MYRTLE BEACH SPINE CENTER, PA

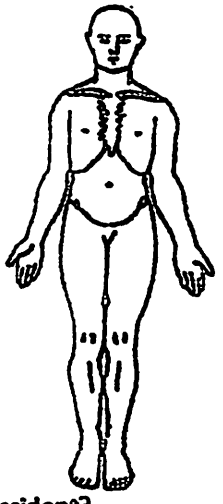
Legal Name: _____ **Preferred Name:** _____
Date of Birth: _____ **Gender Identity:** _____ **Sex at birth:** _____
Address: _____
Social Security Number: _____ **Preferred Language:** _____
Cell Phone: _____ **Home phone:** _____ **Work Phone:** _____
Email: _____ **How can we contact you? (*circle all that apply*):** text phone email
Employment Status: _____ **Employer:** _____ **Occupation:** _____
Name of Significant Other: _____ **Marital status(*circle one*):** married single other
Emergency Contact Name: _____ **Phone Number:** _____
Race (*circle one*): American Indian / Alaska Native / Asian / Black or African American / Native Hawaiian White or Caucasian / Pacific Islander / decline to answer / other _____
Ethnicity (*circle one*): Hispanic or Latino / Not Hispanic or Latino / decline to answer / other _____

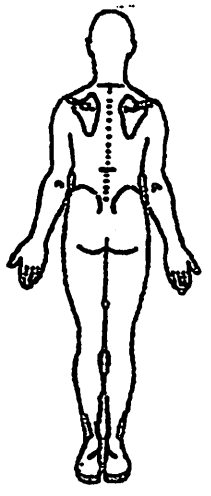
Name of Insurance Company: _____ ***Relationship to cardholder:*** _____
Cardholder's Name: _____ ***DOB:*** _____ ***SS#:*** _____
Cardholder's Place of Employment: _____

****In order of importance, please list the complaints/reason you are seeing the Doctor today:**

1. _____ **How long?** _____
2. _____ **How long?** _____
3. _____ **How long?** _____

Please mark the areas of complaints on the illustration below using the following symbols:
P = Pain N = Numbness B = Burning A = Ache T = Tenderness S = Spasm R = Radiation (where to?)





Is this due to an accident? _____ **Date of Accident:** _____
Do you have an attorney? _____ **Name:** _____
*(***IF DUE TO ACCIDENT LET THE RECEPTIONIST KNOW IMMEDIATELY****)*
Have you ever had pain like this before? Y or N If so, when? _____
Does the pain radiate anywhere (*up, down, left, or right – be specific*)? _____
What is the pain like (*when it is at its worst*) on a scale of 1 to 10, with 10 being the worst: _____
Describe the pain (*circle all that apply*): *throbbing stabbing burning numb dull ache* other: ____

Patient Name: _____ **Signature:** _____ **Date:** _____
(if a Minor: Guardian's Name: _____ *Guardian's Signature:* _____

When does the pain bother you? (*circle all that apply*): Night Day Constant Occasionally Daily Weekly
Has the pain cause you to miss any work or school? Y or N **if so, how much?** _____
When did the pain begin? _____ **What were you doing at the time?** _____
Have you seen any other Doctors for this pain? Y or N If so, whom? _____
How long ago did you see him/her? _____ **What was the progress?** (*circle one*) Same Better Worse
What treatments have you received already for this pain? _____
What have you tried to make the pain feel better (*circle all that apply*): *resting twisting adjustments bending running walking eating sitting working exercising sleeping medications lying down ice standing stretching tylenol/aleve/ibuprofen massage heat other:* _____
Does anything make the pain feel worse (*circle all that apply*): *bending exercising running twisting carrying gardening sitting typing chewing lifting sleeping walking cleaning lying down sneezing working cooking medications standing coughing pulling stretching driving pushing turning* other: _____
Is there anything else you would like the doctor to know about your condition(s)? (*please write it in the space below*)

Who is your Primary Care Physician (PCP)? _____ **When did you last see him/her?** _____
PCP Address: _____ **PCP Phone:** _____

Personal Habits: **Smoker** Y or N **If so, how much/how often?** _____ **Start date:** _____
Alcohol? Y or N **if so, how much/how often?** _____
Exercise? Y or N **if so, how much/what type?** _____
Are you currently Pregnant? _____ **Date of last menstrual cycle?** _____
if you are pregnant, please notify the doctors and staff during your consultation

Please list all of your allergies (*Medication / Food / Environmental / etc*): _____
_____
Please list all the over the counter medicine you are taking and the dosage (*vitamins, Tylenol, Aleve, allergy medicine, etc*): _____
Please list all of the prescription medication you are taking and the dosage and frequency: _____
_____
_____
_____
Please list any surgeries or hospitalizations and when they occurred: _____
_____
_____

How did you hear of our office? _____

I attest that the information that I filled out is accurate to the best of my knowledge and I agree to have this office and physician examine me for further evaluation. This <u>may</u> include: consultation, examination, x-rays (if necessary). If the patient is a minor, I attest that I am legally allowed to provide this consent.

