

# Care Medical Center

## Patient Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Referred By: \_\_\_\_\_

SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: Male/Female

Chief Complaint: \_\_\_\_\_

### **Accident Information:**

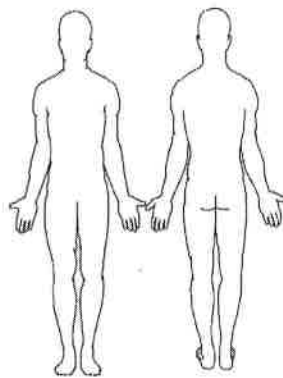
Is your condition due to an accident?  Illness  Other \_\_\_\_\_

Did your accident occur while at work?  Yes  No Were you involved in an automobile accident?  Yes  No

Date \_\_\_\_\_ Time \_\_\_\_\_ Injury reported to employer  Yes  No Name of Supervisor: \_\_\_\_\_

### **Location:**

- Head
- Neck
- Shoulder
- Arm
- Back
- Thorax
- Elbow
- Wrist
- Hip
- Knee
- Ankle
- Foot



### **Quality:**

- Achy
- Dull
- Sharp
- Stabbing
- Throbbing
- Radiating
- Burning
- Itching
- Numb
- Pins & Needles

### **Time of Day:**

- Morning
- Afternoon
- Evening
- Bedtime
- All the time
- Varies

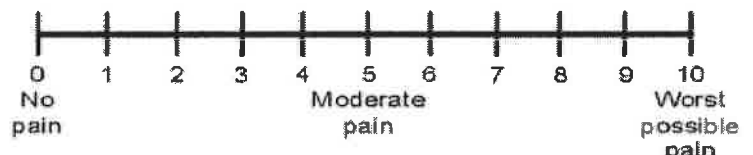
### **Modifying Factors:**

	Increase	Decrease
Standing	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Up Stairs	<input type="checkbox"/>	<input type="checkbox"/>
Down Stairs	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>
Touch	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>
Movement	<input type="checkbox"/>	<input type="checkbox"/>

### **Neurological Signs & Symptoms:**

- Bowel Dysfunction
- Bladder Dysfunction
- Motor Loss
- Sensory Loss
- Radiation to Arm
- Radiation to Leg

### **Numerical Pain Scale:**



<u><b>Medications:</b></u> 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	<u><b>Dosage:</b></u> 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	<u><b>Allergies:</b></u> 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	<u><b>Primary Care Physician:</b></u> Name: _____ Address: _____ Phone: _____ <u><b>Imaging HX:</b></u> What? When? Where? Who ordered it?
<u><b>Family Hx:</b></u> <input type="checkbox"/> Heart Disease <input type="checkbox"/> High BP <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Bleeding Tendency <input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis Type: _____ Other:	<u><b>Social Hx:</b></u> <b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <b>Alcohol:</b> <input type="checkbox"/> Never <input type="checkbox"/> 0-1 / Week <input type="checkbox"/> 1-5 / Week <input type="checkbox"/> Other: _____ <b>Tobacco:</b> <input type="checkbox"/> Never <input type="checkbox"/> Quit <input type="checkbox"/> When? _____ Packs per day _____ Years Smoked _____ <b>Illegal Drugs?</b> Y or N <b>Occupation:</b> _____	<u><b>Medical Hx:</b></u> <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Thyroid <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> GI Disorder <input type="checkbox"/> Hepatitis <input type="checkbox"/> Kidney Disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Ulcer <input type="checkbox"/> Seizure <input type="checkbox"/> Asthma <input type="checkbox"/> Mental Illness <input type="checkbox"/> Infections <input type="checkbox"/> Anemia <input type="checkbox"/> Pregnancy Other:	<u><b>Surgical Hx:</b></u> <input type="checkbox"/> Appendectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Inguinal Hernia <input type="checkbox"/> Ventral Hernia <input type="checkbox"/> Umbilical Hernia <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Cesarean Section <input type="checkbox"/> CABG <input type="checkbox"/> Coronary Stent <input type="checkbox"/> Carotid <input type="checkbox"/> Endarterectomy <input type="checkbox"/> Angioplasty <input type="checkbox"/> Vascular Bypass <input type="checkbox"/> Craniotomy <input type="checkbox"/> Total Hip <input type="checkbox"/> Total Knee <input type="checkbox"/> Rotator Cuff <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Release <input type="checkbox"/> Adverse RXN <input type="checkbox"/> Anesthesia <input type="checkbox"/> Lumbar <input type="checkbox"/> Laminectomy <input type="checkbox"/> Cervical Fusion <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Ganglion <input type="checkbox"/> Mastectomy <input type="checkbox"/> Prostatectomy
<b>OTHER DOCTORS SEEN FOR THIS CONDITION:</b> MD <input type="checkbox"/> DC <input type="checkbox"/> DO <input type="checkbox"/> DDS <input type="checkbox"/> _____ _____ _____ _____ _____			

