CAROLINA
PHYSICIANS AND REHAB, LLC

Today's Date: ______________________

Patient's Name: ______________________ **Date of Birth:** ______________________

Cell Phone Number: ______________________ **Alt. Number:** ______________________

Home Address: ______________________

Email Address: ______________________

Gender: ______________ **Race:** ______________ **Marital Status:** ______________

Emergency Contact Name/Number/Relationship: ______________________

Are you: ☐ **Employed** ☐ **Retired** ☐ **Disabled** ☐ **Unemployed**

Pharmacy Name: ______________________ **Phone Number:** ______________

Referring Physician's Name: ______________________

What brings you to the office today: ______________________

Please answer the following questions regarding the details of the accident you are seeking care for today:

- **What was the date of the accident?** ______________________
- **Were you wearing your seatbelt?**______________________
- **Please give a short description of the accident**______________________

  ____
- **Did the airbags deploy? Yes / No** **Was the car you were in total? Yes / No**
- **Did you sustain any head injuries? Yes / No** **Did you lose consciousness? Yes / No**
- **Were you transported to the hospital via:** ☐ **EMS** ☐ **Private Transport**
- **What hospital did you go to?** ______________________
- **What treatment was provided?** ______________________
- **When did your pain start?** ______________________

Below, please describe the location and type of pain:

_______Sharp_______________________________________ **_______Dull/Aching___________________**

_______Stabbing___________________________________ **_______Burning_______________**

_______Throbbing__________________________________ **_______Pins/Needles_________________**

_______Numbness__________________________________ **_______Pressure_____________________**

_______Electrical/Shocks____________________________ **_______Stinging_______________**

On the pain scale below, please mark your current pain level:

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
No Pain **Worst Imaginable**

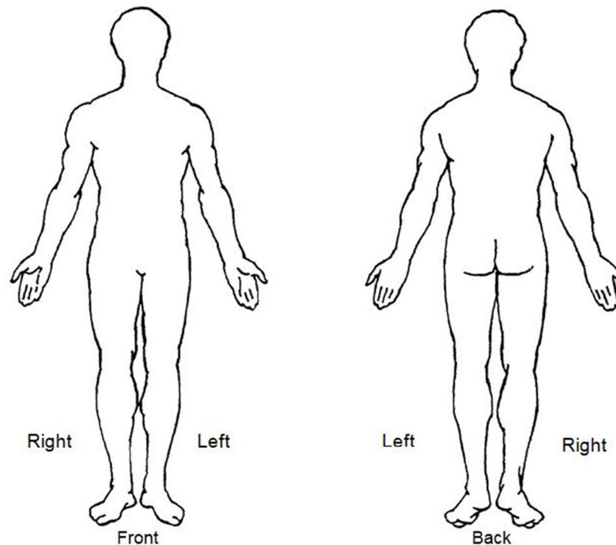
Is the pain always the same: ____

Is the pain: ☐ **Rarely Present** ☐ **Occasional** ☐ **Frequent** ☐ **Constant**

What makes your pain better? ____

What makes your pain worse? ____

On the diagram below, please indicate with an 'x' where your pain is:



What treatment(s) have you tried for your pain?

☐ **Nerve Block/Injections** **Date:________** ☐ **Physical Therapy** **Date:________**

☐ **Chiropractic Care** **Date:________** ☐ **Psychiatry** **Date:________**

☐ **Acupuncture** **Date:________** ☐ **TENS Unit** **Date:________**

☐ **Epidural Injections** **Date:________** ☐ **Psychiatry** **Date:________**

Other: ____

Have you undergone surgery for your pain? ____________________________________

If yes, where, and when? ____

Have you had an imaging taken, i.e., CT, MRI, or X-ray? If so, where?
____

Have you had an EMG (nerve test) done for the area of pain? If so, where? ______________

Are you currently taking any medications, prescribed or over the counter? **Yes/No**

If yes, what is the name?____

Are you on any blood thinning medication? **Yes/No** **If yes, what is the name?_____________**

Are you allergic to shellfish? **Yes/No** **Are you allergic to any medications?** **Yes/No**

If yes, please list the medication(s) along with your reaction: ___________________________
____

Are you currently being treated for an infection? **Yes/No** **If yes, what kind and what's the treatment? ____**

