PATIENT INTAKE FORM

PATIENT INFORMATION

Date: _____

Name: _____ _____ _____
(First Name) (Last Name) (Middle Initial)

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Telephone: _____ _____ _____
(Home) (Work) (Cell)

Email: _____

Emergency Contact: _____ _____ _____
(Name) (Relationship) (Phone Number)

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ Spouse's DOB: _____ Number of Children: _____

Occupation: _____ ☐ Full-time ☐ Part-time ☐ Student ☐ Retired

Employer / School: _____

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Who may we thank for referring you to our office? _____

Would you like to receive emails from us? ☐ Newsletters ☐ Promotions ☐ Announcements ☐ Classes

WHAT BRINGS YOU TO OUR OFFICE?

Primary Complaint: _____

Date when symptom first appeared: _____ Did it begin: ☐ Gradual ☐ Sudden ☐ Progress over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb

Does the pain radiate into your: ☐ Arm ☐ Leg ☐ Does not radiate

Do you have Numbness or Tingling? ☐ Y ☐ N If yes, how often: ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (*1 being no symptoms; 10 being extreme*) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you have any family members who suffer the same complaint? If so, who? _____

_____

Other Complaints (*please describe any additional complaints you have*) _____

_____

_____

_____

ABSOLUTE HEALTH CHIROPRACTIC
95 CLIFTWOOD DRIVE NE ♦ SUITE C ♦ SANDY SPRINGS, GA 30328
404-257-0188 ♦ askdrcathy@clear.net ♦ www.dr-cathy.com

PATIENT INTAKE FORM

Do you smoke? ☐ Y ☐ N If yes, how many packs per week? _____

Have you smoked in the past? ☐ Y ☐ N If yes, when did you quit? _____

Do you take birth control pills? ☐ Y ☐ N Have you ever taken birth control pills in the past? ☐ Y ☐ N

Do you consume alcohol? ☐ Y ☐ N If yes, how many drinks per week? _____ Type: _____

Do you consume caffeine? ☐ Y ☐ N If yes, how many drinks per day? _____

Do you exercise? ☐ Y ☐ N If yes, how many times per week? _____ Type: _____

Do you have a high stress level? ☐ Y ☐ N If yes, list reasons: _____

Please list any medications, vitamins or supplements you are currently taking:

_____

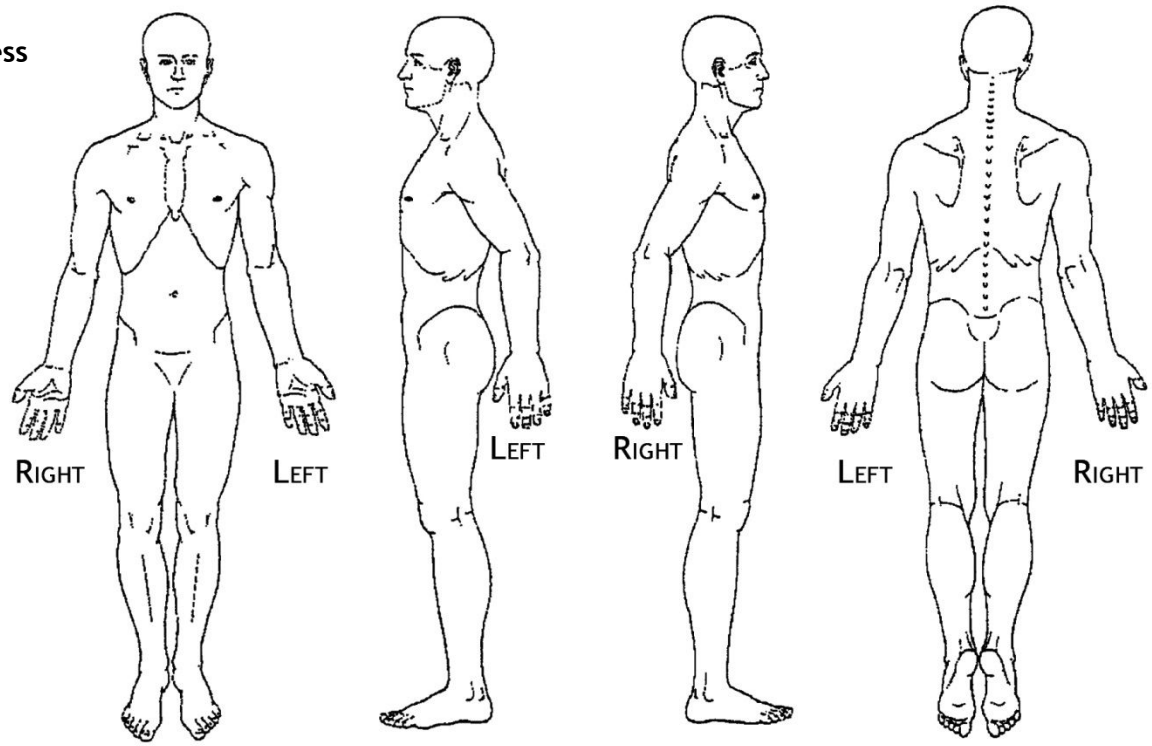
_____

_____

_____

Please mark the areas of your complaint on the diagram with the following indicators:

P = pain
N = numbness
T = tingling
B = burning
C = cramps
X = other



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PATIENT HISTORY

Please list all surgeries, injuries, accidents, falls etc. _____

_____

_____

_____

Please check if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Disc Degeneration
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ MS
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Vascular Disease
- ☐ Venereal Disease
- ☐ Whooping Cough

☐ Other: _____

Patient Signature: _____ **Date:** _____

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 soreness 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 risk 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.

