



Patient Name: _____ DOB: _____

Please answer the following questions:

1. Did you go to the emergency room after your accident? _____ Yes _____ No

Where? _____

2. Did you go to your primary care physician after your accident? _____ Yes _____ No

Physician Name: _____

Location (ex. Cheves St): _____

3. Did you go to any other medical facility after your accident? _____ Yes _____ No

Where? _____

4. Who is your primary care physician? _____

Location (ex. Cheves St)? _____

5. What pharmacy do you use? _____

Location (ex. Cheves St)? _____



Please answer the following questions and sign below

(If any question 1-6 is checked "Yes", Patient **MUST** see Celista **PRIOR** to treatment)

Do You Have a Medical History of the Following:

- 1. Pacemaker? _____ Yes _____ No
- 2. ICD (Implantable Cardioverter Defibrillator)? _____ Yes _____ No
- 3. Seizures? _____ Yes _____ No
- 4. Paralysis, stroke, multiple sclerosis? _____ Yes _____ No
- 5. Do you have any skin conditions or being treated for cancer? _____ Yes _____ No
- 6. Loss of sensation (means that you can't feel pain, heat, or cold)? _____ Yes _____ No

- 7. Have you ever had any neck, upper or lower back surgery? _____ Yes _____ No
- 8. Do you have any numbness, tingling or weakness due to a medical condition? _____ Yes _____ No
- 9. Are you pregnant or is there a possibility you may be? _____ Yes _____ No
- 10. Are you breastfeeding? _____ Yes _____ No

If at anytime any of the above conditions become part of your medical history please inform staff immediately!

By signing below, I acknowledge that I have read and answered the above questions truthfully and to the best of my knowledge. I also understand that if at any time I have any of the above conditions, it is my responsibility to notify a staff member as soon as possible. If you have any questions, please let us know.

Patient Signature: _____

Date: _____

Chiro Assistant Signature: _____

Date: _____



To: _____

Re: Authorization to Release Medical Information

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

Please also include any discharge medication list.

Name of Patient: _____

Date of Birth: _____

Last 4 Digits of SSN: _____

Treatment Date(s) _____

Patient/Guardian Signature: _____

Date: _____

Please return the medical records requested to:

**Keystone Healthcare
491 W. Cheves St Suite A
Florence, SC 29501**

Phone: 843-662-8000

Fax: 843-664-0994

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? _____

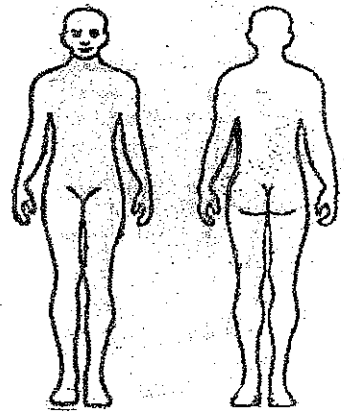
Is it constant or does it come and go? _____

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

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 Type _____ | Herpes | Prostate Problem | Whooping Cough |
| Cataracts | High Cholesterol | Prosthesis | Other, please explain |
| Chemical Dependency | Kidney Disease | Psychiatric Care | _____ |
| Chicken Pox | Liver Disease | Rheumatoid Arthritis | _____ |

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)

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 BENEFITS, AUTHORIZATION TO SETTLE CLAIM
AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY**

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer, and convey to KEYSTONE HEALTHCARE AND WELLNESS, LLC (hereinafter "the Provider") all my rights, title, and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above-named assignee, and I acknowledge that I will timely pay an indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third-party payor with regard to these services, which authorization shall include authority to: (1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointment for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs. (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,

(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the forgoing and understand and agree to each of the above provisions:

Patient's Signature

Date