311 W. Palmetto Street
Florence, SC 29501
843-662-2811

Patient Intake Form

Last Name: _____First Name: _____MI:_____ Date: _____

Mailing Address:_____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Mobile: (_____)_____ Work: (_____)_____

Can we call your work? (Y) (N) Email: _____

Sex: (M) (F) Current Age: _____ Date of Birth: _____ SS#: _____

DL #: _____ Marital Status: (Single) (Married) (Divorced) (Widowed) (Separated) (N/A)

Spouse Name: _____ Phone: (_____)_____

Occupation: _____ Employer: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: Name: _____ Relationship: _____

Home Phone: (_____)_____ Mobile: (_____)_____ Work: (_____)_____

How did you hear about our practice? _____

REASON FOR VISIT: CHECK ALL THAT APPLY:

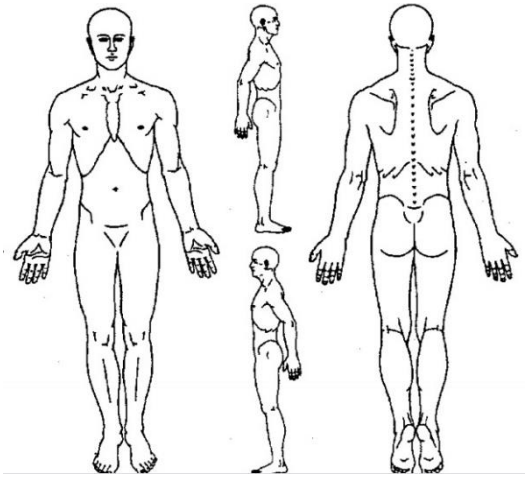
Primary Care_____ Family Care_____ Chiropractic Care _____ Wellness Care _____ Maintenance_____

Main Area of Problem: _____

Is the problem getting worse? (Y) (N) When did your problem start? _____

Is this visit due to an accident? (Y) (N) If yes, what type: Auto_____ Work _____ Other: _____

Has it been reported? (Y) (N) If yes, to whom? Insurance _____ Employer _____ Attorney ____ Worker's Comp _____



Mark an "X" on the image where your current pain or ailment

What Type of pain are you having: Circle all that apply:

Sharp Dull Achy Throbbing Burning Numbness Tingling

Cramping Stiffness Aching Swelling

Other:_____

Does the pain interfere with: (circle all that apply)

Work Sleep Daily Activities

FINANCIAL INFORMATION:

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____

Do you have Insurance? (Y) (N) Name of Carrier: _____

Do you have a secondary Insurance? (Y) (N) Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE A COPY OF YOUR INSURANCE CARD(S)

SIGNATURE (X): _____

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Patient Health History

Name: _____ Date: _____
Primary care physician (Doctor and/or practice) _____
Are you currently under drug and/or medical care? (Y) (N) If yes, explain:_____
How would you rate your overall health? Very Good _____ Good _____ Fair _____ Poor _____

Please check all areas in which you are experiencing problems:

□ neck pain/stiffness	□ pins/needles arms	□blurred vision	□ night pain	□ bladder changes	□ shoulder pain
□ back pain/stiffness	□ pins/needles legs	□ light sensitivity	□ weight loss	□ nausea	□ fibromyalgia
□ arm/hand pain	□ fatigue	□ depression	□ loss of memory	□ cold feet	□ digestive issues
□ leg/knee pain	□ sleep difficulties	□ nervousness	□ jaw problems	□ chest pain	□ hip pain
□ headaches	□ loss of smell	□ tension	□ constipation	□ fever	□ carpal tunnel
□ dizziness	□ loss of taste	□ cold sweats	□ short of breath	□ fainting	□ muscular disease
□ asthma	□ allergies	□ stomach problems	□ bowel changes	□ feet pain	□ other:

Please check all conditions that you have ever had:

□ AIDS/HIV	□ blood thinner	□ hepatitis	□ liver disease	□ rheumatoid arth	□ vascular disease
□ arthritis	□ cancer	□ herniated disc	□ lung disease	□ seizures	□ chronic fatigue
□ asthma	□ chemotherapy	□ hypertension	□ multiple sclerosis	□ skin infections	□ varicose veins
□ bleed/bruise easily	□ diabetes	□ immune disorders	□ osteoporosis	□ stents	□ COPD
□ bleeding disorders	□ fractures	□ implants	□ pace maker	□ stroke/TIA	□ substance abuse hx
□ blood clots	□ heart disease	□ kidney disease	□ pinched nerves	□ tuberculosis	□ other:

Preventive Health Test	Date of Service	Preventive Health Test	Date of Service
Colonoscopy		Dexascan – Bone Density	
Complete Physical		Mammogram (women)	
Hepatitis B Shot / Vaccine		PSA – Prostate Screening (Mene)	
TB Skin Test		Hemoglobin A1C (Diabetic)	
Lipid Profile / Cholesterol Check		Foot Exam (Diabetic)	
Tetanus Shot / Vaccine		EKG	
Pneumonia Shot / Vaccine		Eye Exam	
PAP (Women)		Thyroid Lab	

Please list any surgeries and/or hospitalizations (type/date): _____
_____
_____
Please list any allergies food or medication: _____

Is there any family history of any of the following conditions? (indicate family member including parents, grandparents, siblings)

□ heart disease	_____	□ diabetes	_____	□ MS or ALS	_____
□ cancer	_____	□ arthritis	_____	□ other	_____

How often do you exercise: □ frequently □ moderately □ occasionally □ none What position do you sleep? □ back □ side □ stomach
Which activities do your work mostly involve? □ sitting □ standing □ light labor □ heavy labor

What is the your daily/weekly intake of the following?

□ smoker _____ packs per day _____ length of time _____ years since quit
□ alcohol _____ drinks per day _____ number days per week _____ years since quit
□ illicit drugs _____ type □ currently using _____ dates started and/or stopped

****Please list all medications currently taking, including vitamins/supplements, on medication list****

I, the patient, do certify that the above questions were answered and documented accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____

UPDATED MEDICATION LIST

Patient Name: **Date:**

1. Medication:_____ **Milligrams:**_____ **How often:**_____ **Taken how:** (ex. Orally, injected, etc.) _____	**6. Medication:**_____ **Milligrams:**_____ **How often:**_____ **Taken how:** (ex. Orally, injected, etc.) _____
2. Medication:_____ **Milligrams:**_____ **How often:**_____ **Taken how:** (ex. Orally, injected, etc.) _____	**7. Medication:**_____ **Milligrams:**_____ **How often:**_____ **Taken how:** (ex. Orally, injected, etc.) _____
3. Medication:_____ **Milligrams:**_____ **How often:**_____ **Taken how:** (ex. Orally, injected, etc.) _____	**8. Medication:**_____ **Milligrams:**_____ **How often:**_____ **Taken how:** (ex. Orally, injected, etc.) _____
4. Medication:_____ **Milligrams:**_____ **How often:**_____ **Taken how:** (ex. Orally, injected, etc.) _____	**9. Medication:**_____ **Milligrams:**_____ **How often:**_____ **Taken how:** (ex. Orally, injected, etc.) _____
5. Medication:_____ **Milligrams:**_____ **How often:**_____ **Taken how:** (ex. Orally, injected, etc.) _____	**10. Medication:**_____ **Milligrams:**_____ **How often:**_____ **Taken how:** (ex. Orally, injected, etc.) _____

UPDATED MEDICATION LIST

Additional Medications: _____

_____

☐ current medication list reviewed with patient

☐ **no** changes since last re-eval ☐ **with** changes since last re-eval

PROVIDER SIGNATURE:_____DATE: ___/___/__

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Patient Consent for Treatment, Services and Payment

Consent for Treatment and Services: I hereby give my consent for treatment and related services considered necessary by Health 1st for the patient whose name appears below who is seeking or is under the care of the applicable Health 1st physician, his/her associated, assistants, employees or designees. I hereby understand that such treatment, may include, but is not limited to, necessary examination and/or assessments, laboratory, diagnostic and/or medical care and procedures, prescribed medical information, if available; and/or recordings and/or filming for internal purposes, which the Health 1st provider, his/her associates, assistants, or designees may be deem necessary or advisable. I hereby authorize Health 1st its agents and/or employees to make recording of my voice, image, or likeness in media whatsoever, including but not limited to photographs, videotapes, audiotapes, or any electronic or digital medium. I understand that recordings may be used for research, diagnostic, therapeutic, educational or publication relations purposes. I further understand that I have the right to withdraw my consent to a recording being made at any time before the recording is made and for the use of such recording within a reasonable period of time before the recording is used for any of the permissible purposes.

X-Ray Questionnaire: FOR WOMEN ONLY: Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are pregnant at this time.

☐ There is a possibility that I may be pregnant at this time?
☐ Yes, I am definitely pregnant

Health 1st use Marcaine as a component in some of our injections. If you are pregnant or if it is possible that you may be pregnant or if you are breast feeding you are not a candidate for Marcaine because of possible side effects. It is your responsibility to inform us if you become pregnant at any time during your therapy in our office.

