

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

Phone # _____
(H) _____ (W) _____ State _____ Zip Code _____ (Other) _____

Can we call you at work? Yes No

Date of Birth: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other _____

Has it been reported? Yes No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO Piedmont Medical Center INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ DATE _____

Form 2

PI 4

Assignment of Proceeds, Contractual Lien, and Authorization

I, the undersigned, hereby authorize and direct any and all insurance carriers, attorneys, agencies, government departments, companies, individuals, and/or other legal entities (payers), which may elect to be obliged 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 Piedmont Medical Center 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 Piedmont Medical Center with respect to my charges, applicable to all payers; however, I understand that nothing in this Agreement shall be constructed as an election by Piedmont Medical Center to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but not limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health group insurance, lost wage benefits, lost service benefit, attorney retainer agreements, medical payment benefit, Personal injury protection, no-fault coverage, uninsured and uninsured 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 Piedmont Medical Center, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Piedmont Medical Center 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 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 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 Piedmont Medical Center any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the 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 Piedmont Medical Center to endorse/sign my name on any and all checks listing me as the payee, which are presented to this Office for payment of and account relating to me, my spouse, or any of my dependents, regardless of these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Piedmont Medical Center from their services. This assignment lien does not constitute any consideration for this Office to await payments and it may demand payments form 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 Piedmont Medical Center for all costs of such collection efforts, including, but not limited to, all court costs and all attorneys fees.

This assignment and lien shall not be modified or revoked without the mutual written consent of Piedmont Medical Centers and myself. I hereby revoke any previously signed authorizations, whether executed at this Office or any other Office to the extent the terms of those authorizations conflict with the terms of this agreement and lien.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interests of Piedmont Medical Center and me. 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 provisions of this agreement shall, nevertheless, remain in full force and effect.

Personal Injury cases that the attorneys willfully gave Dr's fees to their clients will be referred to the South Carolina Bar Office of Disciplinary Council.

Please print patient name: _____ Date _____

Patient Signature: _____ Date _____

Name of Custodial Parent or Legal Guardian (please print)

Parent /Guardian : _____ Date _____

Witness: _____ Date _____

PI 2

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
Piedmont Medical Center**

Patient Name: _____ DOB: _____

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

_____ I have received a paper copy of Privacy Notice and Notice of Patient Rights & Responsibilities..

Appointment Reminders and Healthcare Information Authorization

Your doctor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

_____ I acknowledge that it is the policy of Piedmont Medical Center to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, **Beth Mills**, about my concerns.

Signature of Patient/Guardian

Date

If not signed by the patient, please indicate relationship.

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: (Efforts to Obtain/Reasons for Refusal)

PL3

Piedmont Medical Center

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

Patient's Signature

Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient's Signature

Date

Piedmont Medical Center

PI 4

Piedmont Medical Center
3029 White Horse Road,
Greenville, SC 29611

Patient Rights and Responsibilities

Patient Rights:

1. The patient has the right to considerate and respectful service.
2. The patient has the right to obtain service without regard to race, creed, national origin, sex, age, disability, diagnosis, or religious affiliation.
3. Subject to applicable law, the patient has the right to confidentiality to all information pertaining to his/her medical equipment service. Individuals or organizations not involved in the patient's care may not have access to the information without the patient's written consent.
4. The patient has the right to make informed decisions about his/her care, including being able to request or refuse medically appropriate treatment to the extent permitted by law, and being informed of the medical consequences of such action.
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process.

Patient Responsibilities:

1. The patient should promptly notify Piedmont Medical Center of any equipment failure or damage.
2. The patient is responsible for any equipment that is lost or stolen while in their possession and should promptly notify Piedmont Medical Center in such instances.
3. The patient should promptly notify Piedmont Medical Center of any changes concerning their physician.
4. The patient should notify Piedmont Medical Center of any changes to their address and telephone.
5. The patient should notify Piedmont Medical Center of discontinuance of use.
6. Except where contrary to federal or state law, the patient is responsible for any equipment rental and sale charges which the patient's insurance company/companies does not pay.

