Date:_______________

MRN:_______________

NEW SOUTH MEDICAL

PERSONAL INFORMATION / INFORMACION BASICA PERSONAL

Name/Nombre:____________________________ **Date of Birth (mm/dd/yyyy):**_________________ **Age/Edad**__________

Address/Dirección_________________________________ **City/Ciudad:**__________________ **State/Estado**____________

Zip code/Código Postal:______________**Tel.**_________-_________-________ **Cell.**_________-_________-________

Email:____________________________ **SSN#**____________________________ **Sex: M ☐ F ☐**

Marital Status/ Estado Civil: Married/Casado(a) ☐ Single/ Soltero ☐ Divorced/ Divorciado(a) ☐ Widow/Viuda ☐ Domestic Parter/ Socio doméstico ☐

EMERGENCY INFORMATION

Name/Nombre:________________________ **Relationship/Relacion:**_______________ **Tel.**_________-_________-________

PRESENT COMPLAINT/RECLAMO ACTUAL:

Approximately when did the conditions or symptoms begin to occur?/ Cuando empezo su dolor? ____________________

Describe the conditions, symptoms, or purpose of the appointment: ____

Describe your pain: Burning □ Sharp □ Dull □ Ache □ Other □ ____

What caused it?____

What aggravates it? ____

What relieves it?____

Have you ever had the same or similar condition or symptoms previously? Yes ☐ No ☐ When?_______________

Have you seen any other healthcare providers for your conditions or symptoms? If so, please indicate below.

Name	Type of Licensure	Date of Last Visit
____________________________	____________________________	__________________________
____________________________	____________________________	__________________________

If accident, please check the following/Si tuvo un accidente,por favor: Auto ☐ Work/Laboral ☐ Slip/Calde ☐

Date of Accident/Fecha Del Accidente: ______________ **Hospital: Yes/Si ☐ No ☐ Ambulance? Yes/Si ☐ No ☐**

Name of Hospital/Nombre Del Hospital: ______________________ **How&Where?/Como y Cuando:** __________________

Date:__________________

MRN:_________________

Have you ever been in our office before?/Has tratado con nosotros? **Yes/Si ☐ No ☐**

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date/Por favor liste si llas tenido accidents anterioremente y las fechas?

1.____ **Date:**________________

2.____ **Date:**________________

3.____ **Date:**________________

PLEASE PLACE A CHECK MARK ON ANY OF THE FOLLOWING SYMPTOMS YOU ARE EXPERIENCING AS A RESULT OF YOUR ACCIDENT

☐ **Lightheadedness (Mareos Ligeros)**	☐ **Abdominal Pain (Dolor Abdominal)**
☐ **Loss of Balance (Perdida de Balance**	☐ **Low Back Pain (Dolor de la Espalda Baja o Cintura)**
☐ **Nervousness (Nerviosismo)**	☐ **Pelvic Pain (Dolor de la pelvis)**
☐ **Anxiety/Tension (Anciedad/Tension)**	☐ **Difficulty Bending (Dificultad Para Dolarse)**
☐ **Jaw Pain/Clicking (Dolor de Mandibula)**	☐ **Difficulty Standing (Dificultad Para Ponerse de Pie)**
☐ **Neck Pain (Dolor de Cuello)**	☐ **Difficulty Sitting (Dificultad Para Sentarse)**
☐ **Radiation of Pain to Right Arm/Left Arm(Irradiacion de Dolor en el Brazo Derecho)**	☐ **Difficulty Walking (Dificultad Para Caminar)**
☐ **Radiation of Pain to Left Arm (Irradiacion de Dolor en el Brazo Izquierd)**	☐ **Radiation of Pain – Right or Left leg (Radiacion del dolor a la pierna derecha o izquierda)**
☐ **Painful Right/Left Shoulder (Dolor del Hombro Derecho)**	☐ **Weakness in Lower Extremity (Debilidad en la Parte Inferior Del Cuerpo)**
☐ **Elbow Pain Right/Left (Dolor de Codos)**	☐ **Hip Pain, Left or Right (Dolor en la Caderas Derecha, Izquierda)**
☐ **Wrist Pain Right/Left (Dolor de Munecas)**	☐ **Knee Pain, Right or Left (Dolor en la Rodilla, Derecha o Izquierda)**
☐ **Dorsal Pain, between shoulder blades (Dolor de la Espina Dorsal)**	☐ **Ankle Pain, Right or Left (Dolor en el Tobilo Derecho, Izquierda)**
☐ **Weakness in Arms (Debilidad de los Brazos)_**	☐ **Radiation of Pain to Thighs (Irradacion de Dolor en los Muslos)**
☐ **Chest Pain (Dolor de Pecho)**	☐ **Radiation of Pain to Gluteus (Irradacion de Dolor en los Gluteos)**
☐ **Difficulty Breathing (Dificultad Para Respirar)**	

