**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 (___) _____

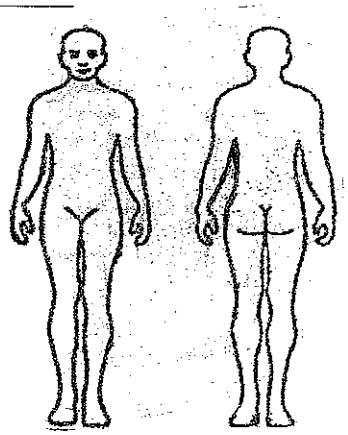
**Patient Condition**

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

**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
AND WELLNESS LLC

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: _____

Social Security Number: _____

Treatment Date(s)_____

Patient/Guardian Signature: _____

Witness 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**

# HEALTH INFORMATION

**GENERAL INFORMATION:**

**Patient Height:** _____

_____ **Patient Weight** _____

First Middle Initial Last **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 (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** | |
|---|---|---|---|
| ___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/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 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: _____

KEYSTONE HEALTHCARE AND WELLNESS LLC

Palmetto ChiroMed

## Please answer the following questions and sign below

Do You Have a Medical History of the Following:

- Pacemaker? _____Yes _____No
- ICD (Implantable Cardioverter Defibrillator)? _____Yes _____No
- Seizures? _____Yes _____No
- Paralysis, numbness or weakness to any part of your body due to stroke, multiple sclerosis or any other condition? _____Yes _____No
  List Condition: _____
- Have you ever had any neck, upper or lower back surgery? _____Yes _____No
  Type of Surgery: _____
- Do you have any skin conditions or being treated for cancer? _____Yes _____No
- Are you pregnant or is there a possibility you may be? _____Yes _____No
- 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: _____