ALLEN CHIROPRACITC

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:_____

Emergency Information

Contact Name:_____

Relationship: _____

Contact 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#:_____

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:_____

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Current Health Information **Name:** _____ **Date:** _____

Reason for beginning care: _____

_____

Describe what occurred to cause the problem and the date it began: _____

_____

Is this problem related to a recent auto accident? Y or N **Is this problem related to a recent work injury? Y or N**

How often do you experience the symptoms? (check all that apply)

_____ **Constantly 100%** _____ **Frequently 75%** _____ **Intermittently 50%** _____ **Occasionally 25%** _____ **Rarely 10%**

What makes the problem feel better? _____

What makes the problem feel worse? _____

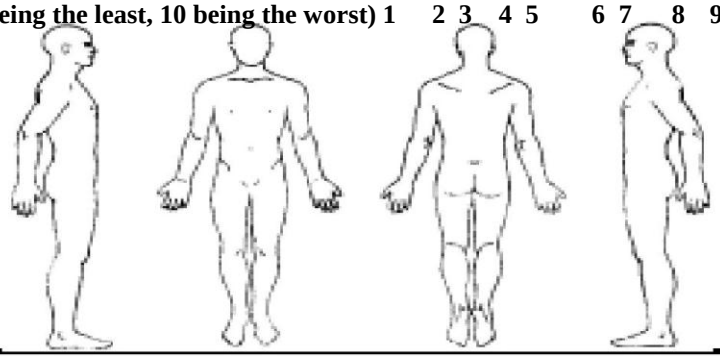
Where does the pain begin and then radiate to? _____

How would you describe the pain? _____ **Sharp** _____ **Dull** _____ **Achy** _____ **Burning** _____ **Throbbing**

_____ **Numbness / Tingling** _____ **other (describe)** _____

How severe is/are the pain/symptoms? (1 being the least, 10 being the worst) 1 2 3 4 5 6 7 8 9 10

Please mark the areas of pain on the pictures:



Previous Health History

Please list any previous treatment you have received for this condition. (name, date, result) _____

_____

Please list all previous surgeries you have had _____

_____

Please list all previous injuries / falls / accidents you have had _____

_____

Please list all medications / supplements you are currently taking _____

_____

Please list all occupational duties that aggravate your problem _____

_____

Please list any recreational activities that aggravate your problem _____

_____

Have you been to a chiropractor before? Y or N. If yes please list below:

Patient Signature _____ **Date** _____

Doctor's Notes: _____

_____

_____

_____

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Health Questionnaire (check all that apply) **Name:** _____ **Date:** _____

Heart	Lungs	EENT	Musculoskeletal	General
__Chest pains	__Asthma	__Allergies	__Neck Pain	__Liver problem
__Shortness of breath	__Bronchitis	__Sinuses	__Mid Back Pain	__Gall bladder
	__Emphysema	__Chronic Influenza	__Low Back Pain	__Diabetes
__Swelling/Edema	__Pneumonia	__Ringing in ears	__Sciatica	__Cancer
__Stroke	__Tuberculosis	__Dizziness	__Arm pain	__Thyroid problems
__Heart Attack	__Difficulty breathing	__Vertigo	__Shoulder Pain	
__Hypertension		__Loss of consciousness	__Headaches	__Epilepsy
__Arteriosclerosis	__Wheezing		__Numbness/Tingling	__Multiple Sclerosis
__Anemia	__Coughing	__Fainting	__Muscle tension	
__Other _____	__Pleurisy	__Blurred Vision	__Muscle Weakness	__HIV positive
_____	__Other _____	__Speech Difficulty	__Arthritis	
_____	_____	__Facial twitching	__Other _____	__Venereal Dx
_____	_____	__Other _____	_____	__Herpes
_____	_____	_____	_____	__Other_____

Digestive	*Urinary / Menstrual*
__Abdominal Pain	__Kidney Problems
__Ulcer	__Kidney Stones
__Heartburn	__Painful Urination
__Reflux	__Incontinence / Hesitancy
__Bloating	__Painful Menstrual Cramps
__Flatulence	__Endometriosis
__Hiatal Hernia	__Other _____
__Other_____	_____

Dr.'s NOTES

ROS _____

_____

_____

_____

_____

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:**_____

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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

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

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 not 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*.

Signature_____

Date_____

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.

Signature_____

Date_____