KEYSTONE
HEALTHCARE
AND WELLNESS LLC

PLEASE SEND STAT

Authorization to Release Medical Records

Hospital ER or Urgent Care: _____

Primary Care Physician: and Location _____

Other Medical Facility: _____

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

******PLEASE DO NOT SEND PATIENT EDUCATION/DISCHARGE INSTRUCTIONS******

Name of Patient: _____

Date of Birth: _____

Last 4 of SSN: _____

Treatment Date(s): _____

_____ _____

Patient/Legal Guardian Signature Date

Please return medical records to:

Keystone Healthcare
491 W. Cheves St Suite A
Florence, SC 29501
Phone: 843-662-8000

*****If records can be emailed please send to*****
Amanda@palmettochiro.com

otherwise please fax to (843) 664-0994

KEYSTONE
HEALTHCARE
AND WELLNESS LLC

Please answer the following questions and sign below

(If any question 1-7 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? _____Yes _____No
6. Are you being treated for cancer? _____Yes _____No
7. Loss of sensation (means that you can't feel pain, heat, or cold)? _____Yes _____No
8. Have you ever had any neck, upper or lower back surgery? _____Yes _____No
9. Do you have any numbness, tingling or weakness due to a medical condition not related to your accident? _____Yes _____No
10. Are you pregnant or is there a possibility you may be? _____Yes _____No
11. 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: _____

DATE: _____

KEYSTONE HEALTHCARE

491 West Cheves St
Florence SC 29501
843-662-8000

PATIENT INFORMATION:

Patient Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ Age:_____ Sex: _____Male _____Female SS#/Patient ID#: _____

Address: _____

City: _____ State _____ Zip Code _____

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

Email address: _____

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

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

Referred by: _____

Emergency Contact:

Name: _____

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

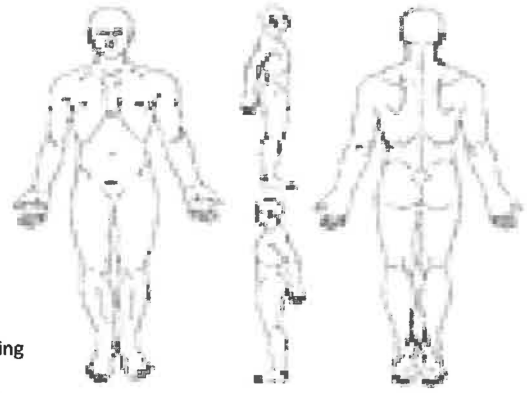
Patient Condition:

Reason for visit: _____

When did your symptoms appear or begin? _____

Is this condition getting progressively worse? _____Yes _____No

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 to 10: _____ (1 least pain and 10 severe pain)

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your _____Work _____Sleep _____Daily Routine _____Recreation

Are any painful to perform: _____Siting _____Standing _____Walking _____Bending _____Lying Down

What type of pain are you having: _____Dull _____Throbbing/Numbness/Aching _____ Shooting _____Burning
_____ Tingling _____ Cramps _____ Stiffness _____Swelling _____ Other

Insurance Information (If applicable):

I certify that I, and/or my dependent(s) have insurance coverage with _____ And assign directly to Keystone Healthcare 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 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

KEYSTONE HEALTHCARE

PLEASE COMPLETE THE FOLLOWING QUESTIONS IF YOUR INJURY IS ACCIDENT RELATED:

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

Accident Location: _____

What type of accident occurred? (ex. Auto Collison, Slip & Fall)_____

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

Did an ambulance come to the scene of the accident? ____YES ____NO

Did you go to the emergency room? ____YES ____NO

Was your vehicle moving at the time of the impact? ____YES ____NO
If yes, approximately how fast? _____

If auto collision, were you struck from:

____Behind ____Right Side ____Left Side ____Front ____Vehicle was Parked

Did your vehicle hit the other vehicle involved or did the other vehicle hit your vehicle?

