Pivotal Health and Rehab, LLC

Patient's Legal Name:_____
Last First MI

Billing Address:_____
Street City State Zip Code

If the above is a P.O. Box, please give home address: _____

E-Mail Address:_____ **Home Phone**: ( ) _____ **Cell**: ( ) _____

I prefer appointment reminders via (check all that apply): ☐ E-Mail ☐ Text Message

Birth Date: _____/_____/_____ **Gender**: ☐ Male ☐ Female **Social Security Number**: _____

☐ Married ☐ Single ☐ Other **Spouse's Name**: _____

Occupation: _____ **Job Status**: ☐Full Time ☐Part Time ☐Unemployed ☐Retired ☐Homemaker

Name of Employer:_____

How did you hear about our office? _____

Within the past six months, have you been involved in an auto accident? ☐Y ☐N Attorney (if applicable): _____

Name of Family M.D. _____ Would you like your records sent to your family M.D.? ☐Y ☐N

List medications you are currently taking (If none, please state "None"): _____
_____
_____
_____

Are you on ANY blood thinning medications? (If none, please state "None"): _____
_____

Please list any supplements or vitamins you are currently taking (If none, please state "None"): _____
_____
_____

Past Surgeries of ANY kind: _____
_____
_____

Do you have any allergies, such as; food/supplements/iodine/etc? (If none, please state "None"): _____
_____

Is there any chance you might be pregnant? ☐Yes ☐No **First day of your last menstrual cycle?** ___/___/_____
Do you have a pacemaker? ☐Yes ☐No

Print Name:_____

Signature: _____ **Today's Date**: _____

YOUR PERSONAL HISTORY – Any History of the Following Problems?

Headaches	☐Current	☐Past	☐Never
Neck Pain	☐Current	☐Past	☐Never
Upper Back Pain	☐Current	☐Past	☐Never
Lower Back Pain	☐Current	☐Past	☐Never
Spinal Disc Problems	☐Current	☐Past	☐Never
Sciatica	☐Current	☐Past	☐Never
Radiating Pain	☐Current	☐Past	☐Never
Other Spine Disorders	☐Current	☐Past	☐Never
Neuropathy	☐Current	☐Past	☐Never
Diabetes	☐Current	☐Past	☐Never
Shoulder Pain	☐Current	☐Past	☐Never
Elbow Pain	☐Current	☐Past	☐Never
Wrist Pain	☐Current	☐Past	☐Never
Hip Pain	☐Current	☐Past	☐Never
Cancer	☐Current	☐Past	☐Never

Knee Pain	☐Current	☐Past	☐Never
Ankle Pain	☐Current	☐Past	☐Never
Numbness	☐Current	☐Past	☐Never
Arthritis	☐Current	☐Past	☐Never
Fractures	☐Current	☐Past	☐Never
Poor Circulation	☐Current	☐Past	☐Never
Heart Condition	☐Current	☐Past	☐Never
Vascular Problems	☐Current	☐Past	☐Never
High Cholesterol	☐Current	☐Past	☐Never
Respiratory Conditions	☐Current	☐Past	☐Never
Stomach Problems	☐Current	☐Past	☐Never
Other Digestive Disorder	☐Current	☐Past	☐Never
Carpal Tunnel Syndrome	☐Current	☐Past	☐Never
Liver Disease	☐Current	☐Past	☐Never

Other: _____

Family History: (Check all that apply)

Diabetes:	☐Grandparent	☐Parent	☐Sibling	☐Self
High Blood Pressure:	☐Grandparent	☐Parent	☐Sibling	☐Self
Stroke:	☐Grandparent	☐Parent	☐Sibling	☐Self

Cancer:	☐Grandparent	☐Parent	☐Sibling	☐Self
Heart Problems:	☐Grandparent	☐Parent	☐Sibling	☐Self
Arthritis:	☐Grandparent	☐Parent	☐Sibling	☐Self

Print Name:_____

Signature: _____ **Today's Date**: _____

HIPAA, INFORMED CONSENT, and FINANCIAL AGREEMENT

Read Carefully, this is a Legal Document

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Information Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have read the Pivotal Injury and Rehab Notice of Privacy Practices. (One copy will be provided upon the patient's request and can also be viewed on the practice website.)

Informed Consent

As with any healthcare procedure, there are certain potential complications that may arise with procedures performed at our clinic. These complications which are unlikely to occur, but which may involve serious consequences include, but are not limited to: Lack of improvement, warmth, pain, swelling, hyper- or hypopigmentation (i.e. darkening or lightening or loss of normal skin pigmentation), and scarring to injection site, bleeding, infection, allergic reaction to injected substances, nerve damage, seizures, short term alterations in taste, elevated blood sugars in diabetics, local tissue breakdown, steroid flare, intravascular injection, loss of use of affected limb, tendon rupture, damage to cartilage, adrenal suppression, avascular necrosis of joint and/or death.