# INFORMED CONSENT FOR TREATMENT

Thereby request and consent to the treatment of medical care, physical therapy and/or chiropractic adjustments. This includes various modes of physical therapy, chiropractic, diagnostic x-rays, and possible medication and/or injections prescribed to me (or to the other patient named below, for whom I am legally responsible). I request to be treated by the doctors named below and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctors named below, including those working at Care Medical Center.

I have had an opportunity to discuss with the doctors named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy there are some risks to treating including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that there are risks to taking medication including, but not limited to, rash, diarrhea, nausea, low grade fever, dry mouth, restlessness, night sweats, increased heart rate, and depression as prescribed by the medical doctor. I do not expect the doctors to be able to anticipate and explain all risks and complications, and I wish to rely on the doctors to exercise judgement during the course of the procedure which the doctors feel at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition(s) for which I seek treatment.

## TO BE COMPLETED BY PATIENT

Patient Name \_\_\_\_\_ Signature of Patient \_\_\_\_\_  
Date Signed \_\_\_\_\_ Witness of Patient's Signature \_\_\_\_\_

## TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient Name \_\_\_\_\_ Signature of Patient \_\_\_\_\_  
Date Signed \_\_\_\_\_ Signature of Representative \_\_\_\_\_  
Relationship/Authority of Representative \_\_\_\_\_  
Translated by \_\_\_\_\_

## TO BE COMPLETED BY DOCTOR OR STAFF

Date \_\_\_\_\_

NAME OF CLINIC/OFFICE:

CARE MEDICAL CENTER

ADDRESS:

2804-C N. OAK ST. VALDOSTA, GA 31602

NAME OF DOCTOR'S TREATING THIS PATIENT:

**Medical:** Kate Paylo, D.O., James Campagna, M.D., Wiley L. Drury (Don), M.D, A.J. Davis, F.N.P.-C, Nathan Roberson, N.P.-C

**Chiropractic:** J. Ryan Moorman, D.C., Daniel Day, D.C., Briggs Smotherman, D.C.

**Physical Therapy:** Joshua Rhue, DPT, Laura Gwillim, P.T., Jonathan Howell, P.T.A., Rebecca Adams, P.T.A., Zoe Chung, P.T.A

# Care Medical Center

## Office Financial Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out of pocket expense and allows you to place your family under care.

**1. If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

**2. If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your complete insurance information, and we qualify and accept your insurance coverage.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

**3. Payment Options:** An affordable payment plan will be given at your report of findings. We offer payment by cash, check, post-dated check, credit card or by care credit.

If you are a Medicare patient and your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Finance Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

Front Desk: \_\_\_\_\_ Date: \_\_\_\_\_

For your convenience you may retain your credit card on file with us. (OPTIONAL)

Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Name as it appears on the card: \_\_\_\_\_ CVC on back of card: \_\_\_\_\_