____My vehicle hit the other vehicle involved

____The other vehicle hit my vehicle

Have you lost any days of work? ____YES ____NO

If yes, what dates? _____

Patient signature: _____Date: _____

KEYSTONE HEALTHCARE AND WELLNESS LLC

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)? _____

KEYSTONE HEALTHCARE

HEALTH INFORMATION

GENERAL INFORMATION:

First Name _____ Middle Initial _____ Last _____ Date of Birth _____

Patient Height _____ **Patient Weight** _____ **Patient Blood Pressure** _____

Race: (circle ONLY 1)

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

Ethnicity (check ONLY 1)

_____Declined to state _____Hispanic or Latino _____Not Hispanic or Latino

Preferred Language: _____

Email Address: _____

Smoking Status (check 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 your family has had):

Condition: _____ Relationship to patient: _____

Condition: _____ Relationship to patient: _____

Condition: _____ Relationship to patient: _____

Condition: _____ Relationship to patient: _____

KEYSTONE HEALTHCARE

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**	
___None	___Sitting	___Smoking	Packs/day_____
___Moderate	___Standing	___Alcohol	Drinks/week_____
___Daily	___Light Labor	____Coffee/Caffeine	Drinks-Cups/Day_____
___Heavy	___Heavy Labor	____High Stress Level	Reason _____

Are you pregnant? ___YES ___NO If yes, what is your due date? _____

Injuries and/or 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: _____ Pharmacy Address: _____

Patient signature: _____ Date: _____

KEYSTONE HEALTHCARE AND WELLNESS LLC

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 to 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 another individual as a person with whom we may discuss your condition and treatment plan.

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 ate on which you last received services from us.

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

_____ _____

Patient or Legal Guardian PRINTED NAME | Authorized Provider Representative

_____ _____

Patient or Legal Guardian SIGNATURE | Date

KEYSTONE HEALTHCARE AND WELLNESS LLC

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 ha 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 Name (printed)

_____ _____

Patient or Legal Guardian Signature Date

KEYSTONE
HEALTHCARE
AND WELLNESS LLC

IMPORTANT NOTICE – PLEASE READ CAREFULLY

"CONSENT TO TREAT"

Throughout your treatment at our facility you may receive services that consists of one or all of the following therapies:

- Hot Therapy
- Cold Therapy
- Electric Stim Therapy
- Active Therapy Exercises
- Chiropractic Adjustments

We also recommend the following:

- We ask that you refrain from wearing skincare products or other substances before your therapy sessions (lotions, creams, perfumes, etc.)
- Do not wear difficult clothing, it's best to wear two pieces (pants/skirt with a shirt)

NOTE: Please understand it is **YOUR RESPONSIBILITY** to **IMMEDIATELY** notify the therapy assistant during your treatment if you are experiencing ANY discomfort (pain, burns, throbbing, etc.) or if there are any physical manuevers beyond what you can tolerate or you feel is beyond your limits.

By signing below, I am authorizing Keystone Healthcare to provide the treatment they may consider necessary or advisable for my health care and Acknowledge I have read and understand the information set forth in this document.

_____ _____

Patient signature Date

_____ _____

Patient Printed name Witness signature

KEYSTONE HEALTH CARE AND WELLNESS LLC

Diagnostic Imaging/X-Ray Pregnancy Consent

Patient Name:_____

Patient DOB: _____

Please Answer the Following Questions: (Females Only 12-55 years of age)

Are you pregnant or any chance you may be:_____YES_____NO

The exam your doctor has ordered uses Ionizing radiation which can have a severe health effect during pregnancy to an unborn baby. The possibility of severe health effects depends on the gestational age of the unborn baby at the time of exposure and the amount of radiation it is exposed to. Unborn babies are particularly sensitive to radiation during their early development, between weeks 2 and 15 of pregnancy. Such consequences can include stunted growth, deformities, abnormal brain function, or cancer that may develop sometime later in life. You should contact your doctor if you believe you may be pregnant to discuss possible side effects and the risks and benefits of the procedure. If you feel that you may be pregnant, please inform the radiologic technologist before your exam.

_____To the best of my knowledge, I am not pregnant or believe there is any possibility that I may be pregnant.

_____I know or believe that I may be pregnant and fully understand the risk and health effects radiation may cause to my unborn baby.

Signature:_____ Date: _____