VISIT OUR WEBSITE!

Dr. Ilyas Munshi would like to invite you to visit our website specially designed for his patients!

Please log on to:

WWW.ILYASMUNSHIMD.COM

ILYAS MUNSHI, M.D.

NEUROLOGICAL SURGERY | BOARD CERTIFIED

BRAIN | SPINE | PERIPHERAL NERVE SURGERY

ILYAS MUNSHI, M.D.
NEUROLOGICAL SURGERY
99 W. MARTIAL AVE.
LAFAYETTE, LA 70508
PHONE 337.234.5344
FAX 337.234.5311

MEDICATION REQUESTS

Please note that any medication prescribed by Dr. Munshi is called in on **TUESDAYS and THURSDAYS** only. Once the medication request has been called into the office, check back with your pharmacy **AFTER 4:00 p.m.** When you call for a medication request, please have pharmacy phone number, name of medication, and your call back number available.

DISABILITY FORMS

Disability, insurance, work evaluations, or any other forms that require Dr. Munshi to fill out and sign will need a **PREPAYMENT OF $30 PER FORM** to be paid in cash or check only. Please allow **7-10 BUSINESS DAYS** for the form to be completed. It is your responsibility to make sure the forms are here in a timely manner with allowance for them to be completed. Please have specific directions as to where and how the forms need to be sent off.

ILYAS MUNSHI, M.D.

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What to expect at your first appointment:

Both Dr. Munshi and his staff understand that every patient is unique in his or her own way. We are committed to providing excellent, personalized service by creating treatment options that are specifically designed to match each individual patient.

What you need to bring:

- Insurance card(s)
- Picture ID
- Co-pay
- List of **ALL** current medications
- Any testing/reports/images – if you have no imaging or if your imaging is old, new imaging may be ordered at the time of your first appointment

You will be required to:

Complete and sign several forms both on paper and computer (iPad) regarding your past medical history, surgical history, and current symptoms. If you are unable to do this, please bring someone who can assist you.

What will happen once you are called to the "back":

You will be brought back by a medical assistant or nurse practitioner who will ask you a series of questions regarding your current symptoms. Next, you will be evaluated by Dr. Munshi and an exam will be performed. He will then review your complaints along with any imaging/reports available.

After meeting with Dr. Munshi, a treatment plan will be recommended. You will then be informed of the risks and benefits of each option and assisted in making the final decision of which treatment option is best for you.

ILYAS MUNSHI, M.D.

PATIENT "NOTICE OF PRIVACY PRACTICES"

This notice describes how your medical information may be used and disclosed by our office and how you can obtain access to this information. Please read the following Notice very carefully. If you have any questions, please ask to speak with our Office Manager.

PURPOSE

This is the notice of Privacy Practices describes how we may use and disclose your protected health information in order to better carry out treatment, payment, and/or healthcare operations. It also describes other uses and purposes that are permitted or required by law. This Notice also describes your rights to access and control your protected information. "Protected Health Information" is information about you, including demographic information, such as your name, age, and address, that my identify you and that relates to your past, present or future; physical or mental health or condition and related healthcare services. Patient health information defined as "protected health information" includes information obtained, maintained, and stored in any form, including electronic, paper, and verbal communications. Privacy rules apply to information obtained from any and all of these sources.

CHANGES IN NOTICE OF PRIVACY PRACTICES

We are required by law to abide by the terms of this Notice of Privacy Practices, but we may change the terms of our notice at any time. The revised notice will then be effective for all protected health information that we maintain at the time of revision. Upon your request, we will provide you with any revised Notice of Privacy Practices. To obtain a copy of the revised Notice, simply contact our office and request that a revised copy be mailed to you, or ask for one at the time of your next appointment.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

You will be asked by your physician to sign a consent form authorizing use and disclosure of your protected health information for treatment, payment, and healthcare operations as described in this section.

