

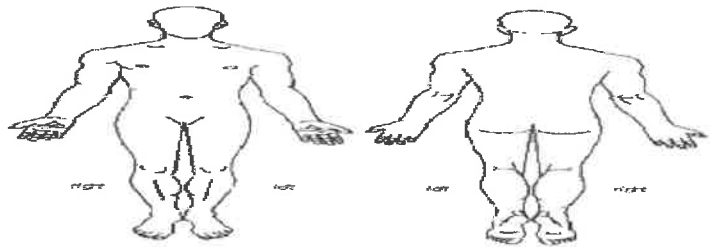
PERSONAL INFORMATION

First Name: _____ M.I. _____ Last Name: _____ Preferred Name: _____
 Date of Birth: ____/____/____ Age _____ Gender: Male Female SSN: ____/____/____ Race: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Email: _____
 If Minor, Name of Parent or Legal Guardian: _____ Relationship: _____
 Employer/School _____ Occupation: _____ Phone No: _____
 Emergency Contact Name: _____ Relationship: _____ Phone No: _____

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 previously had these symptoms? 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:



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 _____

Patient, Parent or Legal Guardian Signature

Date

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 ___ FS Passenger ___ BS 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

Medical Treatment Received After Accident/Injury:

Did you go to any of the following after your accident/injury::

Emergency Room Yes No Hospital Name: _____

Urgent Care Yes No Urgent Care Name: _____

Primary Care Physician Yes No PCP Name: _____

Other Medical Facility Yes No Dr/Facility Name: _____

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 being treated for prior to your accident/injury? Yes No

If so, please list: _____

Patient, Parent or Legal Guardian Signature

Date



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:

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

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, Parent or Legal Guardian Signature **Date**



Please answer the following questions and sign below

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. Bariatric Surgery (Weight Loss Surgery)? ___Yes ___No
- 6. Do you have any skin conditions? ___Yes ___No
- 7. Are you being treated for cancer? ___Yes ___No
- 8. Loss of sensation (means that you can't feel pain, heat, or cold)? ___Yes ___No
- 9. Have you ever had any neck, upper or lower back surgery? ___Yes ___No
- 10. Do you have any numbness, tingling or weakness due to a
medical condition not related to your accident? ___Yes ___No

- 11. Are you pregnant or is there a possibility you may be? ___Yes ___No
- 12. Are you breastfeeding? ___Yes ___No

- 13. Are you being treated for pain management or participate in
a pain management program? ___Yes ___No
- 14. Do you have a history of drug abuse? ___Yes ___No

If any 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.

Patient Name (Printed): _____

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

Medical Assistant 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 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



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

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 ask that you refrain from wearing any skincare products 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.

“X-Ray Consent”

During your examination, the doctor may feel that x-rays are needed in order to provide your treatment. In order to perform x-rays on any patient, our office requires that patients consent for such tests to be performed.

Please choose one of the following:

I understand that the doctor may need x-rays in order to administer my treatment:

- I **GIVE** my permission to perform such tests.
 I choose **NOT** to have any x-rays at this time and release the doctor of all liabilities

“Pregnancy X-Ray Consent”

I have been advised that certain X-Ray examinations involving the pelvis, exposes the uterus to radiation and therefore can be hazardous to an unborn child.

Please choose one of the following:

- To the best of my knowledge I am not pregnant or believe there is any possibility I may be pregnant.
 I know or believe that I may be pregnant and I fully understand the risks that may be caused to my unborn baby.

Please initial each and then sign below:

I give my permission to Keystone Healthcare and Wellness:

- To provide the treatment they may consider necessary or advisable for my health care.
 To communicate with my attorney and his/her office staff the level of care I am receiving if needed.
 To monitor my prescriptions through Sure Script.

By signing below, I acknowledge I have read and fully understand the information set forth in this document and I give my consent as stipulated above.

Patient Name (Printed)

Patient, Parent or Legal Guardian Signature

Date



**PLEASE
SEND
STAT**

Authorization to Release Medical Records

If you received medical treatment after your accident please list below:

Hospital ER or Urgent Care: _____

Primary Care Physician/Location: _____

Other Medical Facility/Location: _____

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
Fax to (843) 664-0994**