Atlas Chiropractic
Humber-Kirk-Umberger-Howell Chiropractic Clinic, LLC

Patient Information Date: _____

Name:_____
Last First MI

Mailing Address:_____

City State Zip Email address: _____

Phone # (H)_____ (W)_____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth:_____ Sex: ❑ Male ❑ Female **SS#:** _____

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

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity: ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

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Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Fainting
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Fever
❑ Arm/Hand Pain	❑ Cold Feet	❑ Nervousness	❑ Loss of Memory	❑ Night Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Blurred Vision
❑ Chest Pain	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Bowel/Bladder Changes
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Please check to indicate if you have ever had any of the following:

Neurological	**Respiratory**	**Skin**	**Emotional/Mental**	**Weight**
❑ Migraines	❑ Recurrent Respiratory Infection	❑ Eczema	❑ Depression	❑ Decreased Appetite
❑ Headaches	❑ Asthma	❑ Excessive Sweating	❑ Anxiety	❑ Weight Gain
❑Slurring of speech	❑ Chest Congestion	❑ Rashes	❑ Mood Swings	❑ Inability to Lose Weight
❑ Ringing in Ear	❑ Wheezing	❑ Brittle Nails	❑ Irritability	❑ Food Cravings
	❑ Frequent Sneezing	❑ Hair Loss	❑ Memory Loss	❑ Binge Eating
Ear/Nose/Throat		❑ Increased Bleeding	❑ Confusion	❑ Water Retention
❑ Altered taste/smell		❑ Numbness/tingling		
❑ Night Blindness	**Cardiovascular**		**Energy**	**GI**
❑ Sore Throat	❑ Chest pain	**Genitourinary**	❑ Fatigue	❑ Constipation
❑ Gingivitis	❑ Palpitations-racing heart beat	❑ Uterine fibroids	❑ Hyperactivity	❑ Stomach Pains or Cramping
❑ Nose bleeds	❑ Swelling in hands/feet	❑ Ovarian cysts	❑ Insomnia	❑ Bloating
	❑ Reflux or Heartburn	❑ Cancer (breast, ovarian, prostate, Uterine)	❑ Restlessness	❑ Gas
Musculoskeletal	❑ Anemia		❑ Decreased Libido	❑ Nausea or Vomiting
❑ Arthritis			❑Stress	
❑ Chronic pain				
❑ Joint Pain				
❑ Muscle Aches				

Please list any allergies: _____
Please list any supplements you are taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do have frequent falls or find that you trip over your feet while walking? NO YES
    Comment: _____
12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES
    Comment: _____
13. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication?
    _____
14. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind?
    _____
15. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for?
    _____
16. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it?
    _____
17. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: _____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Patient's Signature Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reasons to modify your care of provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

_____

Patient Signature Date

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
   a) Any postal correspondent to me at the address provided by me; and
   b) Telephoning my home/cell and leaving a message on my answering machine or with the individual answering the phone.
   c) It is the policy of HKUH to use electronic mail (email) to correspond and/or communicate necessary billing or personal information.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

PLEASE LIST BELOW ANY RESTRICTIONS REGARDING YOUR HEALTH RECORDS:

_____

_____

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) **Signature of Individual**

_____ _____

Signature of Legal Representative **Relationship**

Date Signed ____/____/____ Witness: _____

Consent for Treatment

I authorize Atlas to perform examinations that the doctor deems necessary, and the chiropractic care including spinal adjustments.

Signed: _____Witness:_____

Authorization to Perform X-rays

I authorize Atlas to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed: _____ Witness: _____

Women Only

To the best of my knowledge I am not pregnant and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

Signed: _____

Consent for Treatment of Minor

I (We) being the parent, guardian or custodians of _____ a minor, the age of _____, do hereby authorize, request and direct Atlas to perform in his judgment and necessary examination, x-rays and chiropractic treatment for the condition.

_____ _____

Parent, guardian or custodians Witness

STATEMENT OF OFFICE POLICIES

Welcome to Atlas Chiropractic. Please read and sign this policy statement below. Our staff will be happy to assist you with any questions or concerns you may have. We believe that a clear definition of our office policies will allow you, the patient, and Atlas Chiropractic to concentrate on the big issue—**REGAINING AND MAINTAINING YOUR HEALTH.**

Missed Appointment/Cancellation Policy

A missed/late cancelled appointment is a loss to three people: The patient who missed the valuable time, a patient who could have used the valuable time and the Chiropractor who was fully staffed and prepared for the appointment.
Our office considers a missed appointment to be a cancellation with less than 8 hours notice or when the patient does not show up at all. Occasionally illness or other unexpected emergencies make it necessary to cancel the appointment with less than 8 hours notice. Please contact our office immediately and we will do our best to accommodate your situation.
Failure to give advance notice: We will allow one missed/late cancelled appointment within 12 month period. Additional missed/late cancelled appointments within the 12 month period will be charged $25.00
Our number one concern is you and your family's health. Providing services in a timely manner is critical to accomplish that goal. We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to let us know.