Patient Name: _____ **Signature:** _____ **Date:** _____
(*if a Minor: Guardian's Name:* _____ *Guardian's Signature:* _____)

PERSONAL & FAMILY HEALTH HISTORY

please fill out as completely as possible and be specific where indicated

put "X" where applicable and indiciate which family member and if they are living (L) or deceased (D)

Condition	SELF	mother/father	sibling(s)	children	aunt/uncle	grandparent(s)
alcoholism						
alzheimers						
allergies						
anemia						
arthritis (type)						
asthma						
autoimmune (type)						
back pain						
bleeding disorder						
blood clots						
bowel disease (type)						
cancer (type)						
carpal tunnel						
depression						
diabetes (type)						
drug allergies (type)						
epilepsy						
fatigue						
emphysema						
rheumatic fever						
hepatitis						
heart disease (type)						
high blood pressure						
kidney disease (type)						
HIV/AIDS						
ulcers (type)						
lupus						
migraines						
multiple sclerosis						
neck pain						
obesity						
osteoporosis						
parkinson's disease						
scoliosis						
stroke						
thryoid disorder						
chemotherapy						
radiation						
pacemaker						
seizures						
psychiatric care						

PLEASE LIST ANY CURRENT DIAGNOSIS/ILLNESS YOU HAVE, WHO DIAGNOSED YOU AND WHEN:

Name:		Date:	

CHECKLIST: Review of Systems

Please circle all that apply in each bolded section, that you are currently having or have had in the past 6 months**
If you have experienced any of the symptoms in the past (6+ months ago) and would like the doctor to know about it, please circle the symptom and write when you experienced it.

General-
Weight loss or gain
Fatigue
Fever or chills
Weakness
Trouble sleeping

Skin-
Rashes
Lumps
Itching
Dryness
Color changes
Hair and nail changes

Head-
Headache
Head injury

Ears-
Decreased hearing
Ringing in ears (tinnitus)
Earache
Drainage

Eyes-
Vision
Glasses or contacts
Pain
Redness
Blurry or double vision
Flashing lights
Specks
Glaucoma
Cataracts
Last eye exam
(date)_____

Nose-
Stuffiness
Discharge
itching
Hay fever
Nosebleeds
Sinus pain

Throat
Teeth
Gums
Bleeding
Dentures
Sore tongue
Dry mouth
Sore throat
Hoarseness
Thrush
Non-healing sores
Last dental exam
(date)_____

Neck-
Lumps
Swollen glands
Pain
Stiffness

Breasts
Lumps
Pain
Discharge
Self-exams
Breast-feeding

Respiratory-
Cough (dry or wet, productive)
Sputum (color and amount)
Coughing up blood (hemoptysis)
Shortness of breath (dyspnea)
Wheezing
Painful breathing

Patient Name: _____ Signature: _____ Date: _____

(If a Minor, Guardian's Name: _____ Guardian's Signature: _____)

Cardiovascular-
Chest pain or discomfort
Tightness
Palpitations
Shortness of breath with activity (dyspnea)

Difficulty breathing lying down (orthopnea)
Swelling (edema)

Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

Gastrointestinal-
Swallowing difficulties
Heartburn
Change in appetite
Nausea

Change in bowel habits
Rectal bleeding
Constipation
Diarrhea

Yellow eyes or skin (jaundice)

Urinary-
Frequency
Urgency
Burning or pain

Blood in urine (hematuria)
Incontinence

Change in urinary strength

Genital-
Male-
Pain with sex
Hernia
Penile discharge

Sores
Masses or pain
Erectile dysfunction

STD's (what/when) _____

Female-
Pain with sex
Vaginal dryness

Hot flashes
Vaginal discharge

Itching or rash
STD's (what/when)_____

Vascular-
Calf pain with walking (Claudication)