I have read, or have had read to me, 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 hereby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interests.

_____	_____	_____
Patient Name (printed)	***Patient / Guardian Signature*** *(Guardian, if patient is under 18 years old)*	***Date***
_____	_____	_____
Witness Name (printed)	***Witness Signature***	***Date***

OFFICE FINANCIAL POLICY

Our Mission at **ABSOLUTE HEALTH CHIROPRACTIC** is to provide you the best chiropractic care possible in a caring environment and to improve your relationship with your innate healer. We have established our financial policies to reflect that goal. You will be expected to pay for our chiropractic care at the time services are rendered unless other arrangements are made in advance. Other arrangements include yearly, monthly or weekly payment options. Details of these options will be discussed with you when the doctor goes over our recommendations to get your spine and nervous system as healthy as possible.

Cancellation of your appointment without 24 hours notice will result in a $35 cancellation fee.

HEALTH INSURANCE

ABSOLUTE HEALTH CHIROPRACTIC (AHC) accepts most major Medical Insurance, Medicare and Personal Injury.

- **Major Medical** – **AHC** accepts most major medical insurance. As a courtesy to you, we DO file your insurance. You are responsible for your deductible, any co-pay, and anything your insurance does not pay. After ninety (90) days, if your insurance hasn't responded, we reserve the right to collect the balance from you, the patient.

- **Medicare** – **AHC** is a participating Medicare provider, meaning we will submit all Medicare claims for your convenience. Medicare covers chiropractic adjustments only. All other therapies will be the patient's responsibility.

Due to the increasing difficulty of reimbursement from insurance companies, we will file as a **COURTESY** for our patients, but expect full payments of services rendered at time of service.

Any reimbursements that we receive from filing will be applied directly to your account or you may request a "speed bill" and file directly with your insurance company. If you should choose to file directly, please notify your insurance company to have all reimbursements made out to you and sent to your address.

Our commitment is to <u>your health</u>, not your insurance coverage. Your treatment plan is based on your individual needs not your coverage. Please remember, your agreement with the insurance company is between you and them, not us and them.

Patient Signature: _____ **Date:** _____
(Guardian, if patient is under 18 years old)

INSURANCE AGREEMENT

In consideration of your undertaking to care for me, I agree to the following:

1. In the event any insurance company, obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you, or does not make payment within sixty (60) days of your billing, I will become personally responsible for the amount. I will have thirty (30) days to clear that account. If the account is not cleared in thirty (30) days, I hereby authorize you to collect any outstanding amount on my credit card listed below.

2. Any insurance checks that may be forwarded to me for services received at **ABSOLUTE HEALTH CHIROPRACTIC** and not previously paid for, will be endorsed by me and turned over to **ABSOLUTE HEALTH CHIROPRACTIC** within five (5) working days of receipt, for payment on my account. If I do not clear this portion on my account within five (5) working days of receipt of said payment, I hereby authorize you to collect the full amount of my account on the credit card listed below.

3. Any balance that is on my account will be paid for and cleared within thirty (30) days of notification of amount. If a balance remains after thirty (30) days of notification, I hereby authorize you to collect that amount in full on the credit card listed below.

Name: _____ _____
(First Name) (Last Name)

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Credit Card: ☐ MasterCard ☐ Visa ☐ American Express

Card Number: _____ Expiration Date: _____

Patient Signature: _____ **Date:** _____
(Guardian, if patient is under 18 years old)

Witness Signature: _____ **Date:** _____

HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Before we can begin any health care for you we require you to read and sign this consent form stating that you understand these policies and practices. If you do not sign this consent form, we reserve the right to refuse to provide you care in our office.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Your signature below indicates that you understand and agree to allow this chiropractic office to use your health information for the purposes of chiropractic care, payment, practice operations, and coordination of care. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for care. You may request restrictions on disclosures.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you.

Your consent on this form need only be obtained one time for all subsequent care provided to you by this office. You may provide a written request to revoke your consent at any time during your care. This would not affect the use of those records for any care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. You further agree that we may contact you for appointment reminders and follow-up, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

I have read and understand how my health information will be used by this office and I agree to these policies and procedures.

_____	_____	_____
Name (printed)	***Signature***	***Date***

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