CARRANO CHIROPRACTIC

(864) 552-1142
26 Rushmore Drive
Greenville, SC 29615

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
◯ No ◯ Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name

Your Social Security Number

Birth Date (MM/DD/YYYY)

Age

Your First Name

Your Middle Name (or Initial)

Gender
◯ Male ◯ Female

Race

Address

Marital Status ◯ Married
◯ Single ◯ Divorced
◯ Widowed ◯ Separated

Ethnicity

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Ago

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?
◯ Yes ◯ No

City

State/Province

ZIP/Postal Code

Preferred method of Contact?
◯ Home Phone ◯ Cell Phone
◯ Work Phone ◯ Emal

Primary care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?
◯ Self ◯ Spouse ◯ Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

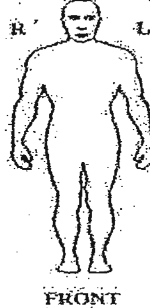
UPSTATE INJURY CENTER

(864) 552-1142
2520 Wade Hampton Blvd
Suite B
Greenville, SC 29615

Your Name: ______________________________

Areas of Complaint

Place **X's or Circles** on the areas where you have pain and **draw lines** to where it radiates:



Check symptoms you have noticed since the injury/ accident /slip & fall (mark all that apply)

□ Headaches	□ Irritability	□ Numbness in Toes	□ Digestive Problems	□ Face Flushed
□ Neck Pain	□ Chest Pain	□ Shortness of Breath	□ Shoulder Pain	□ Buzzing in ears
□ Stiff Neck	□ Dizziness/Loss of balance	□ Fatigue	□ Elbow Pain	□ Fainting
□ Back Pain	□ Head Seems to Heavy	□ Depression	□ Wrist/Hand Pain	□ Loss of Taste
□ Sore throat	□ Pins & Needles in Arms	□ Lights bother eyes	□ Upper Back Pain	□ Loss of Smell
□ Nervousness	□ Pins & Needles in Legs	□ Loss of Memory	□ Ears Ringing	□ Diarrhea
□ Tension	□ Numbness in Fingers	□ Ankle/Foot Pain	□ Heart Burn	□ Cold Sweats
□ Feet Cold	□ Hands Cold	□ Stomach Upset	□ Constipation	□ Fever

□ Bruises, cuts, scrapes and/ or scars if so please explain:

____

□Other: ______________________________

Is your condition getting worse? □ Yes □ No   Is it Constant? □ Yes □ No   Comes and Goes? □ Yes □ No

Have you already seen other doctors for this/these condition(s)? □ Yes □ No

Please list other doctors seen and approximate date seen (including primary care physician):

Doctor / Facility	Approximate Date Seen
1. ______________________________	1. ____________________
2. ______________________________	2. ____________________

Have you ever been involved in an accident/injury/slip & fall prior to this one? □ Yes □ No, If yes what type was it?

□ Auto □ Work □ Slip n Fall □ Leisure □ Sports □ Other ____________ When?: ____________________

Briefly Explain: ______________________________

Are you presently taking any medication? □ Yes □ No Please List: ______________________________

*Signature of Patient, Parent, Guardian or Personal Representative ______________________________

Carrano Chiropractic

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to Carrano Chiropractic, the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with South Carolina Rule 1.15, Article 21.55 of the SC Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits to me/us for treatment rendered by Dr. Carrano/Carrano Chiropractic within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the South Carolina Insurance Code, providing for attornet fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all check payable to Carrano Chiropractic, and send all checks to 26 Rushmore Drive Greenville, SC 29615.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable to Carrano Chiropractic, and send any and all checks to 36 Rushmore Drive Greenville, SC 29615.

STATUTE OF LIMITATIONS: I waive my rights to clam any statute of limitations regarding claims for services rendered by Dr. Carrano/Carrano Chiropractic, in addition to reasonable cost of collection, including attorneys fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant Dr. Carrano/Carrano Chiropractic the power to endorse my name upon any insurance company representing payment for treatments and healthcare rendered by Dr. Carrano/Carrano Chiropractic. I agree that any insurance payment representing an amount in excess of charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing by Dr. Carrano/Carrano Chiropractic.

REJECTION IN WRITING: I hereby authorize Dr. Carrano/Carrano Chiropractic to establish a Med Pay, PIP, or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to Dr. Carrano/Carrano Chiropractic any rejections in writing as they apply to my lack of Med Pay, PIP, or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitles to minimum levels of coverage, as per South Carolina code of Law, and further instruct my carrier to pay up to available limits directly to Dr. Carrano/Carrano Chiropractic, and to send any and all checks and financial instruments to 26 Rushmore Drive Greenville, SC 29615.

TERMINATION OF CARE: I hereby acknowledge and understand that I do not keep appointments as recommended to me by Dr. Carrano at Carrano Chiropractic, he has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify Dr. Carrano at Carrano Chiropractic immediately. I understand that failure to do so may jeopardize my case.

Signature of patient and/or responsible parties:

____ (Patient signature)__________ (Date)

____ (Clinic signature)__________(Date)

____ (Notary Signature)__________(Date)

Requesting Records of Doctor: ______________________________

Name of Facility or Person: ______________________________

Address: ______________________________

Telephone: (   ) ________ - ____________   Fax: (   ) ________ - ____________

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to Carrano Chiropractic all information my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: Yes / No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: Yes / No

Genetic Testing: Yes / No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who the pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release Carrano Chiropractic; its employees, agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand that there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name: ______________________________ D.O.B. ____________

Signature: ______________________________ Date: ____________

PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE OR PASSPORT
ALONG WITH THE COMPLETED AND SIGNED FORM.

Records Requested by:

Doctor's Name: ______________________________

Address: ______________________________ Telephone: ____________

Signature: ______________________________