Do you have a pacemaker? **Yes / No**

Do you have a history of prior surgical procedures? **Yes/No** **If so, please notate what surgeries you have previously had: ____**
____

Have you had prior pain management care? **Yes/No** **If so, please notate where and when: ____**

Do you drink alcohol? **Yes/No** **If yes, ___daily, ___frequently, _socially**

Do you drink caffeine? **Yes/No** **If yes, type___________. How many cups per day ______**

Do you smoke? **Yes/No** **If yes, type___________. How many packs per day _____**

Do you use illicit drugs? **Yes/No** **If yes, type___________. When did you last use?_______**

Sleep Habits:

Do you have difficulty falling asleep? Yes/No Are you awakened by pain? Yes/No

Do you have difficulty staying awake during the day? Yes/No

Does anyone in your family have a history of:

________Migraines ________Seizures ________Stroke ________Cancer

_______ Anxiety/ Depression _______ Diabetes _______ Hypertension ________Neck/Back Problems

_______ Heart Attack ________Other: ____

Do you have a history of the following:

Condition		Condition	
Heart Attack/Heart Disease	Yes / No	Bleeding Disorder	Yes / No
Emphysema/COPD	Yes / No	Thyroid Disease or Diabetic	Yes / No
Hepatitis/Liver Disease	Yes / No	Anxiety / Depression	Yes / No
Stomach Ulcer	Yes / No	Asthma	Yes / No
Cancer (type __________)	Yes / No	Auto-Immune Disease (type ________)	Yes / No
Sleep Apnea	Yes / No	Seizures	Yes / No
Angina	Yes / No	High Cholesterol	Yes / No
Kidney Disease	Yes / No	Arthritis	Yes / No
Hypertension	Yes / No	Fibromyalgia	Yes / No
Stroke	Yes / No	HIV/AIDS	Yes / No

Females only: Are you currently pregnant? Yes / No

Date of your last cycle:_______________

Have you ever been diagnosed with the following:

Constitutional: Do you have fatigue, weight loss or fever?	**Yes/No**	**Neurologic: Do you have seizures, extremity weakness, headaches?**	**Yes/No**
Hematologic: Do you tend to bleed easily?	**Yes/No**	**Psychiatric: Do you suffer from depression, anxiety, suicidal thoughts?**	**Yes/No**
Ears/Nose/Mouth/Throat: Do you have loss of hearing?	**Yes/No**	**Gastrointestinal: Do you suffer from diarrhea, constipation, heartburn, unstable bowels, abdominal pain?**	**Yes/No**
Musculoskeletal: Do you have neck or back pain?	**Yes/No**	**Endocrine: Do you have Diabetes?**	**Yes/No**
Rheumatologic: Do you have joint pain or stiffness?	**Yes/No**	**Genitourinary: Do you have loss of bowel, bladder control?**	**Yes/No**
Cardiac: Do you have chest pain, swelling, arrhythmias?	**Yes/No**	**Allergic/Immunologic: Are you allergic to iodine, contrast dye, shellfish, Novocaine, Aspirin, Anti-Inflammatories? Do you have AIDS/HIV?**	**Yes/No**
Pulmonary: Do you have shortness of breath, chronic cough, wheezing?	**Yes/No**	**Skin: Do you have any rashes, lesions?**	**Yes/No**

By signing below, I am acknowledging that the information provided is accurate.

Patient's Signature ______________________ Date ____________

Witness's Signature (office personnel only) ______________________ Date ____________

RELEASE OF INFORMATION

Patient's Name: ______________________ Date of Birth: ____________

I, ______________________________, authorize the release of information including diagnosis, records, appointment details and claim information to the following:

- ☐ Spouse: ______________________
- ☐ Child(ren): ______________________
- ☐ Other: ______________________

☐ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

______________________________ ____________
Patient's Signature Date

Contact Preference and Authorization

I authorize you to contact the following numbers and leave a detailed message:

- ☐ ______________________ home number
- ☐ ______________________ cell number
- ☐ ______________________ other

I authorize you to contact me via the following email address:

- ☐ ______________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I have been offered a copy of the notice of privacy practices. This notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may change at any time.