FINANCIAL RESPONSIBILITY

INSURANCE:

Charges for treatment are due at the time the service is provided and/or a product is ordered.

Financial responsibility for services rendered rests with the patient regardless of any insurance coverage. It must be understood that your medical insurance is a contract between you and your insurance carrier. The benefits quoted by your insurance carrier is not a guarantee of payment and are subject to review based on the terms of you individual contract. Please note that you are responsible for knowing the limitations of your coverage. Your treatment plan is based on medical necessity as deemed appropriate by the Doctor of Chiropractic Specialists or your referring Physician. It is not our policy to enter into a dispute between you and your insurance carrier over any unpaid portion of your bill. Most insurance company's process claims within 15 days of receipt.

STATEMENTS:

It is the policy of ATLAS to mail as few statements as possible. If a patient balance (due from patient) is incurred, responsible parties are encouraged to mail the payment directly to ATLAS upon receiving the EOB (explanation of benefits) from their insurance company. ATLAS will make three statement attempts as well as three phone calls. If no payment is received within the third attempt the account will be turned over to the collection agency.

COPYING FEES:

Our office will be happy to produce copies of your medical records. A coping fee will be accessed based on the number of pages and you may also be responsible for any retrieval, mailing and certification fees. The fees are based on the State of Georgia's Office of Planning and Budget.

RETURN CHECKS

There will be a $35.00 fee imposed for all checks returned to this office. All returned check must be taken care of within 5 days of receipt. Any unpaid amount after 10 days will be referred to our collection agency unless specific payment arrangements have been made with our staff.

VOLUNTARY TERMINATION OF CARE

It is the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be **immediately due and payable**.

I, the undersigned, have read the statement of office policies listed above and I agree to abide by these policies.

Print name: _____Sign name: _____Date: _____

Atlas Chiropractic
Humber-Kirk-Umberger-Howell Chiropractic Clinic, LLC

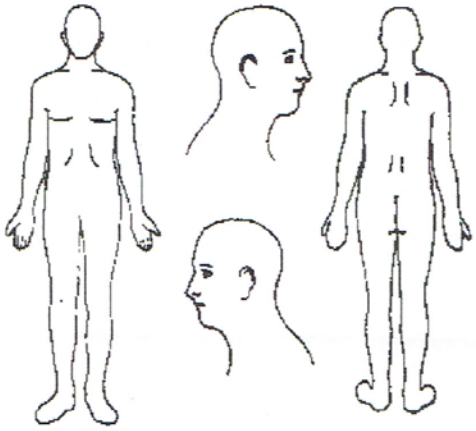
Date of Visit: ___/___/___ Patient: _____ Age: _____

What brought you here today?_____

_____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: _____

_____

Past Hospitalizations: _____

_____

Surgeries: _____

_____

Medications: _____

Patient Signature: X _____

(DO NOT WRITE BELOW THIS LINE)

EXAMINATION

Range of Motion

Cervical	Normal		Pain
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		
Lumbar	**Normal**		**Pain**
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

Health HX Notes:

_____

_____

_____

_____

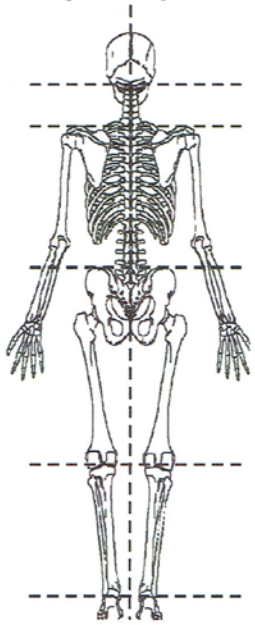
_____

_____

Asymmetry

C0
C1
C2
C3
C4
C5
C6
C7

L1
L2
L3
L4
L5
SAC
L-IL
R-IL

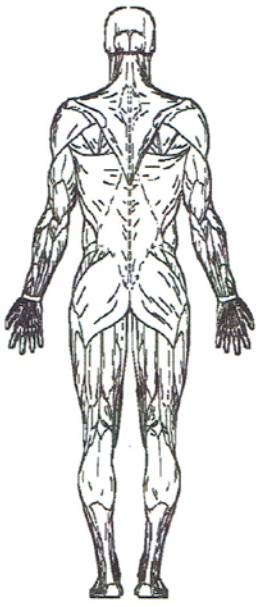


Using arrows (↑↓), mark postural asymmetry

Using arrows (↑ ↓ → ←) mark the misaligned vertebrae

T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

Tissue



Mark tissue abnormalities
TP, LG, TN, SK, FS

TP=Trigger Points; LG=Ligaments (swollen or tender)
TN=Tendons; SK=Skin; FS=Fascial Restrictions