



# 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:**

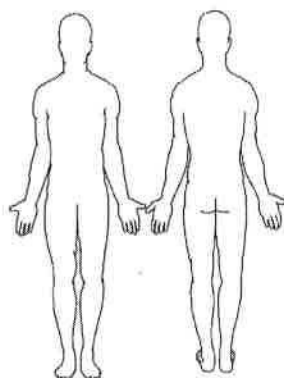
Is your condition due to an accident? ☐ Illness ☐ Other \_\_\_\_\_

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

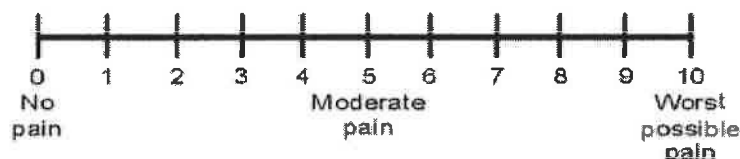
### **Modifying Factors:**

	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:**



<b><u>Medications:</u></b> 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	<b><u>Dosage:</u></b> 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	<b><u>Allergies:</u></b> 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	<b><u>Primary Care Physician:</u></b> Name: _____ Address: _____ Phone: _____ <b><u>Imaging HX:</u></b> What? When? Where? Who ordered it?
<b><u>Family Hx:</u></b> <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:	<b><u>Social Hx:</u></b> <b><u>Marital Status:</u></b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <b><u>Alcohol:</u></b> <input type="checkbox"/> Never <input type="checkbox"/> 0-1 / Week <input type="checkbox"/> 1-5 / Week <input type="checkbox"/> Other: _____ <b><u>Tobacco:</u></b> <input type="checkbox"/> Never <input type="checkbox"/> Quit <input type="checkbox"/> When? _____ Packs per day _____ Years Smoked _____ <b><u>Illegal Drugs?</u></b> Y or N <b><u>Occupation:</u></b> _____	<b><u>Medical Hx:</u></b> <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:	<b><u>Surgical Hx:</u></b> <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 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, Carolyn Hunter, DC, Kirstyn James, DC

Physical Therapy: Joshua Rhue, DPT, Ginger Gatewood, DPT, Laura Gwillim, PT, Jonathan Howell, 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](http://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

**Waycross Office**

1411 Alice Street  
Waycross, GA 31501  
T: (912) 282-2989

# 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 \_\_\_\_\_

# 3<sup>rd</sup> 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



# 3<sup>rd</sup> 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.

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

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

Witness: \_\_\_\_\_

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



## Personal Injury/Worker's Comp

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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

**Waycross Office**  
1411 Alice Street  
Waycross, GA 31501  
PH: 912-282-2989



## 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 from.

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.

## **Waiver & Acknowledgement of Medical Services Lien**

Medical Provider: **Care Medical Center**

### **By signing this agreement, the Patient acknowledges and agrees to the following:**

Patient has considered all possible sources of funding for Patient's medical expenses, including but not limited to, liability insurance medical payments, MedPay, health insurance, HMOs, PPOs, Medicare, Medicaid, Tricare, Champus, VA Insurance, and payments available through any applicable state "no fault" provisions (collectively "Other Funding Sources").

Patient voluntarily elects to receive treatment on a lien and waives use of Other Funding Sources. Upon thorough review and consideration of the availability of Other Funding Sources, Patient has decided that obtaining medical services on a lien against all judgements, settlements, and settlement agreements rendered or entered into that arise from the illness or the injuries necessitating the medical service are preferable and beneficial to the Patient.

Patient acknowledges that no Other Funding Sources will be billed for these services, and that Patient will be solely responsible to the extent permitted by law for the Medical Provider's bills and invoices to Medical Provider or its assignees, if they are not covered, in part or in full, by any judgements, settlements, and settlement agreements arising from patient's personal injury claims and lawsuits. Patient directs Attorney to reimburse Medical Provider and its assignees for all medical services received on a lien and provided pursuant to this Agreement out of any and all judgements, settlements, and settlement agreements rendered or entered into that arise from the illness or the injuries necessitating the medical services.

Patient has reviewed this Agreement with Patient's Attorney.

Patient expressly acknowledges and agrees that Patient is assuming any and all risks associated with obtaining medical services on a lien and released Medical Provider and its assignees, their doctors, officers, employees, and agents from any and all claims for loss, expense, damage, or liabilities of any kind that Patient may incur as a result of this decision, Patient declares and represents that, by signing this acknowledgement, it is understood and agreed that Patient's own judgment, belief and knowledge and that Patient has not been influenced in making this release by any representations made by Medical Provider, its assignees, its employees or agents.

Patient requests and orders Patient's Medical Providers, and its assignees, to not bill any of Patient's Other Funding Sources, and Patient orders Other Funding Sources to not make

any payments to Patient's Medical Provider and their assignees, Patient shall forward this waiver to any Other Funding Sources as Patient deems necessary. Medical Provider and its assignees shall not be required to accept payment from any Other Funding Sources even in the event that Other Funding Sources have a contract with the Patient or the Medical Provider for the payment of the Patient's medical bills.

Medical Provider and its assignees assume no duty to advise or investigate Other Funding Sources, even should they obtain such information. Patient shall have the right to revoke this waiver by providing written notice to Medical Provider anytime prior to receiving medical services.

If Patient is Medicaid beneficiary, Patient acknowledges & agrees that: Medical Provider has explained, and Patient understands that Medical Provider will not be billing Medicaid and will instead be recovering directly from Patient based on amounts and settlement paid by liable third parties. Medical Provider has explained, consistent with requirements under state law, that medical services provided to the Patient may be Medicaid-covered services, and that other medical providers may render the service at no cost to the Patient. Patient hereby understands that Medical Provider and its assignees are entitled to reimbursement from Patient for medical services provided to Patient by Medical Provider. Patient further acknowledges and agrees that such reimbursement is recovery from the third parties for reimbursement owed to Medical Provider for medical services to Patient. Patient hereby acknowledges the Medical Provider has established their own right to payment from any and all settlements or awards from third parties for medical services provider to Patient, and these rights are separate from any amounts claimed and established by Patient from any and all settlements or awards from third parties.

For Medicaid beneficiaries: Patient is liable to the extent medical services are paid out of proceeds obtained from Patient's personal injury claim.

Attorney Name/Firm Name:

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**Representing Attorney Signature**

**Today's Date**

Attorney acknowledges that Patient has signed this Agreement.

Patient or Patient Guardian Name:

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**Patient or Patient Guardian Signature**

**Today's Date**

After careful review of this document, please sign and fax form to 229-241-7672