Your protected health information may be used and disclosed by your physician, our office staff, and selected individuals outside of our office who are involved in your care and treatment, for the purpose of providing you with the best possible healthcare services. Your protected health information may also be used and disclosed to pay your healthcare bills and to support the operation of your physician's practice. Examples of how your protected health information may be used once you have signed our standard consent form include but are not limited to the following:

Treatment: We will use and disclose your protected health information to provide or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party that has already obtained your permission to access your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides you with care. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose this information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may also disclose your protected health information from time-to-time to another physician or healthcare provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it

approves or pays for the healthcare services we recommend for you, such as (a) making a determination of eligibility or coverage for the insurance benefits; (b) reviewing services provided to you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers, such as unconsciousness, if the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other permitted and required uses and disclosures that may be made with your consent, authorization or opportunity to object

We may use or disclose your protected health information in the following situations without your consent or authorization. Those situations include:

When required by law: We may use your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

When public heath is involved: We may disclose your protected health information for public health activities and purposes to a public health care authority that is permitted by law to collect or receive the information. The disclosure will made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if so directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

In the case of Communicable Disease: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audit, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs, and civil laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence, to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state law.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the food and drug administration to report adverse events, product defects or problems, biologic product deviations, or task products, to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized by the order) in certain conditions to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law (2) limited information request for identification and location purposes (3) pertaining to victims of a crime (4) suspicion that death has occurred as a result of criminal conduct (5) in the event that a crime occurs on the premises of the practice and (6) medical emergency (not on the practice premises) and it is likely that a crime has occurred.

Coroners Funeral Directors and Organ Donations: We may disclose protected health information to a coroner or medical examiner for identification purposes determining cause of death, or for the coroner.

Obtain a paper copy of privacy practices upon request – Contact our Privacy Officer.

Request to have your physician amend your health record - You may request amendment of your protected health information; however, we may deny such a request. If we deny your request, you may file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of that rebuttal. Contact our Privacy Officer with questions about amending your medical record.

Obtain an accounting of disclosure of your protected health information – This applies to any disclosure other than treatment, payment, or healthcare options as described in the Notice of Privacy Practices, and excluding disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003, subject to certain exceptions, restrictions, and limitations.

Request confidential communications of your health information by alternative means or alternative locations – We will accommodate reasonable requests and will not question your request. We may, however, request payment for accommodating this request.

Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

This office has verbally explained my rights as a patient; I hereby acknowledge my full and complete understanding of these rights.

________________________________ __________________

Patient's Signature Date

OUR RESPONSIBILITY TO OUR PATIENTS

As your healthcare provider, we are required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this agreement
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

COMPLAINTS

You may complain to us or to the Unites States Secretary of Health and Humana Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Updated Patient Information Sheet

Name: ____
(First) (Middle) (Last)

Date of Birth: ______________________________

Social Security Number: ________-___________-__________

Gender: Female Male

Home Phone Number: ______________________________

Cell Phone Number: ______________________________

Work Phone Number: ______________________________

Mailing Address: ____

____

Race: ________________________

Ethnicity: Hispanic or Latino Non Hispanic or Latino

Language: English Spanish French Italian Dutch Other ______________

Allergic To: ____

____

Smoking Status: Currently ______ per day Former Never

Email Address: ____

Primary Doctor: ____

Pharmacy Name/Phone Number: ____

ILYAS MUNSHI, M.D.

INFORMATION AND HISTORY SHEET

Name (Last, First)	Social Security #	Age	Date of Birth	Marital Status

Address	Home Phone#	Cell Phone#	Work Phone#

Emergency Contact (not living with you)	Relationship	Phone #

Employer	Address	Phone #

Name of First Insurance Co.	Name of Second Insurance Co.	Name of Third Insurance Co.	Occupation

Attorney	Address	Phone #
Family Physician	**Address**	**Phone #**
Referring Physician	**Address**	**Phone #**

Chief Complaints:

Is this a result to an Auto Accident or Job Injury?	Give Date and Location of Injury
Have you worked since accident?	**If disabled due to injury, last date you worked**

Allergies to Medications:

I authorize the release of my medical information necessary to process insurance claim(s) and request payment of medicare benefits (if applicable) either to myself or to the party who accepts assignment.

