Celanese Chiropractic Health & Performance
Dr. Clay Gasparovich

1924 Mt Gallant Rd
Rock Hill, SC 29732
P: (803) 323-5500

PATIENT INFORMATION

Full Name ______________________________ Birth Date ____________________ Gender M F
Address ______________________________ SS# ______ - ______ - ______ Work Phone ____________________
City ________________ State ____ Zip ________ Cell Phone __________________ ____
In order to receive text reminders, please provide phone carrier (AT&T, Verizon, etc.) ____________________

Marital Status S M W D Sep / Spouse Name ______________________________ Birth Date ________________
Are you a student? Y N / Full-time Part-time
Your Employer ____ Your Occupation ____________________________
Employer Address __________________________ City ______________________ State _______ Zip ___________
Spouse's Employer ______________________________________ Spouse's Occupation ________________________

INSURANCE (Please allow our staff to photocopy your current license & health insurance card (s)).

Email: ______________________________ **Referred by:** ____________________________________

Family History

Please take a few moments to complete the following. The better you fill out, the better it will help us to treat your condition. Thanks for your cooperation.

Place an "X" in any box that may apply.

	Mother	Father	Brother	Sister	Children	Spouse
Back Pain						
Neck Pain						
Headaches						
Pinched Nerve						
Scoliosis						
Arthritis						
Numbness						
Cold Hands/Feet						
Carpal Tunnel						
Sport Injuries						

- I authorize payment of medical benefits to this office
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manager.
- I acknowledge having the right to review and obtain a copy of the notice of privacy practices of this office. (Once information is disclosed, it may not be protected by law.)

Patient's Signature ____ Date ______________
Spouse's or Guardian's Signature __________________________________ Date ______________
(Authorization expires 3 years from date above)

CASE HISTORY

History of Present Injury/Illness

Please list below the complaint(s) you have in the order of importance. Also the length of time you have had these complaints.

1. ______________________________ How long?__________
2. ______________________________ How long?__________
3. ______________________________ How long?__________
4. ______________________________ How long?__________

Is your condition(s) related to an accident? ☐ YES ☐ NO

Date of accident: ____________ State: _______ Type of Accident: ☐ Auto ☐ Work Related ☐ Other____________

What words would best describe your condition(s)? (ex. ache, burn)____________________

Circle the number that matches your level of pain at its worst (0=no pain, 10=most severe)

0 1 2 3 4 5 6 7 8 9 10

When is your condition most severe? ____________________

When is your condition least severe? ____________________

What makes your condition feel worse? ____________________

What makes your condition feel better? ____________________

What activities are difficult because of your condition(s)? ____________________

Have you seen any other health care provider for your present condition? ☐ Yes ☐ No

Who? ____________________

Current Medications____________________

Are you or could you be pregnant? ☐ YES ☐ NO

Are you experiencing or do you have any of the following?

☐ A sore that won't heal	☐ Difficulty swallowing	☐ Persistent cough/hoarseness
☐ Any bleeding/discharge	☐ Lump/thickening anywhere	☐ Wart/mole changes
☐ Bladder/ bowel problems	☐ Night pain	☐ Weight loss without trying
		☐ **None of the above**

Review of Systems

In addition to the symptom(s)/dysfunctions(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System

☐ Anxiety	☐ Facial drooping	☐ Loss of balance	☐ Seizures
☐ Atrophy	☐ Headache	☐ Memory loss	☐ Sensory changes
☐ Concussion	☐ Joint deformity	☐ Mood swings	☐ Speech problems
☐ Depression	☐ Joint locking	☐ Muscle weakness	☐ Stiffness
☐ Difficulty walking	☐ Joint swelling	☐ Numbness	☐ Tremors
☐ Dizziness	☐ Lack of coordination	☐ Popping noises	☐ Twitches
☐ Extremity deformity	☐ Limited range of motion	☐ Psychiatric disorders	☐ Vision trouble
			☐ **None of the above**

Cardiovascular System

☐ Ankle Swelling	☐ Chest Pain	☐ Jaw pain	☐ Pin stroke
☐ Blood Clots	☐ Dizziness	☐ Known vascular	☐ Previous stroke
☐ Carotid blockage	☐ Fainting	☐ Mitral valve prolapse	☐ Shortness of breath
☐ Changes in skin color	☐ Hypertension	☐ Phlebitis	☐ Varicose veins
			☐ **None of the above**

Past History

List any surgeries you have had (including appendix, tonsils, wisdom teeth, etc.)

1.____________________ Date __________ 3.____________________ Date __________

2.____________________ Date __________ 4.____________________ Date __________

Have you ever been hospitalized for anything in addition to surgeries? ☐ YES ☐ NO

If so, when and for what reason? ____________________

Have you ever been diagnosed as having a particular condition? (Diabetes, heart trouble, cancer)

☐ YES ☐ NO ____________________

Are you currently under a doctor's care for conditions other than the ones you are seeking care for?