Leg cramping

Musculoskeletal-
Muscle or joint pain
Stiffness

Back pain
Redness of joints

Swelling of joints
trauma

Neurologic-
Dizziness
Fainting
Seizures

Weakness
Numbness
Tingling

Tremor

Hematologic-
Ease of bruising

Ease of bleeding

Endocrine-
Head or cold intolerance
Sweating

Frequent urination (polyuria)
Thirst (polydypsia)

Change in appetite (polyphagia)

Psychiatric-
Nervousness
Depression

Memory loss

Patient Name: _____ Signature: _____ Date: _____

(If a Minor, Guardian's Name: _____ Guardian's Signature: _____)

Myrtle Beach Spine Center, PA

OFFICE POLICIES:

- Following today's consultation, if the doctor feels that you can benefit from care, he/she will make specific recommendations for examination procedures in order to fully understand your condition. At the completion of your examination, you will be scheduled for a separate appointment for the doctor to review these findings with you and make recommendations for treatment (if appropriate). We are committed to providing you with the best care possible in a caring environment and have financial policies consistent with that goal.
- In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policy - our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances: if we are a participating provider in your health plan; if you are covered by a State or Federal program with a mandated fee schedule; if you are a member of DMPO that we may join (patient who are uninsured or underinsured with limited benefits, will be entitled to network discounts similar to our insured patients); if you are eligible and choose a pre-payment or auto-debit payment plan. As part of our compliance plan, our office will be unable to extend any type of discounts other than those listed above.
- You are expected to pay for your treatment at the time service is rendered unless other arrangements have been made in advance. Details of available payment options will be discussed with you when the doctor goes over your specific recommendation for care during your report of findings. This will typically be scheduled on our next business day. You are responsible for any and all expenses incurred in the collection of any overdue account (we reserve the right to charge a delinquency charge of 1.5% per month up to 18% per year and/or there will be a $35 returned check fee on any check payments that are returned.
- We reserve the right to charge $25 fee for missed appointments without prior notification and we request 24 hour notice if you are going to miss an appointment.
- Verification of your insurance benefits is not a guarantee of payment. You will be responsible for any unpaid balances. If we submit your insurance claims, your amount due will be based upon our best estimate according to the information provided to us by your insurance company. If claims process differently than expected, we will update your amount due according to the information provided on your insurance company's Explanation of Benefits (EOB). All payments are due at the time of service or by another previously agreed upon arrangements. You will be refunded any overpayments (if applicable).
- Finances and patient health information will <u>not</u> be discussed over the telephone, if you should have a questions, you may address it on your next scheduled appointment. If you do not have an appointment, you can schedule a consultation with the proper department to handle your question.
- We advise that you follow treatment recommendations given by the doctor(s). There are multiple providers in the clinic and in order to maximize your treatment at Myrtle Beach Spine Center, PA, group therapy is part of the treatment process. Disclosure of Private Health Information, in a limited manner to staff members that are actively involved in your treatment, is required to carry out this procedure. A signature below states that you release the use of that information under HIPAA guidelines.
- A signature below will authorize your consent to release your health information to your insurance company (if applicable and we are filing your health insurance for you), which allows them to make contributions to your care directly to Myrtle Beach Spine Center, PA and gives us limited power of attorney to endorse any check made out to you for services rendered in our office/by our doctors, to you or on your behalf.
- X-rays remain property of this office and will only be duplicated in a digital format (sent via HIPAA secure email) or printed on paper when the proper X-ray request forms have been filled out. Letters or forms requested by the patient will be subject to a $35 administration fee due at the time of request. Medical record copies will be assessed at a fee of: pages 1-30 $.65 per page; pages 31+ $.50 per page plus S/H costs. All records requests must have the proper request form filled out prior to the release of any medical records.

