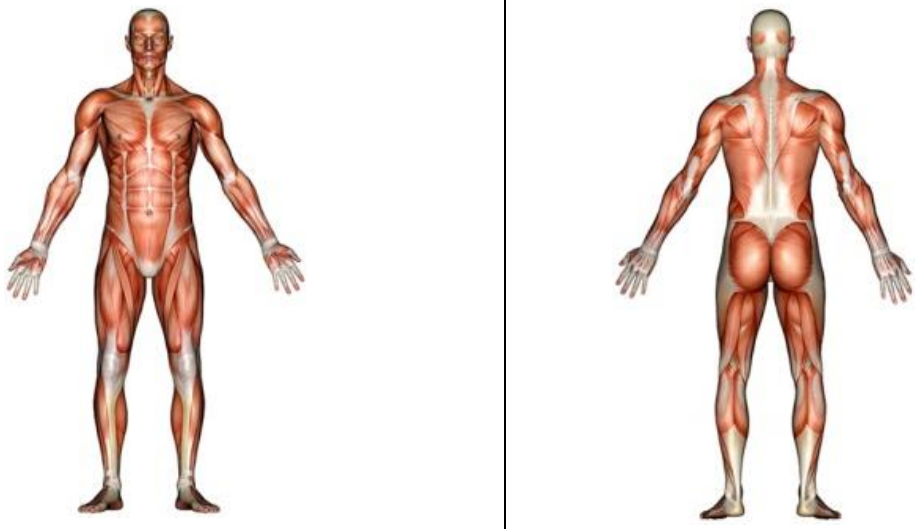


New Patient Intake Form

PATIENT DETAILS	Today's Date		How Did You Hear About Us?		Patient Nickname		
	Last Name		First	MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	Age
	Address		Apt#	City	State	Zip	
	Cell Phone #		Secondary Phone #		Social Security #		
	Appt Reminder Preference <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> None		Cell Phone Provider		Personal Email		
	Married Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorce				Parent Name (for minor patients only)		
	Emergency Contact		Relationship		Phone #		
	Employer Name				Job Title		

CONDITION	Reason for Visit	
	When did your symptoms appear?	Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)	Frequency of Pain
	Type of pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Other	Is it Constant or does it Come and Go
	Does it interfere with your: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation	
	Activities or movements that are painful to perform: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down	
	Mark an X on the picture where you continue to have pain, numbness or tingling:	
		

What treatment have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic Services None Other

Place a mark on "yes" or "no" to indicate if you have had any of the following:

HEALTH HISTORY

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	STD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	



OFFICE FINANCIAL POLICY

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. Low Country Clinic, Inc. may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.
3. If you need to reschedule an appointment you must notify Low Country Clinic, Inc. 24 hours in advance. Additionally, if you miss an appointment you must call within 24 hours and/or make it up within 7 days. Failure to comply with the above-mentioned scenarios will result in a \$25 fee. You yourself are responsible for this fee as no insurance, lien, etc. will pay for this. The fee is due upon your immediate next visit or two days later (whichever comes first).
4. All payments made to the Low Country Clinic, Inc. for insufficient funds will be charged a \$30.00 processing fee regardless of amount. Thereafter acceptable payment will be cash or credit card only.
5. If you have insurance, Low Country Clinic, Inc. will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
6. Low Country Clinic, Inc. accepts assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
7. Low Country Clinic, Inc. accepts assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
8. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check-it will not come from your insurance company. All

insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

9. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
10. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
11. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately; regardless of any claims submitted.
12. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.
13. Any accounts that become overdue 90 Days or more will be subject to a 35% fee and will be referred to a third party collection agency.

I have read and understand this Financial Office Policy and agree to abide by all terms.

Patient's Signature

Date

I understand and agree that all fees associated with my first visit to this office, including but not limited to, exam and all necessary x-rays, will be billed to my insurance company regardless of any discount I receive for the first visit.

Patient's Signature

Date



CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I authorize Dr. Bryan Aldrich to perform a radiographic examination if the Doctor deems necessary to diagnose and to administer whatever examination or treatment is deemed necessary to treat my present problem (or illness).

To the best of my knowledge I am NOT pregnant and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

Patient's Signature

Date



HIPAA PRIVACY POLICY CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to/for:

- Carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient's Signature

Date



AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your undertaking of care from Low Country Clinic, Inc., I agree to the following:

1. Low Country Clinic and/or Dr. Bryan S. Aldrich is authorized to release any information deemed appropriate and necessary concerning my physical condition to any insurance company or adjuster to process any claim for reimbursement of charges I incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney (personal injury cases) , from the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company is obligated to make payment to me or to you for the charges made for your services, refuse to make such payment upon demand by you; I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the State of South Carolina.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

Patient's Signature

Date