Patient Signature: _____ Date: _____

Created: 12/01/2010

Revised: 05-06-2011

Revised : 08-18-2017

PI5

Financial Office Policies

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information necessary to process any claims from this office.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts MasterCard, Visa, American Express, Discover Card, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the front desk or our Case Manager prior to seeing the doctor.

Thank you for your cooperation in this matter.

I have read and fully understand the financial office policy and agree to abide by these terms.

Patient Signature or Responsible Party

_____/_____/_____
Date

Piedmont Medical Center

PI 6

PATIENT MISSED APPOINTMENT POLICY

DEFINITIONS

POLICY- a way of managing affairs so as to achieve some purpose.

APPOINTMENT- a meeting with someone at a certain time and place.

MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because **Treatments** will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. **All cancelled or missed appointments must be rescheduled and made up within one week.**
6. There is a \$5.00 service charge for no call/no show appointments.
7. There is also a \$20.00 charge for missing an appointment with the medical doctor.

I have read, understand, and agree to follow the above policy.

Patient's Name: _____

Signature: _____

Staff Witness: _____

Piedmont Medical Center

PE7

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT
TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH
INSURANCE

I hereby instruct and direct the _____
Insurance Company to pay by check made out and mailed directly to:

3029 White Horse Rd.
Greenville, SC 29611

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it to the above address for medical and/or chiropractic expense benefits allowable, and otherwise payable to me and under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photo copy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.

Dated at _____ this _____ day of _____ 20__.

Signature of policyholder

X _____
Signature of Claimant, if other than
Policyholder

witnessed by: _____

* With my signature above, the full deductible or co-payment
would be a financial hardship on me.

Piedmont Medical Center

RECORDING REQUESTED BY:

WHEN RECORDED MAIL TO:

In the event that the below names "principle" does not acquire or procure licensed legal counsel, then this Healthcare Power of Attorney will be invoked. If principle retains and maintains an attorney, licensed in South Carolina, amounts due to Piedmont Medical Center will be paid to said attorney.

IRRECOVABLE HEALTHCARE POWER OF ATTORNEY

I, _____ (hereinafter, "Principle") of Piedmont Medical Center, County of Greenville, state of South Carolina, do appoint my healthcare provider (hereinafter, "Attorney"), as my true and lawful attorney in fact. In Principal's name, and for Principal's use and benefit, said Attorney is hereby authorized to:

- 1 Endorse any and all checks or other forms of reimbursement made payable to Principal (or members of Principal's family) by any health insurance companies which relate to medical treatment provided by Attorney to Principal (or members of Principal's family) over to Attorney.

- 2 Demand and direct any and all health insurance companies, during the course of Principal's (or members of Principal's family) medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and send such checks directly to Attorney.

This special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare services provided and shall be irrevocable through the duration of the healthcare services provided by Attorney to Principal arising from any injury or major medical conditions sustained either by Principal or members of Principal's family.

Giving and Granting to said Attorney full power and authority to do all and every act and thing whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might our could do if personally present.

All that said attorney shall lawfully do or cause to be done under the authority of the power of the attorney is expressly approved.

Date: _____

_____ (Print Name of Said Principal)

Witness:

Date:

PI 9

Personal Injury Financial Policy

It is important for you to understand that **YOU** are responsible for payment of services rendered from our office for injuries suffered in an automobile accident or personal injury. There are two options for payment:

1. Have an Attorney
2. Pay cash as services are rendered

We will accept assignment from attorney and not require payment at time of service **ONLY** when the following are furnished:

1. Letter of representation from attorney
2. Copy of accident report
3. Authorization to release information
4. Signed Doctor's Lien

If you have contracted with an attorney to handle your case and you have later decided to fire that attorney, the following must happen:

1. Inform Piedmont Medical Center of your replacement attorney.
2. Have new attorney send Letter of Representation.
3. If no attorney is contracted, your balance becomes payable within 14 days.
4. It is our policy to not provide documentation or outstanding balance to a patient filing a 3rd party liability claim.

Patient Signature:

Date:

PI 10

PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

1. **Description of Accident/Injury/Onset**
Enter a full description of the accident, injury or onset in the space below.

2. **During and after accident details**
Enter the details of your condition during and after the accident/onset.