Signature: _____ **Date:** _____

(If a Minor: Guardian's Name: _____ *Guardian's Signature:* _____*)*

- Myrtle Beach Spine Center, PA staff will treat all patients and visitors in a welcoming manner that is free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law. We will treat all of our practice members with respect and expect the same courtesy to be extended to our staff. (Full versions of: Privacy Policy, Non-Discrimination Policy, Financial Policy documents are available upon request to review)
- It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, USPS or by any means convenient to the practice and/or requested by you. We may send you other communications informing you of changes to office policy, schedule changes, promotions, office closures or new technology that you might find valuable or information. You may opt in/out from the text messages and/or emails directly from the message itself or by letting the receptionist know.
  MBSC utilizes a number of vendors in the conduct of business. These vendors may have access *indirectly* to protected health information (PHI), but they have all agreed to abide by the confidentially rules of HIPAA (in writing in the form of a Business Associate Agreement).
- Any gift certificate that you may present in this office is not redeemable for cash. If you wish to receive any additional services that are not described on the gift certificate, you are responsible for payment for those services. Any discounted or free services described on a gift certificate are only applicable on the day that the gift certificate is presented to the office. Gift Certificates can only be redeemed for the services described on the gift certificate. (*NOTE: If you are filing your health insurance for your treatment, you can NOT use a gift certificate for payment towards any covered services – see gift certificates for specific limitations)
- Pictures and videos are periodically taken during patient hours. In the event that you are in the background (meaning: you are not directly identifiable) of one of these images, you give consent to Myrtle Beach Spine Center, PA to use that video or picture without further authorization. In the event that you agree to or would like to be a featured subject, there will be a separate consent form presented for your agreement.
- Your confidential information will not be used for the purpose of marketing or advertising or products, goods or services.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. We will do the best we can to accommodate your request; however, we are not obligated to alter internal policies to confirm to your request.
- Please be courteous to other patients' office experience. We discourage cell phone usage during treatment. If you must take a call, please step outside. If you are watching videos or playing games, please use your headsets as to not disturb those around you.
- Please refer to our website, www.MyrtleBeachSpineCenter.com, to learn more about additional services in our office, patient education, health tips and videos, and more.

Please list the name(s), contact information and relationship of anyone who you would like the office to include in your medical record as an approved party to receive disclosure of your personal health information (PHI) <*this is optional*>:

I, _____, do hereby consent and acknowledge my agreement to the terms stated above and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ **Date:** _____

(If a Minor: Guardian's Name: _____ *Guardian's Signature:* _____*)*

INFORMED CONSENT FORM

***Prior to receiving care in this office, a health history and physical examination will be competed. These procedures are performed to assess your specific condition, your overall health, and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider to treat your condition. All relevant findings will be reported to you along with a care plan prior to beginning care.*

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures (if/when clinically necessary): examination, palpation, vital signs, orthopedic testing, basic neurologic testing, range of motion testing, muscle strength testing, postural analysis, radiographic studies, ultrasound, cold laser, spinal decompression, manual traction, hot/cold therapy, electrical stimulation, mechanical traction, neuromuscular re-education, therapeutic exercises, trigger point therapy.

(NOTE: ONLY the procedures that are clinically indicated for your condition will be performed. The Doctor will recommend and discuss each procedure as applicable)

The material risks inherent in chiropractic treatment and the probability of those risks occurring:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. These complications are generally described as rare. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history, examination and X-ray (if needed). Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers to leaving conditions untreated

Conditions left untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Your condition may continue to deteriorate or worsen. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to the above aforementioned treatment(s).

Patient Name: _____ **Signature:** _____ **Date:** _____

(If a Minor: Guardian's Name: _____ *Guardian's Signature:* _____*)*

Consent for Use or Disclosure of Health Information Service Agreement and Acknowledgement

Myrtle Beach Spine Center, PA (MBSC) is very concerned with protecting your privacy. While the law requires MBSC to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. This office conforms to the current HIPAA guidelines and you may request a copy of our HIPAA and Privacy Policies. There are several circumstances in which we may have to use or disclose your health care information: i.e. another health care provider or hospital if it is necessary to refer you for the diagnosis, assessment, or treatment of your health condition; another party that may be responsible for the payment of your services; within our practice for quality control or other operational purposes.

If there is anyone who you would like to authorize to receive disclosure of your health information, you must provide their name, relationship, contact information in writing BEFORE we can release any information or speak to them on your behalf. You have the right to request that we do not disclose your health care information to specific individuals or organizations. If you would like to place any specific restrictions on the use or disclosure of your health information, please let us know in writing. We will not be able to honor your request if we have already released your health information before we receive written notice from you. If you were required to give your authorization of a condition while obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I hereby authorize Myrtle Beach Spine Center, PA to release and permit the examination or copying of any of my medical records, x-rays, lab reports and the results of all tests of any type or character to such persons or companies as the doctor deems appropriate (i.e. health insurance, insurance adjustor, attorney, etc.) for treatment of my condition and payment for my care.

(INITIAL) _____

Records Release, Assignment of Benefits,

Limited Power of Attorney ONLY for This Case and Payment Agreement

I authorize medical payments to be made directly to Myrtle Beach Spine Center, PA (hereinafter listed as MBSC). I further assign to MBSC a lien in the amount of my bill for health care services against the proceeds of any insurance policy or health care plan and against any claims which I may have against any other party whose negligence may have caused my injuries or who may be legally responsible for my injuries, illnesses or health care costs. I direct payment to be made directly to MBSC on my behalf (assignment of benefits to Myrtle Beach Spine Center, PA). I agree to cooperate with doctor in collecting any such amounts, including appearing in court if necessary.

