KEYSTONE HEALTHCARE AND WELLNESS LLC

Keystone Healthcare and Wellness
491 West Cheves St
Florence, SC 29501
843-662-8000 (P) / 843-664-0994 (F)

PERSONAL INFORMATION

First Name:_____M.I._____Last Name:_____Preferred Name:_____

Date of Birth:_____/_____/_____ Age_____ Gender: □ Male □ Female SSN:_____/_____/_____ Race: _____

Address:_____City:_____State:_____Zip:_____

If Minor, Name of Parent or Legal Guardian: _____ Relationship: _____

Home Phone:_____ Cell Phone:_____Email:_____

Employer/School_____Occupation:_____Phone No: _____

Emergency Contact Name: _____ Relationship:_____ Phone No:_____

MEDICAL INSURANCE INFORMATION

Primary Insurance:_____Policy No:_____Group No: _____

Supplemental Ins:_____Policy No: _____Group No: _____

ASSIGNMENT/AUTHORIZATION/RELEASE:

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

X_____ _____

Signature of Patient, Parent or Legal Guardian (if minor) **Date**

REASON FOR VISIT

What are your symptoms? _____

When did your symptoms begin? _____/_____/_____

Are your symptoms getting worse? □ Yes □ No

How often do you have these symptoms?___Constantly 76-100% ___Frequently 51-75% ___Occasionally 26-50% ___Intermittently 0-25%

What type of pain, if any, are you experiencing: Check all that apply:

____*Sharp* ____*Dull* ____*Sore* ____*Stiff* ____*Tight* ____*Aching* ____*Spasms* ____*Throbbing* ____*Stabbing* ____*Shooting* ____*Burning*
____*Cramping* ____*Nagging* ____*Tingling* ____*Numbness* ____ *Other:* _____

Does the pain radiate or travel to any areas of your body? □ Yes □ No If Yes, where?_____

Does your symptoms interfere with your: ___Work ___Sleep ___Daily Routine ___Recreation ___None

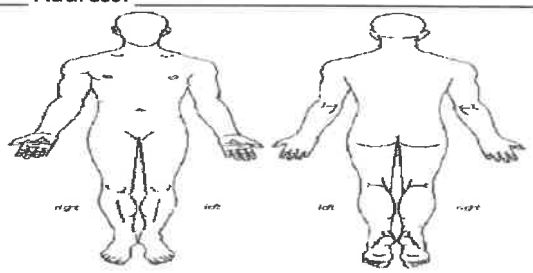
Are any of these painful to perform? ___Sitting ___Standing ___Walking ___Bending ___Lying Down

Have you had these symptoms in the past? □ Yes □ No If "Yes", when?_____

Have you received any treatment? □ Yes □ No Type: ___Medication ___Surgery ___Chiropractic ___PT ___Other:_____

Name of provider who treated you: _____ Address: _____

Please make an "X" on the body diagram to indicate
WHere you are having pain or other symptoms:



KEYSTONE HEALTHCARE AND WELLNESS LLC

Accident / Injury Form

Date of Accident/Injury: _____ Location of Accident/Injury: _____

Type of Accident/Injury? ____Auto Accident ____Slip & Fall ____Pedestrian ____Workers Comp

Please describe how your accident or injury happened:

_____

_____

_____

Employment:

Were you employed at the time of accident/injury? □ **Yes** □ **No**

Due to your accident/injury have you:

____Lost any days of work? □ **Yes** □ **No** If yes, list date(s) _____

____Had any work restrictions? □ **Yes** □ **No** Describe: _____

Auto Accident Only:

Were you the: ____Driver ____Front Sear Passenger ____Back Seat Passenger ____Pedestrian

Were you struck from: ____Behind ____Right Side ____Left Side ____Front ____Vehicle Parked

Was your vehicle moving at the time of the impact? □ **Yes** □ **No** If yes, approximately how fast? _____

Was anyone else in the vehicle with you? □ **Yes** □ **No** If yes, who? _____

Were you wearing a seat belt? □ **Yes** □ **No**

Did the airbags deploy? □ **Yes** □ **No**

Did your head hit the windshield or other object? □ **Yes** □ **No**

Did you lose consciousness? □ **Yes** □ **No**

Medical Treatment Received After Accident/Injury:

Did you go to any of the following after your accident/injury:: (List Provider's Name On Each Line And Their Address)

Emergency Room □ **Yes** □ **No** _____

Urgent Care □ **Yes** □ **No** _____

Primary Care Physician □ **Yes** □ **No** _____

Other Medical Facility □ **Yes** □ **No** _____

What areas of your body were affected by this accident/injury?:

