WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two INSURANCE INFO

Primary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

❑ Credit Card - ____

____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

five 5 REASON FOR VISIT

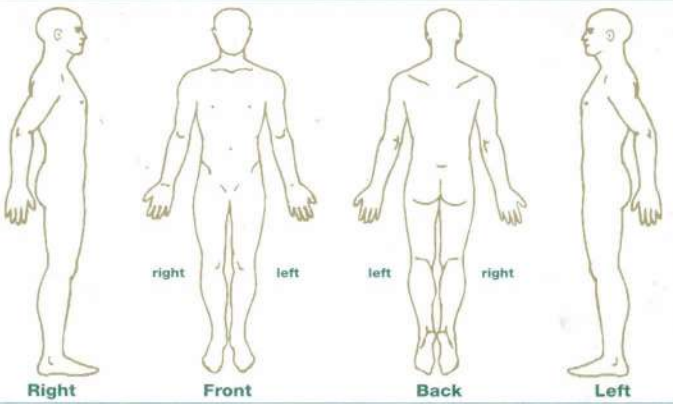
Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness
Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity
When did your condition/accident occur? ___/___/___ Where did your injury occur? _____
Please explain what happened: _____
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.
Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: _____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

Have you ever been treated by a Chiropractor? ❑Yes ❑No
Clinic or Dr's name: _____
Clinic phone#: _____



six 6 HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History: _____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes _____ hours per week
Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
For woman: Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials ___ Date ___/___/___
Comments
Initials ___ Date ___/___/___
Comments
Initials ___ Date ___/___/___
Comments

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____ _____ _____

Printed Name Signature Date

WITNESS:

_____ _____ _____

Printed Name Signature Date

X-RAY CONSENT FORM

Patient: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please Choose One:

_____ I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose not to have any x-rays at this time and release my doctor of all liabilities.

Signature:_____ Date: _____

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant	_____yes	_____no	_____ don't know
I could be pregnant	_____yes	_____no	_____ don't know
My menstrual period is late	_____yes	_____no	_____ don't know
I have an IUD	_____yes	_____no	
I have had a tubal ligation	_____yes	_____no	
I have had a hysterectomy	_____yes	_____no	
I have irregular menstrual periods	_____yes	_____no	
My last menstrual period began	_____		
I have begun menopause	_____yes	_____no	

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: _____ Date: _____

Insurance Compliance Form

We would like to take a moment to welcome you to our office and assure you that your treatment is our top priority. We find that many patients are very confused when using their insurance and are concerned about their financial obligations. This form is utilized to explain your responsibilities when our office files your insurance.

At North Decatur Health Care, our staff provides you with all insurance filing at the time of service. We will verify all insurance benefits to assure your chiropractic/medical coverage's in full. However, we need to make you aware that these benefits are not a guarantee of payment and you will ultimately be responsible for all services that are not paid by your insurance company. It is very important that you understand that our office, as a service to our patients, will submit and make all attempts to collect all outstanding payments. We will not enter into any disputes with your insurance company. If your account remains in an outstanding status, our staff may request your help in expediting payment from your insurance company.

Each patient is required to meet their deductible in full before their insurance company will pay their portion. At this time, our staff will notify you of your out of pocket expense at your time of service. Most insurance company policies require a payment of 30%-50% of the patients visit. Our staff is required to collect this amount at the time of service. If your insurance policy requires a co-pay, this amount will be requested at the time of service. It has become a standard that doctors' request all payment in full at the time of service. Our office continues to service our patients the old fashion way and will do the work for you. This allows you to focus on your health.

Personal Injury Patient With Health Insurance:
If you were involved in an automobile accident and have a health care policy, our office will submit all charges at the time of service. You will not be responsible to pay for any deductible or co-pay at the time of service. Any outstanding balance will be reimbursed by your attorney when your case is settled.

What To Do When My Insurance Company Sends Me A Check:
Many insurance companies will send the member (patient) a check to your home instead of our office by accident. If this situation occurs, please be advised that you are to call our office immediately and send all checks endorsed by you to our office. Under Georgia Law, our office will charge a 25% finance fee for any fees that are received and not returned within 30 days of receipt.

What Do I Do If My Insurance Company Sends Me Forms That I Do Not Know How To Answer?
Many times an insurance company will send a patient a questionnaire for them to fill out. These forms purposely are used as stall tactics and are quite confusing for you to understand. When you receive these letters, please either call our office or bring them to our office manager for proper clarification.

Financial Consent/Patient Agreement:
I understand and agree to the services that my doctor has offered to me. I agree to be fully responsible for any services that are not paid by my insurance company and understand that my doctor will send all outstanding accounts to a collection agency after 60 days if not reconciled by the responsible party.

X_____ Date: _____
Patient Signature

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **North Decatur Health Care** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ❑ I give permission to **North Decatur Health Care** to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

- ❑ I give **North Decatur Health Care** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

- ❑ By signing this form you are giving North Decatur Health Care permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **North Decatur Health Care**. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **North Decatur Health Care** for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **North Decatur Health Care** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

- * A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU * *

Print Name of Patient:_____

Signature of Patient:_____

Date:_____

Signature of Personal Representative:_____

Description of Representative's Authority To Act for Patient:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

_____ _____

Patient Signature Date