I authorize payment of medical benefits to **Ilyas Munshi, M.D.**

Date ______________________ Signature ______________________________

Agreement of Payment

In consideration of the services rendered to the patient, I agree that I am solely liable for, and hereby guarantee the payment of all charges incurred in the treatment of patient, including any charges not paid, for any reason, by any payor or insurance company. I further agree that payment in full is due within 30 days from date of bill and THAT INTEREST AT THE RATE OF 12% PERANNUM MAY BE ASSESSED AGAINST THE BALANCE REMAINING AFTER PAYMENT IS DUE. As well as attorney's fees of 25% of the Principal and interest due if the account is referred to an attorney for collection. I further guarantee the payment of interest charges and attorney's fees, if any, as well as any other fees and cost incurred in said collection.

Date ______________________ Signature ______________________________

ILYAS MUNSHI, M.D.
Neurological Surgery
99 W. Martial Ave.
Lafayette, LA 70508
Phone: 337-234-5344
Fax: 337-234-5311

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Address: ______________________

Date of Birth: ______________________ ______________________

SSN: ______________________ ______________________

I hereby authorize **Ilyas Munshi, M.D.** to use or disclose the following protected health information listed below.

Disclose the following information for treatment dates ________to________.

_X_ Complete Records	___Outpatient Reports	___Emergency Reports
___Abstract	___X-Ray/Diagnostic Films	___Pharmacy/Prescription
___Face Sheet	___Laboratory	___Billing/Statements
___Discharge & Summary	___Pathology	___Other Specified
___History & Physical	___Physical Therapy	
___Consult		

Purpose for Disclosure: ___Medical Care ___Legal ___Insurance ___Other ____________

This authorization expires on the following date: ______________________

________I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

________I understand that the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

________I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee upon request and that I will receive a copy of this form after I sign it.

________I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

________I acknowledge, and hereby consent to such, that the release information may contain alcohol and/or drug abuse, psychiatric care, HIV/AIDS testing and/or treatment, or and/or other sensitive information.

______________________ ______________________
Signature of Patient or Legal Representative *Date*

______________________ ______________________
Printed name of patient or patient's representative *Relationship to patient or authority to act for patient*

Pursuant to HIPAA Rule 45 CFR 164.508(c), et. seq

ILYAS MUNSHI, M.D.

NEUROLOGICAL SURGERY • BOARD CERTIFIED

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Authorized Representative Form

This form is used to confirm a patient's permission that we may discuss or disclose protected health information to a particular person who acts as their Authorized Representative.

Patient Name: ____

Date of Birth: ____________________ SSN: ______________________

HIPAA Representative Information - Please Print

Authorized Representative #1:
Name: ____

Date of Birth: _________________ Phone Number: ____________________

Relationship to Patient: ________________________

Authorized Representative #2:
Name: ____

Date of Birth: _________________ Phone Number: ____________________

Relationship to Patient: ________________________

Limitations on Disclosure: I understand that I have the right to limit information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations to disclosure.

Limitations: ____

____

1. I understand that I may revoke this HIPAA Representative designation at any time by notifying the Physician in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Dr. Munshi's office prior to their receipt of the revocation.
2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.
3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPAA.
4. I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the HIPAA Representative(s) named above to have authority to access to my protected health information (PHI) to assist in my care.