______________________________ ____________
Patient's Signature Date

______________________________ ____________
Witness's Signature (office personnel only) Date

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: ____________________ **Date of Birth:** ____________

Patient's Address: ____

Patient's Phone Number: ____________________ **Email:** ____________

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, or family member to release all health information about me:

Person/Organization to Release Information: ____________________

Address: ____

Facility Phone Number: ____________________ **Fax:** ____________

Requested information: ____

The following medical facility is hereby authorized to receive ***my full medical record, treatment records, labs, diagnostic and pharmaceutical records (if not specified above)****:*

Carolina Physicians and Rehab: Dr. Hutcheson, Dr. Tollison, and Dr. Joseph
P.O. Box 26838
Greenville, SC 29616
Phone: (888) 699-4188
Fax: (864) 335-9252

This release is in effect starting the date signed below and will be ineffective only by written cancellation of authorization.

____________________ ____________
Patient's Signature **Date**

____________________ ____________
Witness's Signature (office personnel only) **Date**

PAYMENT AGREEMENT

I hereby irrevocably authorize and direct any representative of mine to pay directly to Carolina Physicians & Rehab all reasonable sums due and owing for all services rendered or time spent to include any fees and costs incurred by Carolina Physicians & Rehab in connection with my care. I irrevocably authorize such representative to withhold such sums from any Insurance proceeds or any other source as may be necessary to adequately protect Carolina Physicians & Rehab on all funds owing to me by law of insurance payments, or any other source which may be paid to such representative or myself.

I fully understand that I am personally, directly, and fully responsible to Carolina Physicians & Rehab for all medical bills submitted for services rendered to me. I further understand that this agreement is made solely for the additional protection of Carolina Physicians & Rehab and in consideration of Carolina Physicians & Rehab awaiting payment. I understand that nothing herein releases me of the primary responsibility and obligation of paying Carolina Physicians & Rehab in full for services rendered and that Carolina Physicians & Rehab is not obligated to bill my medical insurance, including HMO and/ or other health plans. However, if insurance is available, then Carolina Physicians & Rehab may bill that insurance out of courtesy to the patient.

Notwithstanding this agreement for any representative of mine to pay Carolina Physicians & Rehab, I agree to make monthly payments against the amount owed pursuant to a separate payment agreement until such time as Carolina Physicians & Rehab is paid in full.

In addition to the foregoing, in order to secure my obligation to pay the amount of my charges to Carolina Physicians & Rehab and in consideration for Carolina Physicians & Rehab agreements set forth herein, I hereby grant to Carolina Physicians & Rehab in accordance with the Uniform Commercial Code as in effect in the applicable jurisdiction, a security interest in and lien upon any proceeds received of any kind. I authorize Carolina Physicians & Rehab to file one or more UCC financing statements (and continuations thereof) naming me as debtor and evidencing Carolina Physicians & Rehab security interest in such collateral.

In the event any dispute arises as to the charge for any services rendered by Carolina Physicians & Rehab, I hereby authorize and direct any representative of mine to withhold the full sum claimed by Carolina Physicians & Rehab I also agree that I shall be responsible for all attorney's fees and costs of collection to Carolina Physicians & Rehab including any legal costs arising from my care or associated collection efforts.

By my signature below I have read and understand the terms of this agreement and have been notified of all fees associated with my care or will request such information, as treatment is needed.

Patient's Signature ____________________ Date ____________________

Witness's Signature (office personnel only) ____________________ Date ____________________

ASSIGNMENT OF BENEFITS, RELEASE AND DEMAND

Insurer and patient please read the following in its entirety carefully!

I, the undersigned patient/insured, knowingly, voluntarily, and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling.

If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document.

The undersigned directs the insurer to pay the healthcare provider the maximum amount directly without any reductions and without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for the insurance resulting in the policy of the insurance declared voided, rescinded, or canceled, I as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund checks payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premium paid.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the practice manager) and the insurer as to amount the payable under the insurance policy. The insured and provider hereby contests and objects to any reduction or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreement by the provider to accept a reduced amount as payment in full.

The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of bills submitted. If the PIP insurer states that it can pay claims at 200% of Medicare, then the insurer is instructed and directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address below, after speaking with the practice manager and mailed to the attention of the practice manager. If the insurer scheduled a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax or email, with any and all information that may be contained in the medical records; obtain insurance coverage information (declaration page and policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs and MRIs from any other medical provider or any insurer.

The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration page to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day, the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received on the same day, then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume you understand and agree to the above.

Signature: ____

Printed Name: ______________________________ Date: ______________