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:

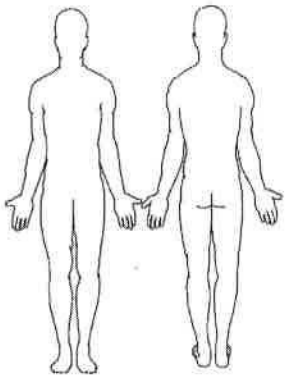
Is your condition due to an accident? □ Illness □ Other _____

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

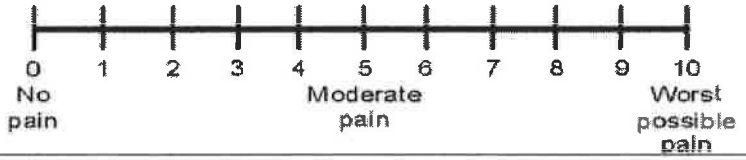
Modifying Factors:

	Increase	Decrease
Standing	□	□
Sitting	□	□
Walking	□	□
Climbing	□	□
Bending	□	□
Squatting	□	□
Sleeping	□	□
Up Stairs	□	□
Down Stairs	□	□
Driving	□	□
Coughing	□	□
Touch	□	□
Sneezing	□	□
Movement	□	□

Neurological Signs & Symptoms:

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

Numerical Pain Scale:



Medications:	**Dosage:**	**Allergies:**	**Primary Care Physician:**
1.	1.	1.	Name:_____
2.	2.	2.	Address:_____
3.	3.	3.	Phone:_____
4.	4.	4.	**Imaging HX:**
5.	5.	5.	What?
6.	6.	6.	When?
7.	7.	7.	Where?
8.	8.	8.	Who ordered it?
9.	9.	9.	
10.	10.	10.	

Family Hx:	**Social Hx:**	**Medical Hx:**	**Surgical Hx:**
☐ Heart Disease	**Marital Status:**	☐ Diabetes	☐ Appendectomy
☐ High BP	☐ Single	☐ Hypertension	☐ Tonsillectomy
☐ Stroke	☐ Married	☐ Thyroid	☐ Inguinal Hernia
☐ Cancer	☐ Separated	☐ Heart Disease	☐ Ventral Hernia
Type:_____	☐ Divorced	☐ Stroke	☐ Umbilical Hernia
☐ Tuberculosis	☐ Widowed	☐ GI Disorder	☐ Cholecystectomy
☐ Bleeding Tendency	**Alcohol:**	☐ Hepatitis	☐ Hysterectomy
☐ Diabetes	☐ Never	☐ Kidney Disorder	☐ Cesarean Section
☐ Arthritis	☐ 0-1 / Week	☐ Cancer	☐ CABG
Type:_____	☐ 1-5 / Week	☐ Ulcer	☐ Coronary Stent
	☐ Other:_____	☐ Seizure	☐ Carotid
Other:	**Tobacco:**	☐ Asthma	☐ Endarterectomy
	☐ Never	☐ Mental Illness	☐ Angioplasty
	☐ Quit	☐ Infections	☐ Vascular Bypass
	☐ When? _____	☐ Anemia	☐ Craniotomy
	Packs per day ____	☐ Pregnancy	☐ Total Hip
	Years Smoked ____		☐ Total Knee
	Illegal Drugs?	Other:	☐ Rotator Cuff
	Y or N		☐ Carpal Tunnel
	Occupation:		☐ Release
	_____		☐ Adverse RXN
			☐ Anesthesia
			☐ Lumbar
			☐ Laminectomy
			☐ Cervical Fusion
			☐ Arthroscopy
			☐ Ganglion
			☐ Mastectomy
			☐ Prostatectomy

OTHER DOCTORS SEEN FOR THIS CONDITION: **MD ☐** **DC ☐** **DO ☐** **DDS ☐**

_____

_____

_____

_____

_____

_____

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 the nature and purpose of chiropractic adjustments and other procedures with the doctors named below and/or with other office or clinic personnel.

I understand and am informed that, as in the practice of medicine, 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 judgment 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 read the above consent to me. 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 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_____

CLINIC/OFFICE: CARE MEDICAL CENTER

ADDRESS: _____

NAME OF DOCTOR'S TREATING THIS PATIENT: _____

Medical:	Kate Paylo, DO, Tambrea Ellison, MD, Inderpal Singh, MD, Wiley L. Drury, MD
Chiropractic:	Ryan Moorman, DC, Daniel Day, DC, Briggs Smotherman, DC
Physical Therapy:	Joshua Rhue, DPT, Ginger Gatewood, DPT, Laura Gwillim, P.T., Jonathan Howell, PTA., Zoe Chung, PTA, Kimberly Lamb, PTA, Amanda King, PTA, Steven Sutton, PT, Marissa Clark, PTA

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 will enable 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 be at most $100 at any time, or care may be terminated. Our payment plans make care an affordable part of your family's 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 be at most $100, or care may be terminated. Our payment plans make care an affordable part of your family's 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 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 an 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 can keep 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 of 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

Valdosta Office
2804 N Oak St
Valdosta, GA 31602
T: (229) 241-8925

Tifton Office
162 Virginia Ave S
Tifton, GA 31794
T: (229) 382-5857

Nashville Office
203 W Hamilton
Nashville, GA 31639
T: (229) 686-2277

Douglas Office
306 Shirley Ave
Douglas, GA 31533
T: (912) 393-3955

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 healthcare 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 is involved in your care and treatment for the purpose of providing healthcare services to you, paying your healthcare bills, supporting the operation of the physician’s practice, and any other use required by law.

