Palmetto ChiroMed
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:_____

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

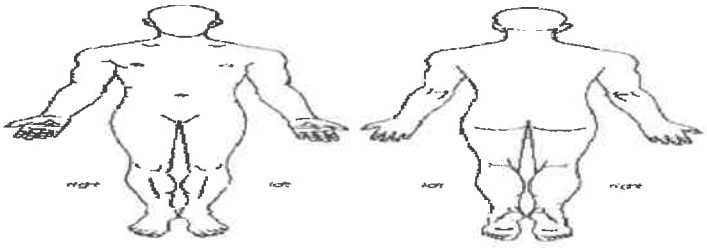
Are any of these painful to perform? ___Sitting ___Standing ___Walking ___Bending ___Lying Down

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 Palmetto ChiroMed 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**

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

_____ _____
Signature of Patient, Parent or Legal Guardian (if minor) **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 Palmetto ChiroMed ("office") such sums as may be owing to Palmetto ChiroMed 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 Palmetto ChiroMed with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by Palmetto ChiroMed 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 Palmetto ChiroMed, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Palmetto ChiroMed 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 Palmetto ChiroMed 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 Palmetto ChiroMed 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 Palmetto ChiroMed 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 Palmetto ChiroMed 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 Palmetto ChiroMed 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 Palmetto ChiroMed 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 Palmetto ChiroMed 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 (PRINT): _____

_____ _____

Patient, Parent or Legal Guardian Signature Date

_____ _____

Witness Signature Date

Palmetto Chiropractic

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 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 Palmetto ChiroMed 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

To: _____

Address: _____

Re: Authorization to Release Medical Information

You are hereby authorized to forward to Palmetto ChiroMed 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, Parent or Legal Guardian Signature: _____

Date: _____

Please return the medical records requested to:

Palmetto Chiromed
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