2501 West Pinhook Road ♦ Lafayette, LA 70508
Phone (337) 269-0136 ♦ Fax (337) 233-8525

OCCUPATIONAL MEDICINE: DEMOGRAPHICS AND CONSENT

(Patient to Complete Shaded Area)

Name: (First) (MI) (Last) **Cell #**

Address: (Address) (City) (State) (Zip) **Phone:**

Social Security #: **Age**: **Date of Birth**: **Sex**: Male Female

Employer: (If Minor, list Parent's Employer)

Emergency Contact: **Phone:**

Preferred Pharmacy: **[*only if being treated]**

AUTHORIZATION FOR EVALUATION/TREATMENT AND RELEASE OF MEDICAL FORMS

I hereby authorize any provider of Acadiana Center to evaluate and or treat the patient. I authorize the release of my medical records to any doctor, employer/employer representative, potential employer, insurance company(s), Voc. Rehab, Rehab nurse(s) all information they may request associated with my medical care. I also request that you release my medical records to the physicians of Acadiana Center.

The opinions rendered in this case are the opinions of the physicians of Acadiana Center. This evaluation is being conducted on the basis of the medial examination and the documentation provided, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment, examination, and documentation. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

AUTHORIZATION FOR EVALUATION AND TESTING AND RELEASE OF MEDICAL INFORMATION

I hereby authorize the physicians and/or the employees of Acadiana Center to perform any procedures necessary to perform appropriate drug and alcohol screen tests, including but not limited to the drawing of bodily fluids, the testing of my breath, obtaining hair samples, or other tissue from my body. I further consent to drug and alcohol testing on these fluids and/or tissues, and I further consent that same may be sent to outside laboratories, and that the results may be released to my employer, and any other individuals who by law may receive reports regarding the drug and alcohol screening referenced above.

FUNCTIONAL SKILLS ASSESMENT AUTHORIZATION AND RELEASE

I understand that I will be undergoing an assessment of flexibility, strength, cardiovascular endurance, body mechanics, and coordination in order to determine my ability to safely perform the essential functional skills of my job as specified by the employer.

I understand that before, during, and after testing, I must keep my evaluator informed of any discomfort or pain, cardiovascular or musculoskeletal difficulties, or any other problems related to performing the tasks. I also understand that I, or the evaluator, have the right to stop the test at any time secondary to any discomfort or pain, cardiovascular or musculoskeletal difficulties, or any other problems or specified reason.

I hold Acadiana Center, its physicians and support staff, harmless and without any liability whatsoever for any possible injury, accident, or incident that may occur during this testing.

PATIENT XRAY CONSENT

I herby authorize the performance of diagnostic x-rays which have been requested by the Acadiana Center and/or the current/prospective employer. I understand that exposure to radiation will be minimized through the use high speed films, only necessary views, collimation, and protective shields over reproductive organs as feasible. At this time, I am aware of no condition for which the taking of x-rays would further complicate.

I have been advised that the ten (10) days following the onset of a menstrual cycle are generally considered to be safe for X-rays. I understand that certain X-rays - especially those of the abdomen/pelvis/lumbar spine/hips - can be hazardous to an unborn fetus.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and will list any restriction(s) concerning my personal medical information: List any restriction(s) here

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Patient Signature/Guardian Date