ALLEN CHIROPRACTIC

This form must be filled out completely before seeing the doctor

Confidential Patient Health Record

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

SS#_____ Age: _____ DOB: _____

Sex: _____ Marital Status: M S W D Number of children: _____

E-Mail:_____

Who referred you to our office? _____

Employment Information

Occupation: _____

Employer: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone: _____

Auto Accident Information

Please complete if you have been in an auto accident in the past 2 years

Date of Accident: _____ State of accident: _____

Auto Insurance Co Name: _____

Policy Number: _____ Dr. Lic#:_____

Was there an accident report? Y / N (Circle One)

Claims Adjuster's Name: _____

Claim Number: _____ Phone#:_____

Attorney: _____ Phone#:_____

Emergency Information

Contact Name: _____

Relationship: _____

Contact Phone: _____

Spouse Information

Spouse Name: _____

Spouse SS#: _____

Occupation: _____

Employer: _____

Work Phone: _____

Do you currently take any vitamin / supplements? Y N Are you interested in learning about nutritional supplements? Y N

Insurance Information

Primary Insurance Co. Name: _____ Policy/Group#:_____

Relationship to Insured:_____ Name of Insured:_____

SS# of Insured:_____ DOB of Insured: _____

Address of Insured: _____City:_____State:_____Zip:_____

Desired method of payment: ( ) Cash ( ) Check ( ) Credit Card

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. I understand the above information and guarantee this form was completed correctly and to the best of knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date:_____

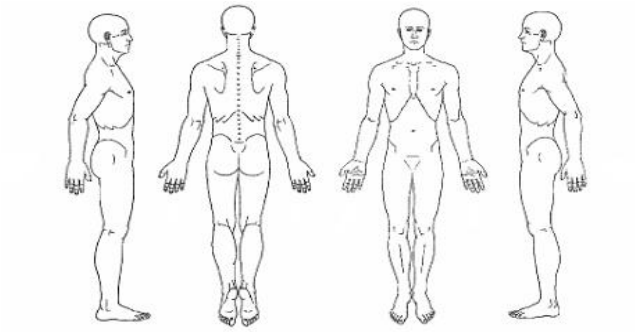
Allen Chiropractic
1050 Richard D. Sailors Pkwy Ste 200
Powder Springs, GA 30127
770 943-8409

PATIENT INTAKE FORM

Patient Name:_____ **Date:**_____

1. Is today's problem caused by: ☐ **Auto Accident** ☐ **Workman's Compensation**

2. Indicate on the drawings below where you have pain/symptoms.



3. How often do you experience you symptoms?
- ☐ **Constantly (76 - 100% of the time)**
- ☐ **Occasionally (25 - 50% of the time)**
- ☐ **Frequently (51 - 75%)**
- ☐ **Intermittently (1 - 125% of the time)**

4. How would you describe the type of pain?
- ☐ **Sharp**
- ☐ **Dull**
- ☐ **Diffuse**
- ☐ **Achy**
- ☐ **Burning**
- ☐ **Shooting**
- ☐ **Stiff**
- ☐ **Numb**
- ☐ **Tingle**
- ☐ **Sharp with motion**
- ☐ **Shooting with motion**
- ☐ **Stabbing with motion**
- ☐ **Electric like with motion**
- ☐ **Other:** _____

5. How are you symptoms changing with time?
☐ **Getting Worse** ☐ **Staying the same** ☐ **Getting better**

6. Using a scale from 0 - 10 (10 being the worst) how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (please circle)

7. How much has the problem interfered with your work?
☐ **Not at all** ☐ **A little bit** ☐ **Moderately** ☐ **Quite a bit** ☐ **Extremely**

8. How much has the problem interfered with your social activities
☐ **Not at all** ☐ **A little bit** ☐ **Moderately** ☐ **Quite a bit** ☐ **Extremely**

9. Who else have you seen for your problem?
- ☐ **Chiropractor**
- ☐ **Neurologist**
- ☐ **Primary Care Physician**
- ☐ **ER Physician**
- ☐ **Orthopedist**
- ☐ **Other:**_____
- ☐ **Massage Therapist**
- ☐ **Physical Therapist**
- ☐ **No one**

