Patient Name: _____

Date: _____

Ivey O'Sullivan Healthcare Services, PA
Dr. Gabriel O'Sullivan, DC
Dr. Stacy Gantt, DC
Dr. Suzzanne Candelaria-Perez, DC
Dr. Michael Neal Quinn, DC
201 S Dean Street, Spartanburg, SC 29302
P: 864.583.3967 F: 864.585.5554

Consultation Questionnaire

Major symptom/chief complaint: _____

Date symptoms appeared or accident happened: _____

Is this due to: ❑Auto Accident ❑Work ❑Other _____

What does this prevent you from doing or enjoying? _____

Have you ever had the same or similar condition? ❑Yes ❑No

If yes, when and describe: _____

Has the condition become worse recently? ❑Yes ❑No

If yes, when and describe: _____

How frequent is your condition? ❑Constant ❑Daily ❑Intermittent ❑Night Only

How long does it last? ❑All Day ❑Few Hours ❑Minutes

Are there any other conditions or symptoms that may be related to your major symptom? ❑Yes ❑No

If yes, describe: _____

Check those that describe your pain: ❑Sharp ❑Dull ❑Numbness ❑Tingling ❑Aching ❑Burning ❑Stabbing

❑Other _____

Place an "X" on the line below to indicate severity of the problem.

No Symptoms ---------- Extreme Symptoms

0 1 2 3 4 5 6 7 8 9 10

Is there anything you can do to relieve the problem? ❑Yes ❑No

If yes, describe: _____

If no, describe what you have tried to do that has not helped: _____

What makes the problem worse? ❑Standing ❑Sitting ❑Lying ❑Bending ❑Lifting ❑Twisting ❑Driving

❑Sleep ❑Sports ❑Walking ❑Other _____

Are you pregnant or is there any possibility you may be pregnant? ❑Yes ❑No ❑Uncertain

List any major accidents you have had other than those mentioned above: _____

_____

Remarks/anything else you want the doctor to know: _____

_____

Doctor's Signature: _____ Date: _____

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Patient Information

Name		Date of Birth	Home Phone
Mailing Address			
City/State/Zip Code			
Email Address		Would you like to receive appointment reminders via text to this phone number? ❑Yes ❑No	Cell Phone
Age	Race	Social Security #	Marital Status
Occupation		Employer	Work Phone
Employer's Address			
Emergency Contact		Relationship to Patient	
Emergency Contact Phone			
How were you referred to our office?			
Family Medical Doctor		May we have permission to update your medical doctor regarding your care at this office? ❑Yes ❑No	

Insurance Information

Please check any and all insurance coverage that may be applicable in this case:

❑Major Medical ❑Worker's Compensation ❑Medicaid ❑Medicare ❑Auto Accident ❑Medical Savings Account & Flex Plans ❑Other

Name of Primary Insurance Company	Name of Secondary Insurance Company

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

The following person(s) have my permission to receive my personal health information: _____

Patient's Signature: _____ Date: _____

Responsible Party's Signature: _____ Date: _____

Patient Name: _____

Date: _____

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Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy **before receiving services**. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

- The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
- The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
- The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
- This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with our privacy official about any suspected violations.
- This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initial _____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initial _____

Printed Name _____ Signature of Parent/Guardian _____

Signature _____ Date _____