="checkbox"/> Left knee | <input type="checkbox"/> Left ankle/foot |
-

PATIENT- BLACK INK STAFF-RED INK DOCTOR-BLUE INK

PATIENT INFORMATION

Last Name: _____ First Name: _____ Sex: M / F
Address: _____ City: _____ State: ____ Zip: _____
Home Phone _____ Work Phone: _____ Cell Phone: _____
Birth Date: _____ Age: ____ Marital Status: Single Married Divorced Widowed
Social Security #: _____ - _____ - _____ Driver's License #: _____
Emergency Contact: _____ Relation: _____

HOW DID YOU HEAR ABOUT US? _____

Employed / Unemployed / Student / Homemaker

Employed by: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____

Attorney's Name: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____

Insurance of person at fault: _____ Phone # _____

Insured's Name: _____ Phone # _____
Address: _____ City: _____ State: _____ Zip: _____
Policy # _____ Claim # _____

Your Auto Insurance Co.: _____ Phone # _____

Policy #: _____ Claim #: _____
Insurance Company: _____ Policy#: _____ Claim #: _____

Health Insurance: _____ Phone #: _____

Policy#: _____ Group # _____

*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered.
AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balance at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from my insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and 25% attorney's fees. I authorize the release of any information pertinent to my case to the insurance company.

Signature _____ Date _____

Louisiana Law requires physicians and other healthcare providers to make certain disclosures to a patient when they refer a patient to another healthcare provider or facility in which the physician has a significant financial interest. If medically necessary, I may refer you, or the named patient for whom you are a legal representative to: Injury Treatment Center New Orleans, 6225 S. Claiborne Ave. Ste. B, New Orleans, LA 70125. I, Jason Kennedy, have a significant financial interest in the healthcare provider to whom we are referring you. I, the below name patient, or legal representative, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

Print Patient's Name Signature of Patient Date

Consent to X-Ray

I hereby authorize New Orleans East Medical Rehab and whomever the clinician may designate as his/her assistant(s) to take x-rays of myself (or said minor).

Date _____

Patient Printed Name

Patient Signature

Signature of Parent or Guardian (if minor)

Consent to X-Ray Pregnancy Release

I hereby release New Orleans East Medical Rehab from any and all liability.

Patient Signature

Signature of Parent or Guardian (if minor)

New Orleans East Medical Rehab
9810 Lake Forest Blvd., Ste 103
New Orleans, La 70127
Tel: 504-242-422 Fax: 504-241-9623

**CONTROLLED SUBSTANCE PRESCRIPTION RESPONSIBILITY
AGREEMENT**

The following is a set of agreements the clinic requires before writing a script for controlled substances to a patient. You are to put your initials on each blank line by the numbers. Then print and sign your name along with today's date at the bottom. This is to indicate that you have read and understand the agreement and its four parts. If it is found out that any of these parts have broken script writing for these medications will not continue. Further actions may be taken at that time.

1. _____ **I agree to store medication properly, Medication may be harmful to children, household members, guest, or pets. The pills should be stored in a safe place, out of reach of children. If anyone besides the patient swallows the medication, the patient must call the poison control center or 911 immediately. These medications may not be sold to others.**

2. _____ **I agree to take the medications only as prescribed. The dose should be taken as suggested, and the patient must not adjust the dose on his or her own. If the patient wishes a dose change, he or she will call the office for an appointment to discuss, and the physician may change order. This will be determined on a case by case basis.**

3. _____ **I agree to notify the doctor's office immediately in the case of lost or stolen medication. I will have a police report filed, and bring a copy to the clinic for the record. Writing out a replacement script will be done on a case by case basis.**

4. _____ **I agree not to be taking other controlled substances PRESCRIBED OR NOPRESCRIBED without disclosing with the medical doctor at this clinic. I understand that not fully disclosing all medications may result in discharge from this clinic. Talk with the physician at this clinic if another doctor you are treating under changing your medication dosage. Violation of this agreement is unlawful and may result in criminal prosecution.**

TO BE COMPLETED BY PATIENT

Patient Signature

Date

Patient Name (PRINT)

Witness

Date

Informed Consent

I understand that all health care treatments carry the possibility of complications, and I have read (or had read to me) Spinal Care Treatment Options: The Risks and Benefits. Dr. Kennedy/New Orleans East Medical Rehab Center has informed me of possible risks of chiropractic manipulation and related treatment, including stroke, and I understand the risk.

I have discussed other treatment options and their associated risks and benefits with Dr. Kennedy/ New Orleans East Medical Rehab Center, and all of questions have been answered. Dr. Kennedy/New Orleans East Medical Rehab Center has recommended chiropractic manipulation and related treatment and I choose to follow Dr. Kennedy/New Orleans East Rehab Center recommendations.

I request and give my consent for chiropractic manipulation and related treatment. I intend for this consent to cover all treatments now and in the future by Dr. Kennedy/New Orleans East Medical Rehab Center or any other doctor appointed to administer treatment.