10. How long have you had this problem? _____

11. How do you think your problem began? _____
_____

12. Do you consider this problem to be severe?
☐ **Yes** ☐ **Yes at times** ☐ **No**

13. What aggravates your problem? _____

14. What concerns the most about your problem: what does it prevent you from doing?_____
_____

15: What is your? Height_____ **Weight**_____ **DOB**_____

16. How would you rate your overall Health?
☐ **Excellent** ☐ **Very Good** ☐ **Good** ☐ **Fair** ☐ **Poor**

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis	☐ Diabetes	☐ Lupus
☐ Heart Problems	☐ Cancer	☐ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking Tobacco
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stone	☐	☐ Allergies
☐	☐ Elbow/ Arm Upper Pain	☐	☐ Kidney Disorder	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper leg pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Abnormal Weight Gain/Loss		
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite		

For Females Only

☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐ Birth Control Pills
☐	☐ Joint Pain/stiffness	☐	☐ Ulcer	☐	☐ Hormonal Replacement
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Pregnancy
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder Disorder		
☐	☐ Cancer	☐	☐ General Fatigue		
☐	☐ Tumor	☐	☐ Muscular In coordination		
☐	☐ Asthma	☐	☐ Visual Disturbances		
☐	☐ Chronic Sinusitis	☐	☐ Dizziness		
☐	☐ Other: _____				

20. List all prescription medications you are currently taking:

_____

21. List all of the over-the-counter medications you are currently taking:

_____

22. What activities do you do at work?

_____

23. What activities do you do at work?

☐ Sit: ☐ Most of the day ☐ Half the day ☐ A little of the day
☐ Stand ☐ Most of the day ☐ Half the day ☐ A little of the day
☐ Computer work: ☐ Most of the day ☐ Half the day ☐ A little of the day
☐ On the Phone ☐ Most of the day ☐ Half the day ☐ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? ☐ No ☐ Yes
If yes why_____

26. Have you had significant past trauma? ☐ No ☐ Yes

27. Anything else pertinent to our visit today?_____

Patient Signature_____**Date:**_____

Allen Chiropractic

This form must be filled out completely before seeing the doctor

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **Allen Chiropractic** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

** I give permission to **Allen Chiropractic** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards information about treatment alternatives or other health related information.

** If **Allen Chiropractic** contacts me by email and/or phone, I give them permission to leave an email and/or phone message on my answering machine or voice mail or leave a message with a family member.

** I give **Allen Chiropractic** 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 **Allen Chiropractic** 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: **April 1, 2020**

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 **Allen Chiropractic.** 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 **Allen Chiropractic** 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, Allen **Chiropractic** will not refuse to provide treatment.

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

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST

_____ _____

Patient Signature Date

If this authorization is signed by a personal representative of the patient, complete the following:

_____ _____

Personal Representative Name Relationship to Patient

Allen Chiropractic

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PATIENT NAME: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Contact Person:_____ at _770-943-8409_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Allen Chiropractic

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR BY PRIVATE INSURANCE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient's Name **Contact Phone**

_____ _____

Address_____

City_____**State**_____**Zip**_____

Claim/Group #_____

SS#/ID# _____

I hereby instruct and direct the _____Insurance Company to pay by check made out and mailed directly to:

Allen Chiropractic
1050 Richard D. Sailors Pkwy Suite 200
Powder Springs, GA 30127

If my current policy prohibits direct payments to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Allen Chiropractic
1050 Richard D. Sailors Pkwy Suite 200
Powder Springs, GA 30127

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this agreement shall be considered as effective and valid as the original.

I hereby authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____

Signature **Witness**

NO SHOW POLICY

Our office requires *a 24-hour notice for all missed appointments*. If you can't make an appointment please give our office a call at 770 943-8409. This will allow others an appointment that may need care. By calling our office you will *avoid a $30.00 no show fee*.

Date_____

Signature_____

Fee for completion of forms, reports and letters:

This is a non-insurance covered service which requires time from administrative staff. As well as doctors; therefore a fee of $15.00 will be charged for the completion of forms or the writing of letters.

Date _____

Signature_____

PAYMENT AGREEMENT:

The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not the insurance company. Allen Chiropractic cannot accept total responsibility for collecting an insurance claim or negotiation a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing the agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or pre-certification procedures

INITIALS: _____

I understand the above information and guarantee this form was completed correctly and to the best of knowledge and I understand it is my responsibility to inform this office of any changes In my medical status.

PATIENT NAME _______ **Date of Birth** _____

SIGNATURE _____ **DATE** _____