___Upper Back	___Mid Back	___Lower Back	___Neck	___Head	___Face	___Jaw	___Chest
___Lt Shoulder	___Rt Shoulder	___Lt Arm	___Rt Arm	___Lt Elbow	___Rt Elbow		
___Lt Hand	___Rt Hand	___Lt Hand Fingers	___Rt Hand Fingers	___Lt Wrist	___Rt Wrist		
___Lt Hip	___Rt Hip	___Lt Leg	___Rt Leg	___Lt Knee	___Rt Knee		
___Lt Foot	___Rt Foot	___Lt Foot Toes	___Rt Foot Toes	___Lt Ankle	___Rt Ankle		

Do you have a primary care physician? □ **Yes** □ **No** PCP Name: _____

Do you have any medical conditions that you are currently or previously being treated for prior to your accident/injury? □ **Yes** □ **No**
If so, please list: _____

_____ _____

Patient / Parent or Legal Guardian Signature Date

KEYSTONE HEALTHCARE AND WELLNESS LLC

Health Information

Patient Name: _____ **Date of Birth:** _____ **Height:**_____ **Weight:**_____

Date of Last: Physical Exam _____ Spinal Exam _____ Spinal Xray _____ Chest Xray _____
Blood Test _____ Urine Test _____ MRI/CT-Scan _____ Bone Scan _____

Please check all conditions that you currently or previously have had:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Anxiety/Depression
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back or Neck Condition
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer_____
- ☐ Cataracts
- ☐ Chemical/Drug Dependency
- ☐ Chicken Pox
- ☐ Dementia/Alzheimer's
- ☐ Diabetes
- ☐ Disc Degeneration
- ☐ Dizziness
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Glaucoma
- ☐ Gout
- ☐ Headache/Migraines
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Insomnia/Sleep Problems
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver disease/cirrhosis
- ☐ Lung Disease
- ☐ LUPUS
- ☐ Lymphoma
- ☐ Measles
- ☐ Miscarriages
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson Disease
- ☐ Peripheral Vascular Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psoriasis
- ☐ Reiter's Syndrome
- ☐ Reynaud's
- ☐ Rheumatoid Arthritis
- ☐ Rheumatoid Fever
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Seizures
- ☐ Spinal Stenosis
- ☐ Spondylolisthesis
- ☐ Spondylosis
- ☐ Stroke / TIA
- ☐ Thyroid Problems
- ☐ TMJ
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Vertigo
- ☐ Weakness/Fatigue
- ☐ Other_____

Have you had any of the following: (Check all that apply and describe)

___Surgeries _____
___Head Injuries _____ ___Falls _____
___Broken Bones _____ ___Dislocations _____

Are you currently taking any medications? ☐ **Yes** ☐ **No**

Medication:_____ Frequency:_____
Medication:_____ Frequency:_____

Do you have any allergies to medication? ☐ **Yes** ☐ **No**

Allergy: _____ Reaction:_____
Allergy: _____ Reaction: _____

Are you pregnant (Females Only): ☐ **Yes** ☐ **No** ☐ **Not Sure**

Do you have any metal/screws/rods? ☐ **Yes** ☐ **No**

Do you smoke? ☐ **Yes** ☐ **No** How Often? ___Packs/Day
Do you drink alcohol? ☐ **Yes** ☐ **No** How Often? ___Daily ___Weekly ___Socially
Do you use any recreational drugs? ☐ **Yes** ☐ **No** How Often? ___Daily ___Weekly ___I prefer not to say
Do you exercise? ☐ **Yes** ☐ **No** How Often? ___Daily ___times a week

Family Medical History (List any medical conditions of immediate family members and their relationship to you):

Condition: _____ Relationship:_____
Condition: _____ Relationship:_____

What pharmacy do you use: _____ **Address:** _____

I hereby declare that the above mentioned information is true to the best of my knowledge and believe I have not withheld any information. I understand it is made for use as evidence in court and is subject to penalty for perjury.

_____ _____
Patient or Parent or Legal Guardian Signature **Date**

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 Name (Printed): _____

Patient/Parent or Legal Guardian Signature: _____Date: _____

Medical Assistant 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, Parent or Legal Guardian 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 7 years after the date on which you last received services from us.

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

IF YES, WHOM: _____

_____

Patient Name (PRINT)

_____ _____

Patient, Parent or Legal Guardian Signature Date

_____ _____

Authorized Provider Representative Signature Date

KEYSTONE HEALTHCARE AND WELLNESS LLC

IMPORTANT NOTICES – 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 maneuvers beyond what you can tolerate or you feel is beyond your limits.

"Diagnostic Imaging/X-Ray Pregnancy Consent"

Please Answer the Following Questions:

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 my unborn baby.

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/Parent or Legal Guardian Signature Date

_____ _____

Witness Signature Date

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/Parent or 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