

PATIENT INFORMATION (Personal Injury)

DATE: _____

Patient Name: _____

Last Name First Name Middle Initial

Date of Birth: _____ SS#/Patient ID# _____

Address: _____

City: _____ State _____ Zip Code _____

Home Phone (____) _____ Cell Phone (____) _____

Email address: _____

Sex: Male Female

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____ Spouse's Date of birth _____

Emergency Contact:

Name: _____

Home Phone (____) _____ Cell Phone (____) _____

Patient Condition

Complaint area(s) _____

When did your symptoms appear? _____

Is this condition getting progressively worse? YES NO Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

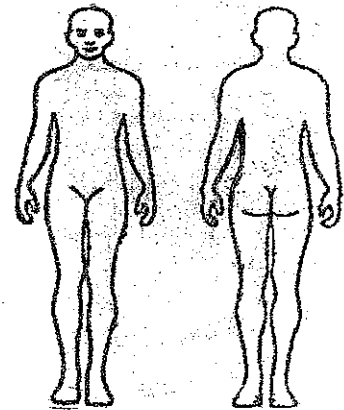
Does it interfere with your ___ Work ___ Sleep ___ Daily Routine ___ Recreation

Activities or movements that are painful to perform:

___ Sitting ___ Standing ___ Walking ___ Bending ___ Lying down

Type of Pain (circle): Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other



Insurance Information:

I certify that I, and/or my dependent(s) have insurance coverage with _____ And assign directly to Keystone Healthcare and Wellness all insurance benefits, if an, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Keystone Healthcare and Wellness may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the sole purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian, or Personal Representative Relationship Date

IF YOUR INJURY IS ACCIDENT RELATED, PLEASE COMPLETE THE FOLLOWING QUESTIONS.

Date of accident: _____ Hour: _____ (AM) (PM)

Location: _____

How did the accident occur? (i.e. auto collision, etc.)

If an auto collision, please describe.

If NOT an auto collision, please describe the circumstances.

If an auto collision, were you: DRIVER PASSENGER PEDESTRIAN

Were there any other persons in the car with you? If so, who?

Did you have your seat belt on?	YES	NO
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Did an ambulance come to the scene of the accident?	YES	NO
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Did you go to the emergency room?	YES	NO
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If yes, where? _____

Have you seen any other doctor for this condition?	YES	NO
--	-----	----

If yes, who? _____

Was your vehicle moving at the time of the impact?	YES	NO
--	-----	----

If yes, approximately how fast? _____

If auto collision, were you struck from					VEHICLE WAS PARKED
BEHIND	RIGHT SIDE	LEFT SIDE	FRONT		

Did your car strike the other (s) involved?	YES	NO
---	-----	----

Did the other car strike you?	YES	NO
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Have you lost any days of work?	YES	NO
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If yes, what dates? _____

Patient signature: _____

Date: _____

HEALTH INFORMATION

GENERAL INFORMATION:

Patient Height: _____

Patient Weight: _____

Patient Blood Pressure: _____

First Middle Initial Last

Race: (circle ONLY 1)

American Indian Alaska Native
Asian White
Black or African American Other Pacific Islander
Native Hawaiian Declined to state

Ethnicity (circle ONLY 1)

Declined to state Hispanic or Latino Not Hispanic or Latino

Preferred Language: _____ Email Address: _____

Smoking Status (circle ONLY 1)

Current every day Smoker Smoking start date: _____ End date: _____

Current some day smoker Former Smoker I have never smoked

In an effort to stop smoking, I am currently taking: _____

Do you have any allergies to medication? YES NO

If yes, please indicate the following (if you need additional space, please use the other side of this sheet):

Allergy: _____ Reaction: _____

Start date: _____ End Date: _____

Are you currently taking any medications? YES NO

If yes, please indicate the following (if you need additional space, please use other side of this sheet):

Medication: _____ Frequency: _____

Route: Oral Intravenous

Other: _____

Date you started use: _____ Date you discontinued use: _____

Family Medical History (Please list any known medical conditions patient's family has had and their relationship to you):

Condition: _____ Relationship to patient: _____

Condition: _____ Relationship to patient: _____

Condition: _____ Relationship to patient: _____

HEALTH HISTORY

What treatment have you already received for your condition? Medication Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Please circle to indicate if you have had any of the following:

- | | | | |
|---------------------|------------------|----------------------|-----------------------|
| AIDS/HIV | Diabetes | Measles | Rheumatic Fever |
| Alcoholism | Emphysema | Migraine Headaches | Scarlet Fever |
| Allergy Shots | Epilepsy | Miscarriage | Stroke |
| Anemia | Fractures | Mononucleosis | Suicide Attempt |
| Anorexia | Glaucoma | Multiple Sclerosis | Thyroid Problems |
| Appendicitis | Goiter | Mumps | Tonsillitis |
| Arthritis | Gonorrhea | Osteoporosis | Tuberculosis |
| Asthma | Gout | Pacemaker | Tumors, Growths |
| Bleeding disorder | Heart Disease | Parkinson's disease | Typhoid Fever |
| Breast Lump | Hepatitis | Pinched Nerve | Ulcers |
| Bronchitis | Hernia | Pneumonia | Vaginal Infections |
| Bulimia | Herniated Disk | Polio | Venereal Disease |
| Cancer | Herpes | Prostate Problem | Whooping Cough |
| Cataracts | High Cholesterol | Prosthesis | Other, please explain |
| Chemical Dependency | Kidney Disease | Psychiatric Care | _____ |
| Chicken Pox | Liver Disease | Rheumatoid Arthritis | _____ |

Are you currently being treated or have you ever been treated for blood clots (i.e. PE, DVT) YES NO

EXERCISE	WORK ACTIVITY	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason _____

Are you pregnant? YES NO If yes, what is your due date? _____

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____

(Please use other side if additional space is needed)

Pharmacy Name: _____ Phone: () _____

Patient signature: _____ Date: _____

Authorization for Use and Disclosure of Health Information

While the law requires us to give you this disclosure, please understand that we respect the privacy of your health information. However, there are some circumstances in which we may disclose your health information.

- We may disclose your health information to another health care provider or a hospital if it is necessary to refer you for diagnosis, assessment, or treatment.
- We may disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed, which you have the right to review before signing this form (164.520). We reserve the right to change our privacy policy, but will notify you in writing of any changes either through the mail or when you come in for treatment. You may request a copy of our privacy policy at any time.

Your chiropractor and members of the practice staff may use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment or other health related information. If contact is made by phone, a message may be left on your voicemail or answering device. By signing this form, you are giving us authorization to contact you in this manner.

Information that we disclose based on this authorization may be subject to re-disclosure by anyone who has access to the communication and may no longer be protected by the federal privacy rules.

You have the opportunity to designate a family member or other individual as a person with whom we may discuss your condition and treatment plan.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM:

Answer: _____

You may **restrict** the individuals or organizations to which your health care information may be released by notifying us in writing. We are not required to agree to your restrictions; however, if we do agree, the restriction is binding on us. You may **revoke** your authorization to us at any time, but your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse to give us this authorization. This decision will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I acknowledge that I have read and received a copy of this policy and authorization request and I hereby agree to the terms and authorize you to disclose my health information in the manner described above. This authorization is effective as of the date printed below and will expire seven years after the date on which you last received services from us.

Patient **PRINTED** name

Authorized Provider Representative

Patient **SIGNATURE**

Date

**ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION
("Agreement")**

I, the undersigned, hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payees"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly to and exclusively in the name of Keystone Healthcare and Wellness ("office") such sums as may be owing to Keystone Healthcare and Wellness for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("charges"). I further grant a contractual lien to Keystone Healthcare and Wellness with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by Keystone Healthcare and Wellness to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, lost wage benefits, lost services benefit, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, malpractice proceeds, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Keystone Healthcare and Wellness, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Keystone Healthcare and Wellness to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide full accounting of such funds to the Office upon its request.

I hereby direct all payers to release to Keystone Healthcare and Wellness any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Keystone Healthcare and Wellness to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Keystone Healthcare and Wellness to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Keystone Healthcare and Wellness for their services. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Keystone Healthcare and Wellness for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Keystone Healthcare and Wellness and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

I agree that each and every provision of this Agreement is reasonable necessary for the protection of the rights and interest of Keystone Healthcare and Wellness and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall nevertheless, remain in full force and effect.

Patient Name (Please print): _____

Patient Signature: _____ DATE: _____

Name of Custodial Parent or Legal Guardian (Please Print): _____

Parent/Guardian Signature: _____ DATE: _____

Witness: _____ DATE: _____



TO: _____

RE: Authorization to Release Medical Information

You are hereby authorized to forward to Keystone Healthcare and Wellness any and all information or medical records regarding the undersigned, including history and physical, laboratory and x-ray reports, with diagnosis and treatment.

Name of Patient: _____

Signature: _____

Date of Birth: _____

Social Security Number: _____

Treatment date needed: _____

Witness: _____

Today's date: _____

PLEASE RETURN MEDICAL RECORDS REQUESTED TO:

KEYSTONE HEALTHCARE AND WELLNESS
491 W. CHEVES ST., SUITE A
FLORENCE, SC 29501

PHONE: 843-662-8000

FAX: 843-664-0994