TREATMENT: We will use and disclose 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 your 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 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 restrictions on your 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 ask that any portion of your protected health information not be shared with 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 the use and disclosure of your protected health information, it 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 let you know 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 we have violated your privacy rights. 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.

Signature _____ Date _____

3rd Party Medical Lien & Assignment

Patient: _____
Claim # / Group #: _____
Date of Injury: _____

I hereby authorize and direct _____, to pay to Dr. _____ such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to said doctor, which would otherwise be paid to myself, as the result of the treatment charges incurred for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable by me.

_____ _____
Date Patient Signature

The undersigned Attorney does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

_____ _____
Date Signature of Attorney Representing Patient

_____
Print First and Last Name

Please date, sign and return one copy to the doctor's office below. Also, keep one copy for your records.

_____
Doctor's Name

_____
Address

_____
City / State / Zip

3rd Party Medical Lien & Assignment

Patient: _____
Claim # / Group #: _____
Date of Injury: _____

I hereby authorize and direct _____ Insurance Company, to pay to Dr. _____ such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to said doctor, which would otherwise be paid to myself, as the result of the treatment charges incurred for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable by me.

_____ _____
Date Patient Signature

The undersigned insurance company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

_____ _____
Date Signature of Insurance Company Representative

_____
Print First and Last Name

_____
Insurance Company Name

Please date, sign and return one copy to the doctor's office below. Also, keep one copy for your records.

_____
Doctor's Name

_____
Address

_____
City / State / Zip

Power of Attorney to Endorse Checks

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint the. _____ Clinic and any of its duly authorized agent and employees as and to be the undersigned's true and lawful Attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders, which are made payable to the undersigned alone or to the undersigned and the said _____ Clinic, which checks, drafts or money orders are to pay for Chiropractic/Medical services or the like, which have been made by _____ Clinic at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said _____ Clinic as attorney the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as full to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these present.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 20_____

_____
Witness to Patient's Signature

_____
Patient's Full Name (typed)

_____
Signature of Patient

INSTRUCTIONS TO COUNSEL

I, the undersigned, clearly understand that all past, present, and future bills incurred at Care Medical Center are my responsibility for payment.

I hereby ratify my agreement to pay all bills incurred during my health care at this clinic.

I also hereby irrevocably agree to have the doctor's entire bill paid from my proceeds of any nature by way of settlement, judgment, or otherwise, I or you might receive. I do hereby irrevocably instruct you to pay the doctor in full from any such proceeds of settlement, judgment, or enforcement of judgment actions. You are to pay the doctor disbursing any proceeds to me.

I also understand that if the settlement does not cover the doctor's entire bill, I am still responsible for the remainder.

I do hereby waive any applicable statute of limitations on the collection of my account with this clinic.

I instruct you not to attempt to negotiate my doctor's bill, who has provided all services billed for, and I agree to pay in full.

Signature: _____ Date: _____

Witness: _____ Date: _____

Care Medical
Spine, Pain & Rehab

Personal Injury/Worker's Comp

Our office policy is that Personal Injury / Worker's Compensation Cases must adhere to one of the following guidelines:

1. Pay as you go or pay upfront.
2. File your MedPay to cover your treatment.
3. Insurance company of the at-fault party agrees to sign a lien and pay Care Medical Center directly.
4. Retain an attorney of your choice within 2 weeks of starting care.

If you do not choose options 1-4, we will file a lien against your settlement in Superior Court. The at-fault party's insurance will pay us prior to dispensing settlement funds.

If you drop your attorney or your attorney drops you during the time of your care, then you have two weeks to retain another attorney.

If you settle directly with the insurance company, you have 7 days to pay the bill with a 25% reduction. If the account is not paid within 7 days of settling your claim, we will file a civil suit in small claims on day 8 for the full amount, plus interest and court costs.

*I agree that I have read and understand the above-mentioned requirements for treatment in this office and take full responsibility for any charges accumulated during my treatment. I am responsible for payment to this office regardless of the outcome of any settlement.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

Valdosta Office
2804 N Oak St
Valdosta, GA 31602
229-241-8925

Tifton Office
162 Virginia Ave S
Tifton, GA 31794
229-382-5857

Nashville Office
203 W Hamilton
Nashville, GA 31639
229-686-2277

Douglas Office
306 Shirley Ave
Douglas, GA 31533
912-393-3955

www.caremedicalcenter.com

Care Medical
Spine, Pain & Rehab

Accident Questionnaire

Patient Name: _____ Date: _____

1. Date of the Accident: _____
2. Was anyone else in the vehicle with you? **Yes** **No** If yes, who? _____
3. Do you have a Claim #? _____

• Name of the car insurance for the person at fault: _____
• Insurance Address: _____
• Insurance Phone #: _____

4. Does your car insurance have Med Pay or Medical Coverage that covers medical expenses?

Yes **No** **Unknown**

If so, How much? _____
Insurance Name: _____
Insurance Address: _____
Insurance Phone #: _____

5. Do you have Health Insurance? **Yes** **No**

Insurance Name: _____
Insurance Address: _____
Insurance Phone #: _____
Insured Name: _____ DOB: _____
ID#: _____ Group#: _____

6. Do you have a police report? **Yes** **No**
7. Have you signed anything from the insurance or agreed to any settlement? **Yes** **No**
8. Have you lost any work since the collision? **Yes** **No**

Since when? _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Care Medical Center

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 released/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 the Patient.

Witness:_____ _____

Date:_____

Note: if the above address is not the patient's, please complete the following:

Patient Address:_____

_____

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