Patient Name: _____

Date: _____

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)
I. Current Symptom: (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.)

1. Check only one body location below

- Headaches LQ RQ BQ
 - Front of Head
 - Top of Head
 - Back of Head
 - Jaw LQ RQ BQ
 - Eye LQ RQ BQ
 - Neck LQ RQ BQ
 - Upper Back LQ RQ BQ
 - Mid Back LQ RQ BQ
 - Low Back LQ RQ BQ
 - Chest LQ RQ BQ
 - Abdomen LQ RQ BQ
 - Ribs LQ RQ BQ
 - Buttocks LQ RQ BQ
 - Shoulder LQ RQ BQ
 - Upper Arm LQ RQ BQ
 - Forearm LQ RQ BQ
 - Hand LQ RQ BQ
 - Hip LQ RQ BQ
 - Leg LQ RQ BQ
 - Foot LQ RQ BQ
- Other locations: _____

2. Types of pain

- Dull Sharp Aching Cutting
- Throbbing Burning Numbing Tingling Cramping
- Spasm Stinging Shooting Pounding Constricting

Other types of pain: _____

3. Pain Frequency

- Up to 1/4 of awake time 1/4 to 1/2 of time
- 1/2 to 3/4 of awake time Most all the time

4. Pain Intensity (How it affects daily activities)

- Doesn't affect Somewhat affects
- Seriously affects Prevents activities

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Other locations of radiation: _____

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Actions: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

How Often: _____ Constant _____ Comes&Goes _____ Upon Mvmt. _____ Time Each Day: _____

Radiates: _____ No / Yes - Where: _____

Ever Before: _____ No / Yes - When: _____

Better/ Worse: B: _____ W: _____

Other Tx / Meds: _____

Notes: _____

II. Current Symptom: (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.)

1. Check only one body location below

- Headaches LQ RQ BQ
 - Front of Head
 - Top of Head
 - Back of Head
 - Jaw LQ RQ BQ
 - Eye LQ RQ BQ
 - Neck LQ RQ BQ
 - Upper Back LQ RQ BQ
 - Mid Back LQ RQ BQ
 - Low Back LQ RQ BQ
 - Chest LQ RQ BQ
 - Abdomen LQ RQ BQ
 - Ribs LQ RQ BQ
 - Buttocks LQ RQ BQ
 - Shoulder LQ RQ BQ
 - Upper Arm LQ RQ BQ
 - Forearm LQ RQ BQ
 - Hand LQ RQ BQ
 - Hip LQ RQ BQ
 - Leg LQ RQ BQ
 - Foot LQ RQ BQ
- Other locations: _____

2. Types of pain

- Dull Sharp Aching Cutting
- Throbbing Burning Numbing Tingling Cramping
- Spasm Stinging Shooting Pounding Constricting

Other types of pain: _____

3. Pain Frequency

- Up to 1/4 of awake time 1/4 to 1/2 of time
- 1/2 to 3/4 of awake time Most all the time

4. Pain Intensity (How it affects daily activities)

- Doesn't affect Somewhat affects
- Seriously affects Prevents activities

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Other locations of radiation: _____

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Actions: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Date of Onset: _____

How Often: _____ Constant _____ Comes&Goes _____ Upon Mvmt. _____ Time Each Day: _____

Radiates: _____ No / Yes - Where: _____

Ever Before: _____ No / Yes - When: _____

Better/ Worse: B: _____ W: _____

Other Treatment: _____

Notes: _____

Accident Information Sheet

Patient Name: _____

Date: _____

Type of Accident: Auto Work-Related Slip and Fall

Date of Accident: _____

Location: _____

Description of Accident: ___ Single-vehicle ___ Multi-vehicle (check one)

Wearing Seatbelt? Yes No

Airbags Deploy? Yes No

Number of people inside vehicle: _____

Driver or Passenger

If passenger, where seated? _____

Upon impact, did any part of the patient's body hit any part of the inside of the vehicle?