We will make every reasonable effort during your examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

We will make every reasonable effort during your examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history, during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. If this account is assigned to an attorney/outside agency for collection and/or suit, Pivotal Injury and Rehab shall be entitled to reasonable attorney's fees and for cost of collection. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I certify that I have read and fully understand all of the above information.

Signature:_____ Date:_____

Assignment of Benefits and Release of Medical Information

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Pivotal Injury and Rehab all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature:_____ Date:_____

PIVOTAL
HEALTH & REHAB

Authorization to Release Confidential Information

I _____, DOB _____, hereby authorize and request,

Name: _____

Phone: _____

Fax: _____

Address: _____

To release confidential information, including personal and medical records and opinions, resulting from my contacts with the above to:

Pivotal Health and Rehab
103 Sum-Mor Dr.
West Columbia, SC 29169
PH: 803-254-4699
FX: 803-851-1235

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy or facsimile of this authorization shall be as effective and valid as the original.

I furthermore release all parties stated here within from any legal liability resulting from this release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

Signature _____ Date _____

Primary Symptom Survey **Patient Name:**

1.) **What symptoms are you having?** _____

2.) **Please indicate the average intensity of your symptoms by marking an 'X' on the line where appropriate.**

_____

No Symptoms Worst Pain Imaginable

3.) **When did you first notice these symptoms?** _____

4.) **How often do you feel the symptoms?**

- ○ Less than 26% of the time
- ○ 26-50% of the time
- ○ 51-75% of the time
- ○ 76-100% of the time

5.) **Are your symptoms worse:**

- ○ In the morning
- ○ At mid-day
- ○ At the end of the day
- ○ At night before bed
- ○ My symptoms are the same throughout the day

6.) **How would you describe your pain and/or symptoms? (Please check all that apply)**

○ Dull	○ Sharp	○ Throbbing
○ Burning	○ Deep	○ Aching
○ Tingling	○ Stabbing	○ Cramping
○ Numbness	○ Radiating	

7.) **What aggravates your symptoms? (Please check all that apply)**

○ Sitting	○ Stooping	○ Coughing	○ Looking up	○ Laying Down	○ Household chores
○ Standing	○ Lifting	○ Straining	○ Looking down	○ Driving	○ Exercise
○ Walking	○ Sleeping	○ Reaching	○ Movement	○ Typing	○ Stair Stepping
○ Bending	○ Sneezing	○ Twisting	○ Rest	○ Scooping	○ Other:_____

8.) **What relieves your symptoms? (Please check all that apply)**

○ Sitting	○ Knees Bent	○ Movement	○ Heat	○ Medicine
○ Standing	○ Support	○ Not Moving	○ Ice	○ Chiropractic Adjustments
○ Laying Down	○ Rest	○ Stretching/Exercise	○ Topical Solution	

9.) **Have you seen any other health care provider for this condition?**

○ Yes ○ No Name of Provider:_____

10.) **Have you ever been to a chiropractor before?**

○ Yes ○ No If Yes, when?_____

Signature:_____ Date:_____

****If you have more than one area of complaint (i.e. both low back pain and neck pain), please complete the next page for the additional complaints.****

Secondary Symptom Survey **Patient Name:**

1.) **What is the secondary reason for coming to our office today? _____**

2.) **Please indicate the average intensity of your symptoms by marking an 'X' on the line where appropriate.**

_____

No Symptoms Worst Pain Imaginable

3.) **When did you first notice these symptoms? _____**

4.) **How often do you feel the symptoms?**

- ○ Less than 26% of the time
- ○ 26-50% of the time
- ○ 51-75% of the time
- ○ 76-100% of the time

5.) **Are your symptoms worse:**

- ○ In the morning
- ○ At mid-day
- ○ At the end of the day
- ○ At night before bed
- ○ My symptoms are the same throughout the day

6.) **How would you describe your pain or symptoms? (Please check all that apply)**

○ Dull	○ Sharp	○ Throbbing
○ Burning	○ Deep	○ Aching
○ Tingling	○ Stabbing	○ Cramping
○ Numbness	○ Radiating	

7.) **What aggravates your symptoms? (Please check all that apply)**

○ Sitting	○ Stooping	○ Coughing	○ Looking up	○ Laying Down	○ Household chores
○ Standing	○ Lifting	○ Straining	○ Looking down	○ Driving	○ Exercise
○ Walking	○ Sleeping	○ Reaching	○ Movement	○ Typing	○ Stair Stepping
○ Bending	○ Sneezing	○ Twisting	○ Rest	○ Scooping	○ Other:_____

8.) **What relieves your symptoms? (Please check all that apply)**

○ Sitting	○ Knees Bent	○ Movement	○ Heat	○ Medicine
○ Standing	○ Support	○ Not Moving	○ Ice	○ Chiropractic Adjustments
○ Laying Down	○ Rest	○ Stretching/Exercise	○ Topical Solution	

9.) **Have you seen any other health care provider for this condition?**

- ○ Yes ○ No

Signature:_____ Date:_____