Signature of Patient: ___________________________________ **Date:** ____________

ILYAS MUNSHI, M.D.
NEUROLOGICAL SURGERY BOARD CERTIFIED
BRAIN | SPINE | PERIPHERAL NERVE SURGERY

Assignment of Benefits Form

Patient Name: ______________________________ **Date:** ____________________________

I, ________________________, understand that services rendered to me by Dr. Ilyas Munshi are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Dr. Ilyas Munshi and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance carrier.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance send payment to me, I will forward the payment to Dr. Ilyas Munshi within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Dr. Ilyas Munshi to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated: ____________________________ Witness: ______________________

Signature of Policyholder, Patient or Guardian: ____________________________________

99 W. Martial Ave. • Lafayette, LA 70508 • O: 337.234.5344 • F: 337.234.5311
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ILYAS MUNSHI, M.D.
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Patient Health History Form

Today's Date: ________________

Patient Name: ________________________________ Date of Birth: __________ Age: _____

Reason for today's visit (please list in detail):

____
____
____

When did the problem first begin? _________________________

History of the same problem? _____Yes _____No

If yes, please list previous treating physician and treatment:

____
____

Current problem is the result of (please check all that apply):
_____Car Accident _____Work Accident _____Legal Case _____Unknown
_____Other (explain):____

Date of injury if accident, work injury, or legal case: ________________

Work History

Occupation: ______________________ Type of Work: ___________________________

Does your work require lifting? _____Yes _____No

Are you currently working? _____Yes _____No Date last worked _______________

Have you been deemed disabled? _____Yes _____No

If yes, reason for disability:

____

Past Medical History

Do you suffer from or are you currently being treated for any of the following medical problems:

	Yes	No		Yes	No
Arthritis			Liver Disease		
High Blood Pressure			Urinary/Bladder Problems		
High Cholesterol			Asthma		
Irregular Heart Beat			COPD/Emphysema		
Seizures			Anemia		
Headaches			HIV/AIDS		
Anxiety			Kidney Disease		
Depression			Psychological Illness		
Cancer Type:__________			Diabetes Type I / Type II		
Thyroid Dysfunction Type: High/Low			Hepatitis Type:__________		
Heart Problems Type:__________			Other:		

Do you have the following in your body? (circle) Pacemaker/Coronary Stent/Metal

Are you Claustrophobic? (circle one) YES NO

Medication

List ALL current medications (prescription and over-the-counter):

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

Do you have ALLERGIES to any MEDICATIONS? ____Yes ____No

List Drug Allergies:

____

____

Allergies to IODINE or BETADINE? ____Yes ____No

Past Surgical History

List ALL previous surgeries and dates:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Social History

_____Right Handed _____Left Handed _____Both

Do you have any children? _____Yes _____No How many children? _________

Single / Married / Divorced / Widow / Significant Other (circle one)

Do you smoke? _____No, I do not smoke _____No, I have never smoked

_____Former smoker; Quit (when)? _______

_____Yes, I smoke ______ per day.
Cigarettes/Cigars/Pipe/Chewing Tobacco (circle one)

Do you drink alcohol? _____No, Never. _____No, but I used to. Quit (when)? _____

_____Yes (circle) Daily / Socially / Occasionally

Do you use any type of illegal drugs? _____Yes _____No
If yes, what type? _________________________

Family History

Family Member	Alive	Deceased	Age	Medical Problems or Cause of Death
Grandmother (mom)				
Grandfather (mom)				
Grandmother (dad)				
Grandfather (dad)				
Mother				
Father				
Siblings				

PATIENT NAME: ______________________ DATE: ___/___/_____

Please place a mark (X) next to any symptoms you have OR have experienced in the past.