Date:__________________

MRN:_________________

Please list all of your current medications:____

____

____

Surgeries/Cirugias: Yes/Si ☐ No ☐ ____

Allergies/Alergias: Iodine ☐ Shellfish ☐ Contrast ☐
Other____

Do you have any personal history of Diabetes? Has tenido usted unhistorical de diabetes? Yes/Si ☐ No ☐

Women/Mujeres: Are you pregnant?/Estas Embarazada? Possible/Posiblemente ☐ Yes/Si ☐ No ☐

Do you have a personal history of Cancer/malignancy?/Has tenido usted un historial de cancer? Yes/Si ☐ No ☐

Do you have any other pertinent personal history, including but not limited to any of the following?/Por favor marque si tienes algunas de las siguientes problemas de salud? Please check all that apply.

☐ Neurological (Cerebrales)	☐ High Blood Pressure	☐ Thyroid (Tiroideas)	☐ Epilepsy (Epilepsia)
☐ Circulation (Circilatorias)	☐ Alcohol (Alcoholismo)	☐ Migraines (Migranias)	☐ Problems Breathing (Problemas para respirar)
☐ Kidney (Renales)	☐ Smoke (Fumar)	☐ Arthritis (Artritis)	☐ Digestive Problems (Problemas digestivos)
☐ Heart (Cardiacos)	☐ TB (Tuberculosis)	☐ Asthma (Asma)	☐ No History (Ningun Historial)

Before your accident, have you ever had any of the following/Has tenido dolor de las siguentes ANTES del accidente?

☐ Jaw Pain (mandibula)	☐ Arm Pain (brazo)	☐ Leg Pain (piema)	☐ Foot/Ankle Pain
☐ Neck Pain (Cuello)	☐ Mid Back Pain (centro)	☐ Hip Pain (cadera)	☐ Shoulder Pain (hombro)
☐ Low Back Pain (espalda baja)	☐ Knee Pain (rodilla	☐ No History (Ningun Historial)	

The information which I have provided is true and complete to the best of my knowledge.

Patient Signature:______________________________ **Date:**____________________

Any person who knowingly files a statement of claim containing any False or Misleading information is subject to criminal and civil penalties.

Date:__________________

MRN:_________________

NEW SOUTH MEDICAL

CONSENT TO TREAT

_____ I, the undersigned, hereby authorize the Doctors of New South Medical (NSM) and whomever they may designate as their assistants to perform diagnostic tests and to administer treatment as is necessary to me. I also certify that no guarantee or assurance has been made to the results that may be obtained.

CONSENT FOR TREATMENT OF MINOR

_____ I hereby authorize the Doctors of NSM and whomever they may designate as their assistants to perform diagnostic test and to administer treatment as he/she deems necessary to my child.(Child's name) ____________________ of which I am the legal guardian.

REQUEST FOR PAYMENT

_____ I hereby authorize my insurance Company/Insurance Administrator to pay to New South Medical for any benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in the current manner, any balance of said applicable charges out of the proceeds of my settlement and understand that my attorney will be billed for said balance. I agree that this office be given power of attorney to endorse/sign my name on any and all draft of payment of my outstanding medical bill.

DISCLOSURE

_____ I hereby acknowledge I have been informed that New South Medical may have a direct or indirect vested interest in the services provided by Empire Rehab Clinics.

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

_____ I the undersigned patient am directing my Attorney ____ to pay any outstanding bills out of my settlement and in effect protect any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement judgment or verdict by which I may eventually recover said fee. 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 payment as services are rendered.

3414 Peachtree Road, Suite 775
Atlanta, Georgia 30326

PAYMENT POLICY

_____ Health Insurance: Proof of insurance must be provided for us to file claims with your insurance company. Please understand that benefits through health insurance policies differ. Insurance companies pay according to your individual policy limits. Benefits are between you and your insurance company. You with your insurance company MUST handle any discrepancies regarding benefit coverage. Any portion of your bill that is not paid by your health insurance will be billed to your Attorney and will be paid at the time of your settlement.

_____ Auto Insurance: We cannot file against the adverse driver's insurance in an automobile accident. If MED PAY is available, we can and will file against either your automobile insurance, or the owner of the vehicle you were a passenger in. If medical benefits are available there may be a maximum allowable amount of coverage, which may not cover all charges in full. In that event you will be responsible for the remaining balance and your Attorney will be billed

_____ Worker's Compensation: We will file with your workers compensation insurance company upon approval of each visit or procedure by the proper authority in the case. Should the case be controverted or denied for any reason we cannot file with the workers compensation insurance on future claims, and you will be responsible for the unpaid claims unless financial arrangements with your attorney have been made.