**Care Medical**  
**Spine, Pain & Rehab**

## **PRIVACY ACT OF 1974**

The Privacy Act of 1974, 5 U.S.C. 552a, prohibits disclosures of records contained in a system of records maintained by a federal agency (or its contractors) without the written request or consent of the individual to whom the record pertains. This general rule is subject to various statutory exceptions. In addition to the disclosure information for other purposes compatible with the purpose for which the information was collected by identifying the disclosure as "routine use" and publishing notice of it in the Federal Register. The Act applies to all federal agencies and certain federal contractors who operate Privacy Act systems of records on behalf of federal agencies. Some federal agencies and contractors of federal statutes and regulations. For example, if the privacy regulation permits a disclosure, but the disclosure is not permitted under the Privacy Act, the federal agency may not make the disclosure. If, however, the Privacy Act allows a federal agency the discretion to make a routine use disclosure, but the privacy regulation prohibits the disclosure, the federal agency means not making the disclosure.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

[www.caremedicalcenter.com](http://www.caremedicalcenter.com)

Valdosta  
2804-C N. Oak Street  
229-241-8925

Tifton  
917 W. 20<sup>th</sup> St  
229-382-5857

Nashville  
203 W. Hamilton Ave  
229-686-2277

# HIPPA Notice of Privacy Practices

Care Medical Center

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out our treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and any information that relates to your past, present or future physical or mental health condition and related healthcare services.

## 1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

**TREATMENT:** We will use and disclosed your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**PAYMENT:** Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose you protected health information in the following situations without your authorization. These situations included as Required by Law, Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; defense of professional liability claims asserted by patients, Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law we must make the disclosure to you, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT. UNLESS REQUIRED BY LAW.**

You may revoke this authorization at any time, in writing, except to the extent that this practice has taken an action in reliance on the use of disclosure indicated in the authorization.

## 2. YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request restriction of you protected health information. This means you may ask not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your doctor is not required to agree to a restriction that you may request. If your doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to have your doctor amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made of any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### COMPLAINTS

You may make a complaint to our office or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer at (229) 241-8925 of your complaint. We will not retaliate against you for filing a complaint.

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Signature

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Date

**Care Medical Center**

2804-C N. Oak St.  
Valdosta, Ga 31602  
P:(229)241-8925  
F: (229)241-7672

162 S. Virginia Ave.  
Tifton, GA 31794  
P:(229)382-5857  
F: (229)382-7640

203 W. Hamilton Ave.  
Nashville, GA 31639  
P: (229)686-2277  
F: (229)686-2099

306 Shirley Ave.  
Douglas, GA 31533  
P: (912)393-3955  
F: (912)389-2044

**AUTHORIZATION FOR RELEASE OF INFORMATION OR INDIVIDUAL ACCESS TO INFORMATION**

I hereby authorize Care Medical Center to:  release  obtain medical information of:

\_\_\_\_\_  
(Patient's Full Name)  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

I request **only** the following information to be release/obtained:

- Emergency Report      Laboratory      Pathology Report      Itemized Billing Statement
- Discharge Summary      Radiology Reports      MRI CD/Reports      Pain Management
- History and physical      X-Rays Reports      Other (specify)\_\_\_\_\_

Date(s) of Treatment: \_\_\_\_\_

Requested from: Physician/Institution/Agency: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone:(\_\_\_\_\_) \_\_\_\_\_:

**ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.**

I understand that neither Care Medical Center nor any of its affiliated health care providers can make me sign this Authorization as a condition of getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. This does not apply to the billing of medical claims. I agree that I have received a signed copy of this Authorization if I choose to do it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will Expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I need to mail, fax, or bring the letter to the address or fax number noted at the top of this page.

**If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate if the patient did not expire in the facility the information is being requested form.**

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above-referenced care. The decision to enter into any such conversation is that of the health care provider. However, disclosure that exceeds the scope of this authorization may subject the health care provider to civil liability. This Authorization, contrary to the notice above, shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have an original authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional authorization is required.

**Note: Records will be mailed to the above address unless otherwise noted below.**

\_\_\_\_\_  
**Signature of Patient/Legal Guardian/Personal Representative** **Date**

\_\_\_\_\_  
**If someone else signs on behalf of the patient, state the relationship to Patient.** **Date**  
**Witness:**\_\_\_\_\_

\_\_\_\_\_  
**Date**

**Note: if above address is not the patient's, please complete the following:**  
**Patient Address:**\_\_\_\_\_

**Check if a patient will pick up copies at Care Medical Center.**