I understand that I am fully responsible for any and all charges that are brought on behalf of the care received at MBSC, regardless of any medical insurance coverage. I understand and agree that health and accident polices are an arrangement between an insurance carrier and myself. Furthermore, I understand that MBSC will prepare any necessary reports and forms to assist me in making collections for the insurance company and that any amount authorized to be paid directly to MBSC will be credited to my account upon receipt.

I clearly understand and agree that all services rendered are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

While MBSC will do the submission of claims on my behalf, the insurance company may send payment directly to me instead of MBSC. MBSC will do their best to inform me when to expect those payments and paperwork from the insurance company. MBSC also asks that I bring in any and all paperwork attached to the check from my insurance company so that we can apply those payments appropriately. In the event that I receive payment directly, at a time when there is still a balance due to the MBSC, I agree to deliver such monies immediately upon receipt to be applied to my bill.

*(INITIAL)*_____

Patient Name: _____ **Signature:** _____ **Date:** _____

(If a Minor: Guardian's Name: _____ *Guardian's Signature:* _____*)*

Myrtle Beach Spine Center, PA
100 Legends Drive, Suite A
Myrtle Beach, South Carolina 29579
PH: 843-236-9090

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Myrtle Beach Spine Center, PA or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

_____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name _____

Date of Accident_____ Time of Accident _____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Where you the: ☐ Driver ☐ Front Passenger How many people
☐ Rear Passenger ☐ Pedestrian in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other_____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from:

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking Up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE (if applicable)

Make and model of other vehicle_____

Which Direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐Yes ☐No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐Yes ☐No

When did you go? ☐Immediately after accident ☐Next Day ☐2 days or more after the accident

How did you get to the hospital? ☐Ambulance ☐Private transportation

Name of hospital_____ Name of doctor _____

Diagnosis_____

_____

Treatment received _____

X-rays taken_____

SYMPTOMS / INJURIES

Have you been able to work since this injury? ☐Yes ☐No How many work days have you missed?_____

Prior to the injury were you able to work on an equal basis with others your age? ☐Yes ☐No

If you have had any of the following symptoms since your injury, please ☑check:

☐Arm/shoulder pain
☐Back pain
☐Back stiffness
☐Chest pain
☐Dizziness
☐Ear buzzing
☐Ear ringing
☐Fatigue
☐Feet/toe numbness
☐Hand/finger numbness
☐Headaches
☐Irritability
☐Jaw problems
☐Leg pain
☐Memory loss
☐Nausea
☐Neck pain
☐Neck stiff
☐Shortness of breath
☐Sleep difficulty
☐Stomach upset
☐Tension
☐Vision blurred

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 (sever pain)_____

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness
☐Aching ☐Shooting ☐Burning ☐Tingling
☐Cramps ☐Stiffness ☐Swelling ☐Other_____

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

Movements that are painful to perform: ☐Sitting ☐Standing ☐Walking
☐Bending ☐Laying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Myrtle Beach Spine Center, PA

100 Legends Drive, Suite A, Myrtle Beach, SC 29579
(843) 236.9090 • Fax (843) 236.9099
www.myrtlebeachspinecenter.com

Office policies for Personal Injury patients

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following:

1 - Copy of police report and/or a copy of the exchange slip.

2 - Copy of personal automobile policy
This is to verify Medical Payments covered by your Automobile Insurance.

3 - Name of individual and insurance company of party that's liable. Please include policy number.

4 - Name and telephone number of attorney if an attorney has been retained.

You are asked to give 24 hour notice if you need to reschedule an appointment. All appointments that have been missed without notice may be billed to your account.

Signature_____ Date_____

LIEN

TO: Attorney/ Insurance Carrier

_____

_____

_____

Myrtle Beach Spine Center, PA
100 Legends Drive, Suite A,
Myrtle Beach, SC 29579

RE: Patient Records and Doctor's Lien.

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report concerning all examination, diagnosis and treatment of myself in regard to my accident/illness which occurred/began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgement, or verdict as a result of said accident/illness and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor out of first proceeds such sums from settlement, claim, judgement, or verdict as may be necessary to protect the doctor adequately; first proceeds is inclusive of any and all insurance benefits that might be in force, PIP, Med Pay, Group Health. I have further given the attending physician permission to endorse my name to all checks received in my behalf. I, therefore, request that all checks or drafts be sent directly to and made payable to the attending physician.