Was your car towed from the scene of the accident? Yes No

What is your vehicles: Make? _____ Model? _____ Year? _____

Bruises or Lacerations from accident: _____

Was patient taken to the hospital? Yes No

By Ambulance? Yes No

Which Hospital? _____

Date went? _____

Kept overnight or longer? Yes No

How long? _____

X-rays performed? Yes No

Which? _____

CT scan or MRI Yes No

Where? _____

Braces or Supports given by Hospital?

What? _____

Have seen or currently seeing any Doctor, Chiropractor, or Physical Therapist since the accident? Yes No If so, who? _____

Is this therapy related to the accident? Yes No

Did patient have any previous disabilities, physical impairments, handicaps, or medical conditions prior to this accident?
Yes No

List: _____

NAME: _____

Date: _____

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty.

1 = "I can do it without any difficulty", 2 = "I can do it without much difficulty, despite some pain", 3 = "I manage to do it by myself, despite marked pain", 4 = "I manage to do it, despite the pain, but only if I have help", 5 = "I cannot do it all, because of the pain". Only fill in areas affected.

Difficulties with Self Care and Personal Hygiene Activities

Bathing _____ Drying hair _____ Brushing teeth _____ Putting on shoes _____ Preparing meals _____ Taking out trash _____
Showering _____ Combing hair _____ Making bed _____ Tying shoes _____ Eating _____ Doing laundry _____
Washing hair _____ Washing face _____ Putting on shirt _____ Putting on pants _____ Cleaning dishes _____ Going to toilet _____

Difficulties with Physical Activities

Standing _____ Walking _____ Kneeling _____ Bending back _____ Twisting left _____ Leaning back _____
Sitting _____ Stopping _____ Reaching _____ Bending left _____ Twisting right _____ Leaning left _____
Reclining _____ Squatting _____ Bending forward _____ Bending right _____ Leaning forward _____ Leaning right _____
Standing for long periods _____ Sitting for long periods _____ Walking for long periods _____ Kneeling for long periods _____

Difficulties with Functional Activities

Carrying small objects _____ Lifting weights off floor _____ Pushing things while seated _____ Exercising upper body _____
Carrying large objects _____ Lifting weights off table _____ Pushing things while standing _____ Exercising lower body _____
Carrying brief case _____ Climbing stairs _____ Pulling things while seated _____ Exercising arms _____
Carrying large purse _____ Climbing inclines _____ Pulling things while standing _____ Exercising legs _____

Difficulties with Social and Recreational Activities

Bowling _____ Jogging _____ Swimming _____ Ice Skating _____ Competitive Sports _____ Dating _____
Golfing _____ Dancing _____ Skiing _____ Roller Skating _____ Hobbies _____ Dining out _____

Difficulties with Travelling

Driving a motor vehicle _____ Riding as a passenger in a motor vehicle _____ Riding as a passenger on a train _____
Driving for long periods of time _____ Riding as a passenger on an airplane _____ Riding as a passenger for long periods _____

Use the following 1 to 5 scale to describe the difficulties below:

1 = "This area is not affected by my condition", 2 = "This area is slightly affected by my condition", 3 = "My condition moderately restricts my ability in this area", 4 = "My condition seriously limits my ability in this area", 5 = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating _____ Hearing _____ Listening _____ Speaking _____ Reading _____ Writing _____ Using a keyboard _____

Difficulties with the Senses

Seeing _____ Hearing _____ Sense of touch _____ Sense of taste _____ Sense of smell _____

Difficulties with Hand Functions

Grasping _____ Holding _____ Pinching _____ Percussive movements _____ Sensory discrimination _____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep _____ Being able to participate in desired sexual activity _____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

I have NOT had prior symptoms similar to my current complaints.
 My current complaints DID exist before, but had not been bothering me.
 My current complaints ALREADY existed and were worsened.

My most recent prior similar symptoms (if applicable) occurred _____
Write in below any other Prior Symptom History, not covered above:

Has your History Contributed to your Current Symptoms?