☐ YES ☐ NO ____________________

CELANESE CHIROPRACTIC HEALTH & PERFORMANCE

AUTHORIZATION TO RELEASE INFORMATION

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released you must sign this form. Signing this form will only give consent to release this information to the individuals indicated below. This consent form will not allow Celanese Chiropractic Health & Performance to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow Celanese Chiropractic Health & Performance to release my medical and/or billing information to the following individual(s):

1. ______________________________ Relation to Patient:__________________

2. ______________________________ Relation to Patient:__________________

3. ______________________________ Relation to Patient:__________________

Patient Name:____

Patient Signature:__________________________ Date:________________________

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE:

Occasionally it is necessary for the staff of Celanese Chiropractic Health & Performance to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of Celanese Chiropractic Health & Performance discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name:____

Patient Signature:__________________________ Date:________________________

*For Office Use Only: Patient ID*________________

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To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Celanese Chiropractic Health & Performance to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows: I irrevocably assign to Celanese Chiropractic Health & Performance any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on ________________ to the extent of the Chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Celanese Chiropractic Health & Performance, from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workers compensation benefits, judgements, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Celanese Chiropractic Health & Performance for services rendered.

In the event that I retain one or more attorneys to represent me in this matter who are not located in SOUTH CAROLINA, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

I appoint Celanese Chiropractic Health & Performance as my attorney in fact to affix my name as an endorsement upon the reverse of any checks or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Celanese Chiropractic Health & Performance. I authorize Celanese Chiropractic Health & Performance to release to any insurance with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Celanese Chiropractic Health & Performance for services rendered, including any balance remaining after the application of insurance payments and settlement or judgement proceeds. If Celanese Chiropractic Health & Performance is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Celanese Chiropractic Health & Performance for its costs of recovery, including reasonable attorney's fee.

______________________	______________________
Patient Name (Printed)	Patient Signature
______________________	______________________
Date	Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Celanese Chiropractic Health & Performance hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise. Celanese Chiropractic Health & Performance hereby requests that if its claim is not paid in full from the foregoing proceed, a full disclosure and accounting of proceeds by provided in conformity with N.C.G.S. 44-50.1. Celanese Chiropractic Health & Performance agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Celanese Chiropractic Health & Performance
By:______________

Celanese Chiropractic Health & Performance
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Dr. Clay Gasparovich

DOCTOR'S LIEN

I do hereby authorize Celanese Chiropractic Health & Performance and Dr. Clay Gasparovich to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the inquiries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

________________ ____

Date Patient's Signature

The undersigned being attorney of record for the above 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.

________________ ____

Dated Attorney's Signature

Please date, sign and return one copy to the doctor's office. Also keep one copy for your records.

Automobile Accident Description

Name: ______________________ Date: ______________

Date of Accident: ______________________ State: ______________

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

Your Vehicle Type	Your Position in the vehicle	What was your vehicle doing at time of impact?
❑ Car ❑ Van ❑ Large Truck ❑ Bus ❑ Station Wagon ❑ Pickup Truck Other:____________	❑ Driver ❑ Front Passenger ❑ Left Rear Passenger ❑ Right Rear Passenger Other:______________	❑ Stopped at intersection ❑ Stopped in traffic ❑ Making a left turn ❑ Parking ❑ Making a right turn ❑ Slowing down ❑ Proceeding along ❑ Accelerating Other:______________________

Time/Speed/Damage	Details of Accident	
Time of Accident:________ Your vehicle's speed:______ Other vehicle's Speed:_____ **Damage to your vehicle** ❑ Mild ❑ Moderate ❑Totaled Estimated Damage: $__________	**Visibility at time of accident** ❑ Poor ❑ Fair ❑ Good **Road Conditions** ❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and Dry	**Point of Impact** ❑ Head On ❑ Right Front ❑ Rear End ❑ Right Rear ❑ Left Front ❑ Left Rear

Body Position, Etc.

Did you see the accident coming?	❑ Yes ❑ No	Did you have your seatbelt on?	❑ Yes ❑ No
Were you braced for impact?	❑ Yes ❑ No	Did any airbags deploy?	❑ Yes ❑ No

Additional Accident Information

Enter any additional information not included by the check list above.

During Accident	Treatment History
Did your body strike the inside of your vehicle? ❑ Yes ❑ No If yes, describe:______________________ Did you lose consciousness during the injury? ❑ Yes ❑ No Did police arrive on scene? ❑ Yes ❑ No Was an accident report filled out? ❑ Yes ❑ No	**Where did you go after the accident?** ❑ Home ❑ Work ❑ ER ❑ Other Doctor How did you get there? ❑ Drove Self ❑ Someone Else ❑ Ambulance ❑ Police Where X-Rays done? ❑ Yes ❑ No **Fill in any other Doctor seen prior to you first visit here.** Dr.______________ Visit Date:__/__/___ Specialty:______________________ Dr.______________ Visit Date:__/__/___ Specialty:______________________

Patient Signature: ______________________________

Guardian's Signature:______________________________

Date: ___/ ___/ ___

To whom it may concern,

Celanese Chiropractic Health and Performance will release medical bills when the contract below has been signed and dated.

The following Insurance Company ______________________________ has agreed to pay the medical bills for Celanese Chiropractic Health and Performance **DIRECTLY** in the case of a settled claim;

(Claim #): ______________________________ (Patient Name): ___________________________.

I have read and understand the following paragraph and agree to the terms as described above.

Authorized Signature: ______________________

Printed Name: __________________________

Date: _________________________________

Patient Signature: ____________________

Patient Name: _______________________

Date: ______________________________

If you have any questions or need any additional information please feel free to call our office and our staff will be happy to assist you. (803) 323-5500.

Regards,

Celanese Chiropractic Health & Performance