ATLANTA HEALTH & CHIROPRACTIC

WELCOME

ABOUT YOU

Today's Date:_____ /_____/_____

Patient's Name:_____ Preferred Name:_____

Last First MI

Male ☐ Female ☐ Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Birthdate: _____ /_____/_____ Age: _____ Email_____

Mailing Address: _____ Home Phone: _____

_____ Work Phone:_____

City _____ State_____ Zip _____ Cell Phone: _____

How Did You Hear About Us (Circle): Facebook Google Yelp Instagram Twitter Pinterest Other: _____

Employer: _____ Occupation:_____

Spouse's Name: _____

Do you have children? ☐ Yes ☐ Divorced If yes, how many?_____

Sports

Affiliation: (ex. Alta Tennis) _____

Interests: ☐ Golf ☐ Tennis ☐ Football ☐ Soccer ☐ Cheerleading ☐ Running ☐ Weight Training ☐ Baseball

Other Interests: _____

Type of Injury: _____

Reason For Visit

The reason for this visit is a result of (Please Check): ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic

Explain what happened: _____

_____

Please describe the pain and its location:_____

_____

When did the condition begin? _____ /_____/_____

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is this condition interfering with your (Please Check): ☐ Work ☐ Sleep ☐ Daily Routine

If so, please explain: _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: _____

Have you been treated by a medical Physician for this condition? ☐ Yes ☐ No

If so, where? _____

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No

If so, whom? _____ Phone # _____

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Lifestyle

Do you take Supplements or Vitamins? ☐ Yes ☐ No

If so, what kind: ☐ Multi ☐ Energy ☐ Anti-Inflammatory ☐ Joint Care ☐ Immune Building ☐ Bone Care

Other: _____

Do you exercise regularly? ☐ Yes ☐ No If yes, what type of exercise? _____

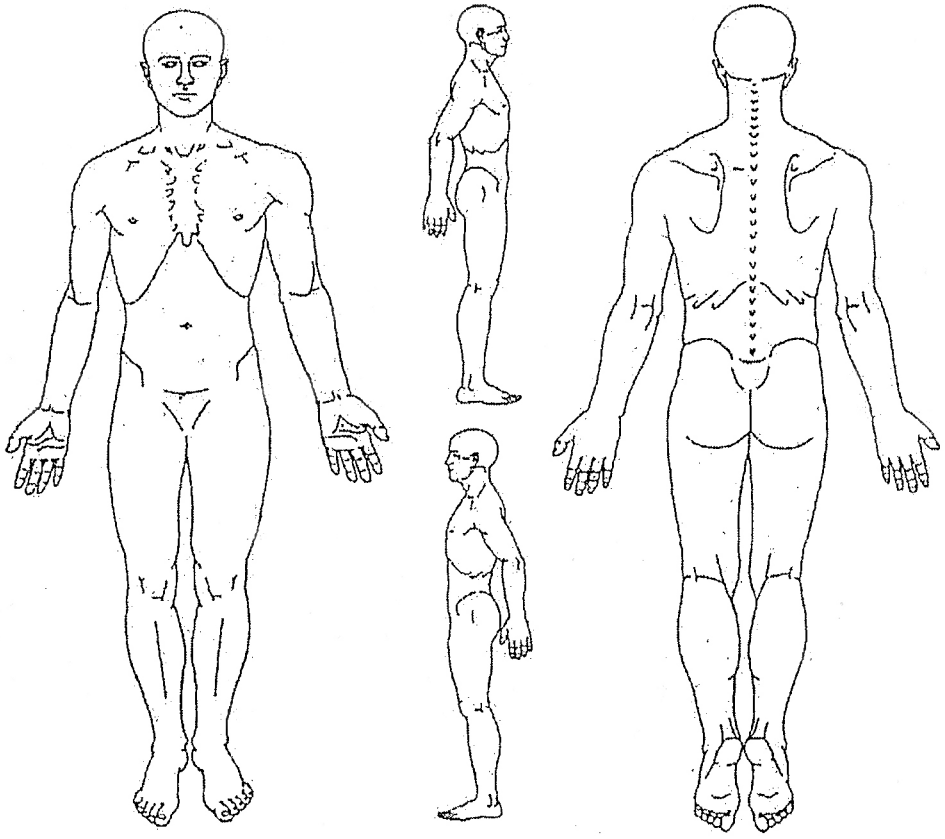
Do you have allergies? ☐ Yes ☐ No If yes, for how many years?_____

Are you interested in weight loss? ☐ Yes ☐ No

Pain Chart

Please mark area(s) of injury or discomfort as show in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Description	→ Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol	→ NNNN	PPPP	BBBB	AAAA	SSSS



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In the event of an emergency

Who should we contact: _____

Relation: _____

Home Phone: _____ Work Phone: _____

Who is your Medical Doctor: _____ Phone: _____

Health History

Are you taking any of the following medications?