PATIENT REFUND POLICY

The doctors of New South Medical expect to be paid by the first available means whether by health insurance, med pay or settlement of your case. Should an overpayment be made, and you have a credit balance on your account, a refund will be issued to either you or the appropriate party.

I understand, agree to, and will abide by all of the above information.

Print Name: ____

(Patient name or responsible party)

Patient Signature:____ Date:________________________________

Date:__________________

MRN:_________________

NEW SOUTH MEDICAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.
NEW SOUTH MEDICAL is required by law to maintain the privacy and confidentiality of your protected health information.

DISCLOSURE OF YOUR HEALTH INFORMATION

Treatment-We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment-We may disclose your health information to your insurance provider for the purpose of treatment, payment, or healthcare operations.

Workers Compensation-We may disclose your health information as necessary to comply with State Workers Compensation Laws.

Emergencies-We may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infections exposure.

Public Health- As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting disease or infection exposure. Judicial and administrative Proceedings-We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement- We may disclose your health information to law enforcement official for purposes such as identifying or location a suspect fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.
Deceased Persons-We may disclose your health information to coroners or medical examiners.
Organ Donation- We may disclose your health information to an organization involved in procuring, banking or transplanting organs and tissues.

Research we may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

Public Safety-It may be necessary to disclose your health information to appropriate person in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized Government Agencies- we may disclose your information for military nation's security, prisoner and government benefits purposes.

Marketing-We may contact you for marketing purposes or fundraisings purposes. We may call you at home to remind you of appointments and may Leave a message is there is no answer you are not available. No health information will be disclosed other than the date and time of your next appointments we may send a letter, postcard, invitation, or call your home in order to participate in certain events. We may from time to time send you newsletters, birthday cards, reminder cards, holiday greeting cards, thank you cards or office letters.
Change of Ownership In the event that. NEW SOUTH MEDICAL is sold or merges your health information/record will become the property of the new owner.

Your Health Information Rights- You have the right to request restrictions on certain uses and disclosures of your health information. of New South Medical is not required to agree to the restriction. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location. You have the right to provided and explanation and about how you can disagree with the denial. You have the right to receive an accounting of disclosures of your protected health information. You have a right to a copy of this Notice of Privacy Practice any time upon request.

Treatment-This office uses open room adjusting and therapy. Per request we will accommodate you to a closed room for adjusting and therapy.

Changes to this Notice of Privacy Practices- NEW SOUTH MEDICAL reserves the right to amend this Notice of Privacy Practices at any time and will make the new provisions effective for all information it maintains. If you have any questions about any part of this notice or if you want more information contact NEW SOUTH MEDICAL. If no one is available you may make an appointment to meet with a manager in person or via telephone within two workings days.

Complaints-Complaints about how anyone has handled our health information show are directed towards a manager. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS,office of Civil Rights
200 Independence Ave, S.W;
509F HH Building; Washington D.C, 20201

This notice is Effective as of May 1, 2023

I have read the Privacy Notice and understand my rights contained in the notice, By way of my signature I provide NEW SOUTH MEDICAL with my authorization and consent to use and disclose my protected health information for the purposes of treatment. Payment and heal care operations as described in this notice. The staff of NEW SOUTH MEDICAL has explained the Notice of Privacy Practices to my satisfaction. I am aware the NEW SOUTH MEDICAL has the right to change the terms of its notice and make any new provisions effective for all protected health information that it maintains.

Patients Name (PRINT) **Patients Signature** **Date**

Date:________________

MRN:________________

NEW
SOUTH
MEDICAL

RELEASE OF MEDICAL RECORDS

Patient Name:___________________________

Date of Birth:____________________________

SSN:___________________________________

I,___________________________________, request the release of my X-Rays, MRI's, CT's, and/or medical

records from ____.

I release NEW SOUTH MEDICAL from any and all claims resulting from the release as I realize they are part of your permanent records.

______________________________ ____________________
Patient Signature **Date**

Please email all records from _____________ to _____________ to info@newsouthmedical.com.

3414 Peachtree Road, Suite 775
Atlanta, Georgia 30326

Date:___________________

MRN:_________________

NEW SOUTH MEDICAL

MOTOR VEHICLE COLLISION QUESTIONNAIRE

Date of accident: _________________________

Did the pain start instantly? Yes ☐ No ☐

Did you lose consciousness? Yes ☐ No ☐

X Ray, MRI, or CT Testing Yes ☐ No ☐

Any prescribed medications? Yes ☐ No ☐ If yes, what and who prescribed it? _________________________________

COLLISION DESCRIPTION (PLEASE CIRCLE ALL THAT APPLY)

Single vehicle collision	Three or more vehicles	Rear end collision	Head on collision
Driver side collision	Passenger side collision	Off center impact	Roll over
Ran off the road	Hit guard rail, tree or other object		