I fully understand that I am directly and fully responsible to said doctor all medical bills submitted by him for services rendered to me and that this agreement is made solely for the said doctor's additional protection and in consideration of awaiting his payment. It is for this reason that I have given him all rights to the first proceeds in this case necessary to protect the charges that I have incurred. I fully understand that such payment is not contingent on any settlement, claim, judgement, or verdict by which I may eventually recover said fee.
I have voluntarily entered into the above contract and lien with the attending physician, and it has been fully explained to me. By this lien and contract, I am putting all parties on notice of my obligations as well as the way way I wish my business to be transacted in this matter.

I have voluntarily entered into the above contract and lien with the attending physician, and it has been fully explained to me. By this lien and contract, I am putting all parties on notice of my obligations as well as they way I wish my business to be transacted in this matter. I am requesting my attorney and/or any other interested parties to make signature on this form acknowledging its receipt. However, in the event that they do not choose to sign the form, for whatever reason, I wish to point out that they have been priced on notice that a contract exists between myself and the attending physician; I order that they have honor this contract in full. I hereby state and agree that the lien may not be withdrawn unilaterally. It is further agreed that a copy of this agreement will be considered the same as the orignal.

Should I dismiss any attorney of record, I authorize that attorney to provide you with all information regarding this claim that he has in his possession. This is including but not limited to names of all insurance companies, adjusters and claims numbers.

Dated:_____ Patient's Signature:_____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient, does herby acknowledge receipt of the above lien and does agree to honor the same to protect adequately said above named doctor.

Dated:_____ Authorized Signature:_____

NOTICE: Please date, sign & return one copy to doctor's office at once.
Keep one copy for your records.

AUTHORIZATION AND ASSIGNMENT

TO Myrtle Beach Spince Center, PA

In consideration of your undertaking to treat me, I agree to the following.

1. You are authorized to release any information concerning my physical condition to any insurance company, attorney or adjuster in order to process my claim for reimbursement of charges incurred for services rendered to me by you or any member of your staff acting in your behalf. It is further agreed, however, that until my account is paid in full or that there is adequate promise of payment that is approved by you, medical records do not have to be sent.

2. I request, authorize, and further direct that any insurance company which is obligated to reimburse for services rendered or pay for damages make such payments directly to you. I further direct that checks should be made payable to you or the clinic, specifically, so that you may obtain immediate payment. Insofar as any payment is concerned, I allow you to stand in my place and receive all payments as they would have been made to me. I further authorize and give my permission to you to endorse any and all checks, drafts or payments received in my behalf. Thus authorization is to endorse checks, whether they be received for settlement purposes or services rendered. It is further understood that if any point the monies received exceed my indebtedness, those funds will be returned to me from your office.

3. I hereby assign and transfer to you any cause of action (tort liability) that exists in my favor against such company, individual, or insurance company, which are liable to provide, defend and pay damages (the names which are believed to be correctly set forth under permanent data below) and authorize you to prosecute said action, either in my name or in your name, as you see fit. It is agreed, however, that in transferring this cause of action it is agreed between all parties that your interest in this case shall be limited to the amount of the medical bills rendered to me by you or your appointee at any of your clinic facilities. It is further understood and agreed by all parties that the transfer of this cause of action shall not exceed those medical bills that are rendered for my benefit and that are related to the case in question. For the above-named purpose I further authorize and transfer to you my limited power of attorney so that you may act in my behalf in this regard, and in this regard only. It is further understood that until all reasonable efforts have been made to collect sums due from the insurance carriers obligated, you will refrain form attempts to collect amount from me. I understand whatever amount you do not collect from insurance proceeds, whether it be all or part of what is due. I personally owe you.

DATE:_____ SIGNED:_____

WITNESSED:_____ DATE OF INJURY:_____

PERTINENT DATA

Names of insurance companies to be involved:

My companies:

_____

_____

Companies of person responsible for accident

_____

_____

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved.

Chiropractic Authorization, Release, & Explanation

Myrtle Beach Spine Center, PA
100 Legends Drive, Suite A
Myrtle Beach, SC 29579

Medical Notes and X-Ray Release

I hereby acknowledge the release of medical information, S.O.A.P notes, and x-ray reports, to Myrtle Beach Spine Center PA.

_____ _____
(Patient Signature) (Date)

_____ _____
(Witness Signature) (Date)