I have read (or had read to me) the above consent.

Patient's Signature

Date

Printed Name of Patient

Signature of Parent or Guardian

Signature of Witness

Printed Name of Parent of Guardian

Printed Name of Witness

Translated by:

__ The patient was able to understand the informed consent, including Dx, Tx, Tx options, risks and benefits () Doctor's initials

__ The patient was not able to understand the informed consent () Doctor's initials

Risk/Benefits of Pain Medication

Dear Patient;

If our Doctor chooses to treat your pain with narcotics in addition to muscle relaxants and anti-inflammatory medications, these, along with our Chiropractic and Therapy treatment will hopefully allow you to accomplish your activities of daily living and even return to work if necessary. Yet, these narcotics may have an occasional side effect which the Doctor will discuss with you. These side effects include Constipation, Nausea, Itching, Urinary Retention, Sedation, even Confusion and possible Breathing problems. Should any of these occur, please discuss them with the doctor. Our clinic policy is to wean you off of these narcotics within the first 3 months. Longer periods of narcotic treatment are often associated with a demising of their ability to lessen pain called TOLERANCE. Should this occur, the doctor will add other medications to help fill the gap. Hopefully, our therapies will have lessened your discomfort, by then to where strong pain relievers are not needed. Some people develop a dependency upon the medication and abruptly stopping it could cause an emotional and physical withdrawals. The Doctor will discuss this possibility with you. If you have any addictive tendencies, they may carry out to narcotics. Should prolonged narcotic pain management be required we will refer you to pain management, where they will address this problem. Along the way, if your pain continues, we will ask your attorney to order specialized testing and specialist referrals to determine the cause and more specific treatment for your pain.

TO BE COMPLETED BY THE PATIENT:

Patient Signature

Date

Patient Name (PRINT)

New Orleans East Medical Rehab

Acknowledgement of Privacy Practice Procedures

Patient acknowledgement

By signing my name below, I acknowledge that the Privacy Practice Procedures have been explained to me, and I understand that I may request a copy at any time. If you have any questions about our Privacy Practices, please contact any staff member in this office.

Patient Name (Print) _____

Patient Signature _____

Date _____

If signed by someone other than the patient, please indicate:

Relationship: parent or guardian of minor parent

guardian or conservator of an incompetent patient

beneficiary or personal representative of deceased patient

other (specify)

Exceptions:

New Orleans East Medical Rehab may share my health information with the following individual(s):

Name(s): _____ Patient Initial: _____

New Orleans East Medical Rehab may share my report to my primary care physician:

Physician Name: _____ Patient Initial: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of Privacy Procedures, but it could not be obtained because:

Individual refused to sign

Witness Signature _____

Date Witness _____

Witness Name (Print) _____

NEW ORLEANS EAST MEDICAL REHAB
9810 LAKE FOREST BLVD., STE. 103
NEW ORLEANS, LA 70127
(504) 242-4221

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by New Orleans East Medical Rehab or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I acknowledge that I have received a copy of the new "Notice of Patient Privacy Policy", and give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date

Print Patient's Full Name

Time

Witness Signature

Date

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing New Orleans East Medical Rehab as your Accident Injury Center. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care if your case was found to be "no good" by an attorney that referred you to our office.
- Patient's are responsible for the payment of all treatments that were received from the 1st date of treatment until the last date of treatment.
- This cost cannot be billed to your medical insurance; therefore, you will be billed at a self pay discounted rate.
- Charges may occur for any forms to be completed and submitted to any outside disability company.

Patient Authorization:

By my signature below, I hereby authorize New Orleans East Rehab physicians and staff to proceed with treatment with the understanding that my personal injury case is not finalized. Once my case is finalized through my attorney, payment will be resolved through my attorney and New Orleans East Rehab. If for any reason my case was found to be "no good", I _____ agree to pay New Orleans East Medical Rehab any balances due upon receipt of notification.

I have read and understand, and agree to the provisions of this Patient Financial Responsibility Form:

* Signature of Patient or Guradian: _____

Date: _____



Jason Kennedy, D.C.

Date: _____

Patient's Name: _____ Patient's Date of Birth: _____

Patient's Address: _____

Date of Injury: _____ Date of Service: _____

Date of Initial Consultation to your office: _____

Doctor/Clinic/Hospital: _____

I authorize New Orleans East Medical Rehab, to request my medical records for their evaluation and/or comparative study purposes. Please provide New Orleans East Medical Rehab, with the following records that are check below:

- X-Rays/MRI Reports (Films)
- Medical/Progress Notes
- Lab Tests
- Any and all records
- Other _____

I hereby voluntarily consent to the release of all medical records including but not limited to information concerning drug and alcohol abuse and psychological conditions that may be included in such records. My signature on this authorization expires one (1) year from the date signed. The X-Rays may be on a temporary basis if you so desired.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

If you should need additional information or if I can be of further assistance; please do not hesitate in contacting our office.

Health & Happiness.

Dr. Jason Kennedy
Clinic Director