Musculoskeletal		**Ear, Nose, Throat, Mouth**		**Gastrointestinal**	
Broken Bones		Wearing Hearing Aid		Indigestion When Eating	
Neck Pain		Hearing Loss		Nausea	
Arm Weakness		Ear Pain		Vomiting	
Arm Pain		Ear Infections (right / left)		Blood in Vomit	
Finger Pain		Balance Disturbance (Vertigo)		Jaundice	
Finger Numbness/Tingling		Nosebleeds		Changes in Bowel Habit	
Back Pain		Nasal Drainage		Colon Cancer	
Leg/Foot Pain		Inability to Smell		**Genitourinary**	
Leg/Foot Weakness		Sinus Problems		Urinary Tract Infection	
Leg/Foot Tingling		Sinus Headaches		Painful Urination	
Joint Pain or Swelling		Tongue Numbness		Blood in Urine	
Arthritis		Mouth Sores		Difficulty Urinating	
Neurological		**Integumentary**		Inability to Control Urine	
Fainting Spells		Skin Disease		Kidney Stones	
Seizures		Skin Cancer		Prostate Cancer	
Loss of Memory		Breast Pain/Tenderness		Endometriosis	
Disorientation		Breast Swelling		Uterine/Cervical Cancer	
Coordination		Nipple Discharge		**Respiratory**	
Headaches		**Endocrine**		Asthma	
Numbing Sensations		Diabetes Type I / Type II		Chronic Cough	
Difficulty with Speech		Thyroid Disease		Emphysema	
Inability to Concentrate		Increased Appetite		Bloody Sputum	
Double or Blurred Vision		Excessive Thirst/Urination		Shortness of Breath	
Face Weakness		Hormone Problems		Lung Cancer	
Cardiovascular		**Eyes**		Bronchitis	
Chest Pain/Angina		Wear Glasses		Pneumonia	
High Blood Pressure		Wear Contacts		**Hematologic/Lymphatic**	
Irregular Pulse		Double Vision		Blood Transfusion	
Heart Murmur		Eye Injuries		Anemia	
High Cholesterol		Glaucoma		Hemophilia	
Swelling in Feet/Hands		Cataracts		Bleeding Tendencies	
Leg Pain while Walking		**Allergic/Immunologic**		Swollen Glands/Nodes	
Cardiac Disease		Food Allergies		**Psychiatric**	
Strokes		Inhalant (Nasal) Allergies		Anxiety	
Pacemaker		Immunologic Disorders		Depression	
Heart Attacks		Shellfish/Iodine Allergies			

Please list any other health problems:______________________________

Physician Initials ____________

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To help us better understand your symptoms, please complete the following two pages to the best of your ability. Follow the directions above each figure.

If you have any of the following symptoms, please mark (X) in the space provided and circle right, left, or both when applicable. Also, please rate your pain intensity on the scale that follows.

PAIN LOCATION		Pain Quality	
Head		Aching	
Face		Burning	
Neck		Cramping	
Shoulder right/left/both		Crushing	
Arm right/left/both		Dull	
Hand right/left/both		Heavy	
Upper Back		Non-Descript	
Between Shoulder Blades		Numbness	
Lower Back		Pressure	
Hip right/left/both		Sharp	
Buttock right/left/both		Shock-like	
Groin right/left/both		Stabbing	
Thigh right/left/both		Throbbing	
Knee right/left/both		Tightness	
Lower Leg right/left/both		Tingling	
Foot right/left/both		Weak	
Other Areas (list):		Other Quality (list):	

Pain Intensity

Rate your pain on a scale of "0-10"

(Circle one)