TYPES OF VEHICLES INVOLVED

Year, make, and model of the vehicle you were in:___________________________________

Year, make, and model of the other vehicle(s):______________________________________

BODY DESCRIPTION

Were you the driver? Yes ☐ No ☐ If no, where were you sitting?________________________________

Were you wearing a seatbelt Yes ☐ No ☐ If yes, did it bruise you?______________________________________

Did your body hit inside the car? Yes ☐ No ☐ If yes, which body part?______________________________________

Did the airbags deploy? Yes ☐ No ☐

Did the seat break? Yes ☐ No ☐

Did your head hit the headrest? Yes ☐ No ☐

Both hands on the steering wheel? Yes ☐ No ☐

Was your foot on the break Yes ☐ No ☐

Did the driver of your car or you get a cited ticket? Yes ☐ No ☐

Did the driver of the other vehicle get a cited ticket? Yes ☐ No ☐

Was your car able to drive away? Yes ☐ No ☐

Did the police issue a report? Yes ☐ No ☐

____

Patient/Guardian Signature:

____

Date:

Date:__________________

MRN:_________________

NEW SOUTH MEDICAL

INFORMED CONSENT

I hereby request and consent to the performance of medical care and medical procedures, including various modes of interventional pain management, joint and spine injections, and diagnostic procedure on me (or on the patient named below, for whom I am legally responsible) by the medical doctor/nurse practitioner/physician assistant/medical assistant named below and/or other licensed doctors who now or in the future work at the clinic or office listed below or any other office or clinic affiliated with NEW SOUTH MEDICAL.

I have had an opportunity to discuss with the medical provider named below and/or with other office or clinic personnel the nature and purpose of medical care and medical procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine there are some risks to treatment, including but not limited to; temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first visit. Dizziness, nausea, and flushing: these symptoms are relatively rare. It is important to notify the medical provider and/or clinic if you experience these symptoms during or after your care. Fractures: When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your medical provider if you have been diagnosed with a bone weakening disease or condition. If your medical provider detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. Disc herniation or prolapse. spinal disc conditions like bulges or herniations may worsen even with medical care. It is important to notify your medical provider if symptoms change or worsen. Stroke: A stroke may be associated with medical procedures. Other symptoms or outcomes associated with medical care and/or procedures may be, but not limited to the following: redness, itching, burning at site of injection; bleeding, bruising at site of injection; extremity weakness, numbness, tingling; paralysis; blood clot; death.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I will rely upon the doctor to exercise judgment during the course of the procedure.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: ______________________________ **Date:** ______________________________

3414 Peachtree Road, Suite 775
Atlanta, Georgia 30326

Date:_________________

MRN:________________

NEW SOUTH MEDICAL

ASSIGNMENT OF PROCEEDS AND/OR LIEN FOR MEDICAL SERVICES HIPPA AUTHORIZATION

ATTORNEY NAME AND ADDRESS:

____

____

____

DATE OF INJURY:

____

I hereby authorize and direct my attorney, to pay directly to New South Medical ("NSM"), such sums as may be due and owing for professional services rendered to me both by reason of this accident aby by reason of any other bills that are due to the provider and to withhold such sums from my settlement of judgement as is necessary to adequately protect the provider.

I hereby further give a lien to the provider on any proceeds to which I may become entitled as a result of any settlement of judgment in any claim or litigation arising out of the injuries for which I have been treated of injuries in connection therewith, whether such proceeds are remitted directly to me or to you, my attorney.

I fully understand that I am directly responsible to the provider for all professional bills submitted by the provider for services rendered to me by the provider and that this agreement is made solely for the providers' additional protection and in consideration of the provider awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

Additionally, I understand that, in accordance with the Health Information Portability and Privacy Act of 1996 (HIPPA), my medical information may be shared in order to manage and expedite my medical care. I authorize **NEW SOUTH MEDICAL** and its affiliated medical providers to secure, release and disclose such medical information as provided herein. My signature is an acknowledgement that I have received a copy of this authorization assignment.

Finally, the undersigned attorney agrees to notify the doctors immediately of the name and contact information of any attorney substituted in his or her place.

ATTORNEY'S SIGNATURE | DATE

SIGNATURE OF PATIENT | SIGNATURE OF PARENT/GUARDIAN

ACKNOWLEGEMENT OF ASSIGNMENT & LIEN BY ATTORNEY

The undersigned being the attorney of record on his/her own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his/her stead 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 **NEW SOUTH MEDICAL.**

ATTORNEY'S SIGNATURE | DATE

*NOTE TO ATTORNEY, PLEASE SIGN AND RETURN ONE COPY OF THIS DOCUMENT TO **NEW SOUTH MEDICAL** AND KEEP A COPY FOR YOUR RECORDS.