☐ No, I am definitely not pregnant at this time. Date of last menstrual period: _____

Assignment of Insurance Benefits and Third Party Claims: I hereby authorize payment directly to Health 1st of medical benefits otherwise payable to me, including major medical Questionnaire insurance benefits, PIP benefits, sick benefits, or injury due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless I pay the account in full upon the receipt of services. I also authorize payment of medical benefits, directly to Health 1st, but not to exceed charges for these services. I understand that I am financially responsible to Health 1st and providers of service for charges incurred, whether or not covered by this assignment. I understand that should the account be referred to an attorney for collection, I shall pay all reasonable attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate. I further agree that in the event medical benefits exceed charges for services in connection with this episode of care, that such excess amount be first applied to the payment of any other indebtedness due by me for treatment and services rendered or any for amount for which I am responsible on account of other episodes of care of services received from Health 1st, and the balance, if any remains, to be paid to me. I further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverage is subject to the coordination of benefits clause. I further agree that Health 1st is authorized to act on my behalf in the endorsement of benefit checks made payable to me and/or Health 1st. If I am participate/beneficiary of an employee welfare plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), I designate Health 1st as my authorized representative and grant to Health 1st to act on my behalf in pursuing and appealing a benefit determined under the plan. Such authority shall include the right to request and receive a copy of the plan description and/or summary plan description. Not all insurance plans cover all services rendered. In the event your plan determines services rendered are "non-covered" you will be responsible for the complete charge. Payment is due upon receipt of statement or at time of services rendered. Certain laboratory services are processed and billed by outside laboratory companies. Therefore, you will receive separate billing from these companies for services rendered. Disability/FMLA/Leave of Absence forms could incur a minimum charge of $20 for completion. This fee would be collected prior to the completion of the document requested. Documents would be prepared within 10 business days upon request. Some cases may require an office visit.

Payment Guarantee: I hereby jointly and severely agree to pay all charges for services received by the patient named below during this "episode of care" and/or subsequent visits. Acceptable payments are credit cards, cashier checks, personal checks (with valid driver's license) and cash. A $30 fee for all returned checks. Unpaid balances over 90 days may be subject to collections.

Follow-up/New Episodes of Care: I understand that the patient named below may come in for subsequent care following his/her initial visit to Health 1st. I understand that the patient named below may receive subsequent care and/or treatment related to such episodes of care. I hereby acknowledge that I/he/she will not be required to complete a subsequent registration form containing all of the information stated within this Patient Consent for Treatment, Services and Payment but agree to be bound by the terms and conditions herein.

I have read the above Patient Consent for Treatment, Services and Payment, have had the opportunity for clarifications and understand the same and certify that no guarantee or assurance has been made as to the results that may be obtained as related to such treatment and services.

Patient or Authorized Representative Signature | Date | Witness

Print Name

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Designation of Care Givers for Communication of Protected Health Information

For the following patient:
Patient Name:_____ Date of Birth: _____
At my request, I authorize the person(s) listed below to inquire about my personal health and/or billing information on my behalf. In case of a minor child, this person(s) may inquire about the appointment on my behalf.

Name	Relationship	DOB	Phone
Name	Relationship	DOB	Phone
Name	Relationship	DOB	Phone

OR
_____(initial) I do not want any of my personal or financial information to be given to anyone other than myself and my physicians.

At my request, I authorize Health 1st to communicate my protected health information to me via the following methods:

- □ Leave detailed message on my answering service (phone:_____)
- □ Leave message with a call back number only
- □ Leave detailed message on my work voice mail (phone:_____)
- □ Ok to mail my home address
- □ Ok to mail my work address
- □ Email/Fax detailed medical information (email:_____/fax:_____)

I understand that my health care provider will use judgment in determining the minimum amount of information that must be shared in order to care for me. Health 1st will make diligent good faith effort to determine the identity of the requestor before the release of my personal health and/or billing information by verifying the address, date of birth and phone number for the authorized representatives I have designated. Health 1st is not liable for any misuse of my personal health or billing information by the representative(s) authorized (listed) above. I understand this authorization will remain in effect unless otherwise notified and/or revoked.

Health 1st Medical is operated by a Nurse Practitioner. In the state of South Carolina, Nurse Practitioners can operate without the supervision of a medical doctor. The nurse practitioner is solely responsible for the diagnosis and treatment you will receive. Becoming a patient of Health 1st Medical establishes a provider/patient relationship with the nurse practitioner and does not establish a relationship with any doctor or specialist. Should your condition fall outside the nurse practitioner's scope of practice, you will be referred to an appropriate specialist. Health 1st Medical is not operation or connection with or affiliated with any other physician, clinic or medical group.

Privacy Pledge
I hereby acknowledge that I have been offered a paper copy of the Notice of Privacy Practices, which sets forth the manner in which the protected health information of the patient name below may be used or disclosed by Health 1st and outlines applicable rights with respect to such information. I also acknowledge that I have been allowed to ask questions related to the Notice of Privacy Practices. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf as indicated below.

Patient or (Authorized Representative) Signature | Date | Witness

Print Name

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will not affect any action Health 1st took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation:_____

Date of Authorization:_____