0 1 2 3 4 5 6 7 8 9 10

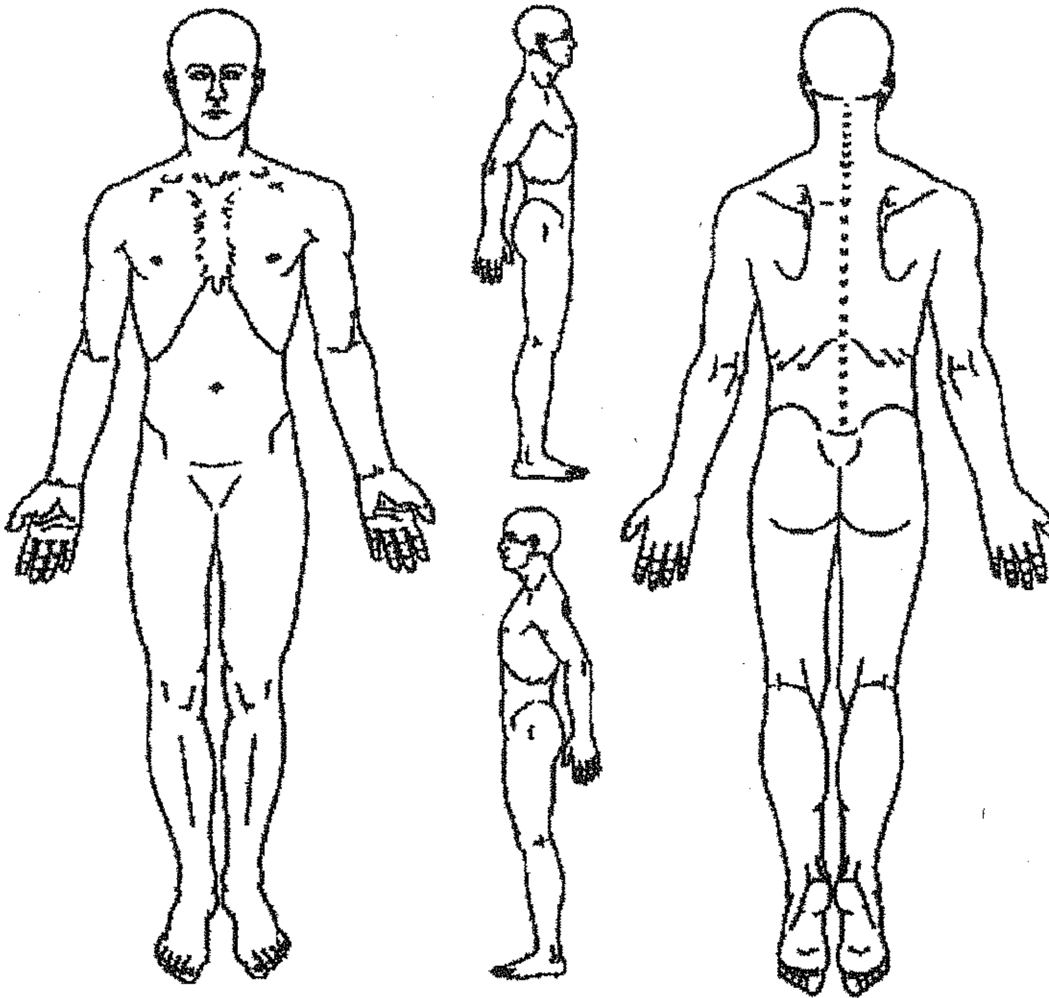
No Pain — Worst Pain

Patient Pain Diagram

Patient's Name: ____

On the diagram below, please indicate where you are experiencing pain or other symptoms. Use the following to describe your symptoms:

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing O = Other



Please rate your current level of pain on the following scale (circle one):

Mild Mild-Moderate Moderate Moderate-Severe Severe

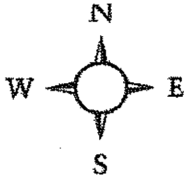
All of the information given on these Patient History Forms is accurate to the best of my knowledge.

Patient Signature:________________________________ Date:____________________

(For Office Use Only)

I have reviewed the above information with the patient.

Physician Signature: ______________________________ Date:____________________



LAFAYETTE

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EXIT
100
INTERSTATE 10
10
EVANGELINE THRUWAY
BERTRAND DR.
COLLEGE RD.
JOHNSTON ST.
CONGRESS ST.
COLLEGE RD.
AMBASSADOR CAFFERY PKWY.
LAFAYETTE
REGIONAL
AIRPORT
KALISTE SALOOM RD.
PINHOOK RD.
GUILBEAU RD.
VERMILION RIVER
JOHNSTON ST.
EVANGELINE THRUWAY
PINHOOK RD.
CAMELLIA BLVD.
AMBASSADOR CAFFERY PKWY.
W. MARTIAL
Dr. Munshi
SHELL
RUE LOUIS XIV
VEROT SCHOOL RD.
TARGET