☐ Never Pills ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers

☐ Insulin Other(s):_____

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

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	Y	N	Shingles	Y	N	Cancer
Y	N	Frequent Neck Pain	Y	N	Emphysema/Glaucoma	Y	N	Anemia
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	Ulcer/Colitis
Y	N	Fainting/Seizures/Epilepsy	Y	N	Sinus Problems	Y	N	Asthma
Y	N	Diabetes/Tuberculosis	Y	N	Difficulty Breathing	Y	N	Chemotherapy
Y	N	Lower Back Problems	Y	N	Artificial Bones/Joints	Y	N	Arthritis

Please list any other serious medical condition(s) you have or ever had:_____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List past serious accidents with dates: _____

Family Health History: _____

Are you on a special diet: ☐ Yes ☐ No If yes, since: _____ /_____/_____

Do you smoke: ☐ Yes ☐ No How much: _____ How long:_____

Are you wearing: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

Current Height _____ft _____in Current Weight _____lbs

For Women:

Are you taking Birth Control ☐ Yes ☐ No

Are you pregnant: ☐ Yes ☐ No If yes, how long: _____ Nursing: ☐ Yes ☐ No

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Late Policy for Chiropractic Appointments

Chiropractic adjustments are scheduled for 15-20 minutes. If you are 10 minutes late to your chiropractic appointment, your appointment will have to be rescheduled. This keeps the doctors on schedule and patient wait time down. You may also elect to see the doctor for a shortened appointment if needed. However, the full fee will still be collected.

Cancellation Policy for Appointments

All patients must cancel their scheduled message and/or chiropractic appointments 24 hours in advance. Failure to do so will result in a 100% charge if appointment is not cancelled within 24 hours of the scheduled time.

Thank you for your cooperation,

Atlanta Health & Chiropractic

I am aware of the late policy for chiropractic appointments and cancellation policy

Patient Name _____

Signature _____

Date____/____/_____

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Consent to use PHI & Authorization for Treatment

Acknowledgement for Consent to Use and Disclose Protected Health Information & Authorization for Treatment

Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Use and Disclosure of your Protected Health Information: Your protected Health Information will be used by Atlanta Health & Chiropractic, or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices: You should review the Notice of Privacy Practices for a more complete description of how Your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

_____ *Patient Initials*

Requesting a Restriction on the Use and Disclosure of Your Information:

1. You may request a restriction on the use and disclosure of your Protected Health Information.

2. This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

3. If we agree to your request, the restriction will be binding with this office. Use or disclosure of Protected Health Information in violation of an agreed upon request will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas: Atlanta Health & Chiropractic utilizes common treatment rooms for restorative therapies including, but not limited to, Hyperbaric Oxygen Therapy, Micro-Current, and Class IV Laser. A private treatment room can be provided upon request.

Resolution of Disputes: In the rare circumstance that a dispute arises regarding any matter connected with this office, I agree that independent arbitration will be entered into and completed before any legal action can be taken. I further understand that If I am not satisfied with the results of the arbitration, I am free to pursue any other legal remedy at that time.

(Female Patients ONLY) Verification of Non-Pregnancy: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed, at this particular time.

The date of last menstrual period _____ (start/end).

Permission to Evaluate and Treat a Minor Child/Dependent Adult: I authorize the office to evaluate and treat _____.

Revocation of Consent: You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation and consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information & receive treatment.

_____ _____

Patient or Legally Authorized Individual Signature Date

???

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OFFICE FINANCIAL POLICY

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity and expertise required of the care rendered to you. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Our policy requires payment at time of service unless specific arrangements have been made in advance. Our agreement is with you and not your insurance company. Payment to our office is not contingent upon payment by your insurance company. You are considered a cash patient and you are financial responsible for you bill. If you do not pay your bill or set up a payment plan in a timely manner we will send you to collections.

If you have pre-paid for any services and do not receive them or if you cancel any pre-paid services, you will receive a pro-rated refund following a complete resolution of any outstanding payments.

If a check is returned, there will be a $30 service fee charged.

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I have read and understand my financial responsibilities under this financial policy.

Guarantors Printed

Name:_________________________ Relationship: _______________________

Signature: ____ Date: ___________________________

ONLY if the responsible party will not be present to make payment, you may leave your Credit Card information on file with us. We follow the PCI Regulations for your protection.

( ) American Express ( ) Master Card ( ) Visa ( ) Discover Card #:____

Expiration Date: __________________ Name as it appears on card:____

Billing Zip Code __________ Signature: ____
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