101 Spring Hall Drive, Goose Creek, SC 29445
Phone: 843-302-0920 Fax 843-302-0925

Motor Vehicle Accident Information

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date: _____ Date of Accident: _____

Last Name:_____ First:_____ Middle:_____

Email Address _____

Marital status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Birth date:_____ Age:_____ Sex: ☐ M ☐ F SS #_____

Home phone:_____ Cell phone:_____

Street Address _____

City/State/Zip _____

Employer:_____ Work Phone:_____

Were there other passengers in the vehicle with you? _____

After Accident: (Circle all that apply)

Immediately Response: Dizzy/Dazed Upset Weak Nervous Headache Disoriented
Other: _____

Treatment Information

Did you receive medical care? Yes No
Time of care: At time of accident Next day Other: _____
Transportation: Drove Self Ambulance Other: _____
Went to: Emergency Room Chiropractor Orthopedist Neurologist Family Doc
Other: _____
Admitted to Hospital: Yes No Days spent in Hospital: _____
Tests Performed: X-rays MRI CT Scan Lab Work Other: _____
Treatment: Ice Heat Cervical Collar Medication Other: _____

Current Symptoms

Head: (Circle all that apply)

Headache Dizziness Blurred Vision Light Headedness Fainting

Memory Loss Ear Pain Ringing Ears Double Vision Other: _____

Neck Pain with Various Movement: (Circle all that apply)

Forward Backward Turning Left Turning Right Bending Left Bending Right

Does your neck pop or crack? Yes No **Have You Had Muscle Spasms?** Yes No

Do you have neck pain even without head movement? Yes No

Shoulders: (Circle all that apply)

Pain in R/L shoulder joint Tension in Shoulders Muscle Spasms in Shoulders

Are you unable to raise your arm(s) above your shoulder or head? Yes No

Arms and Hands: (Circle all that apply)

Pain in Fingers Numbness in L / R Arm Cold Hands Pin & Needles in Hands

Pins & Needles in Fingers Loss of Grip Strength Swollen Joints in Fingers

Chest: (Circle all that apply)

Chest Pain Rib Pain Shortness of Breath Breast Pain Other: _____

Abdomen: (Circle all that apply)

Nervous Stomach Nausea Diarrhea Gas Constipation Other: _____

Mid Back: (Circle all that apply)

Sharp Pain Stabbing Pain Dull Ache Pain in Kidney Area Muscle Spasms

Lower Back: (circle all that apply)

Sharp Pain Stabbing Pain Dull Ache Numbness Muscle Spasms

Hips, Legs & Feet: (Circle all that apply)

Pain in Buttocks Pins & Needles in Legs Pain down Leg Pain in Hip Joint

Feet feel Cold Swollen Feet Numbness in Toes Numbness of Leg

Knee Pain Leg cramps Cramps in Feet Other:_____

General:

Loss of Sleep: Yes No If yes, how many hours per night? _____

Loss of Weight: Yes No Weight Gain: Yes No

Are you suffering with any other symptoms or conditions? Yes No

If yes, please explain: _____

Have You Suffered Previous Injuries? Yes No

Do You Have Residual Pain from Previous Injuries/ Accidents? Yes No

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

Claim or File#_____ Insured's Name:__ _____

Date of Loss:_____ Insured's Address:_____

Patient's Name:_____ _____

To whom it may concern:

I hereby authorize and direct you, my insurance company, liability insurance adjustor, and/or my attorney, to pay directly to Real Health Clinic, LLC, such as may be due and owing this office for services rendered to me, both by reason of an accident or illness, and by reason of any other bills that are due this office and to withhold such sums from any disability benefits, or any other insurance benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. For and in consideration of continuing care without pre-payment to Real Health Clinic, LLC, I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all processes of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's service provided. In exchange for my care proceeding with no payment to Real Health Clinic, LLC, I am conveying a lien on any recovery and/or insurance reimbursement for the services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for their services refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this assignment, Lien and Authorization does not constitute any consideration for the office to wait for payments and they may demand payments from me immediately upon rendering services at their option. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this office, including reasonable attorney fees.

I authorize this office to release any information pertinent to my case to any insurance company, adjustor or attorney to facilitate collection under this assignment, lien and authorization. I agree that the above mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien and inherent to the settlement and enforceable upon the case as if it was executed by him. A photocopy of this agreement shall be considered as effective and valid as the original.

Date:_____ Patient's Signature _____

Witness' Signature _____

The undersigned being the attorney of record for the above mentioned patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named.

Date:_____ Signed:_____
Note to attorney: If you prefer, please send your acknowledgement of this lien on your letterhead.

Real Health
ADVANCED CARE CLINICS

Claim Number: _____

Insurance Company Name: _____

Policy Number: _____

Date of Accident: _____

To Whom It May Concern:

I have made a written agreement with Dr. Renee Hunter of Real Health Clinic, LLC that the services (medical and chiropractic pay) check due from your company upon settlement will be made payable directly to him on my behalf.

Sincerely,

_____
Patient's Signature

_____
Today's Date

_____
Witness' Signature

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Real Health Clinic.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

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 not pregnant at this time.

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

_____ _____
Patient's Signature Date

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies. I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Patient's Signature Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care of provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

_____ _____

Patient Signature Date