My history HAS contributed to my current symptoms.
 My history HAS NOT contributed to my current symptoms.
 I'm NOT SURE if my history has contributed to my current symptoms.
_____ months ago / _____ years ago OR on Date: _____/_____/_____

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ | |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | |

Do you exercise: Frequently Moderately Occasionally None

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ DATE _____

Piedmont Medical Center

PI13

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please explain under comment and notify the Doctor:

- | | | |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do our legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Have you tried any medications such as anti-inflammatory?
If yes, what kind of medication? _____
_____ | NO | YES |
| 12. Have you tried any Physical Therapy or Chiropractic treatments before?
If yes: When? For how long? What kind? _____
_____ | NO | YES |
| 13. Have you had an MRI?
If yes: When? Who ordered it? What was it ordered for? _____
_____ | NO | YES |
| 14. Have you used any splint or braces or other prescribed treatment by an MD?
If yes: When? What kind? Who ordered it? _____
_____ | NO | YES |
| 15. If you have tried any treatment or medications, did this make your problem better?
Comment: _____ | NO | YES |

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

Piedmont Medical Center

PE 14

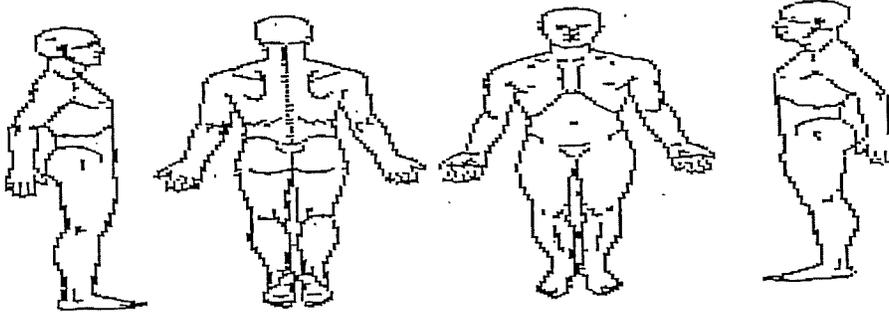
Personal Injury Consultation

Patient Name: _____

Date: _____

Date of Accident: _____

Age: _____



Complaint 1: _____
How Often? Constant, Intermittent, or only with movement/activity? Which: _____
Type of pain: Ache/Throbbing, Sharp/Stabbing, Stiffness/Tightness, Burning, Muscle Spasms, Cramping, Other: _____
Radiation: Shooting pain: From patients _____ to _____
Numbness, Tingling, Weakness Part of body: _____
Pain level 1(Mild) to 10(Severe): Now _____ At its worst _____ Average _____

Complaint 2: _____
How Often? Constant, Intermittent, or only with movement/activity? Which: _____
Type of pain: Ache/Throbbing, Sharp/Stabbing, Stiffness/Tightness, Burning, Muscle Spasms, Cramping, Other: _____
Radiation: Shooting pain: From patients _____ to _____
Numbness, Tingling, Weakness Part of body: _____
Pain level 1(Mild) to 10(Severe): Now _____ At its worst _____ Average _____

Complaint 3: _____
How Often? Constant, Intermittent, or only with movement/activity? Which: _____
Type of pain: Ache/Throbbing, Sharp/Stabbing, Stiffness/Tightness, Burning, Muscle Spasms, Cramping, Other: _____
Radiation: Shooting pain: From patients _____ to _____
Numbness, Tingling, Weakness Part of body: _____
Pain level 1(Mild) to 10(Severe): Now _____ At its worst _____ Average _____

Complaint 4: _____
How Often? Constant, Intermittent, or only with movement/activity? Which: _____
Type of pain: Ache/Throbbing, Sharp/Stabbing, Stiffness/Tightness, Burning, Muscle Spasms, Cramping, Other: _____
Radiation: Shooting pain: From patients _____ to _____
Numbness, Tingling, Weakness Part of body: _____
Pain level 1(Mild) to 10(Severe): Now _____ At its worst _____ Average _____

Other Complaints: (Headaches _____) (Fatigue _____) (Tension _____) (Mood Swings _____)
Able to work? Yes No Less Productive at work? Yes No
Difficulty: Sleeping, Sitting, Standing, Bending, Lifting, Walking, Twisting and Turning, Reaching,
Housework, Working, Exercising, Other: _____

Reviewed by Provider: _____

[Handwritten Signature]

