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

# Patient Information Date: _____

Full Name:_____ I prefer to be called:_____
Date of Birth:_____ SS#: _____ Spouse/Guardian: _____
Mailing Address: _____
Email: _____ How did you hear about our practice? _____

Phone: (C) _____ (W/H) _____Can we call you and leave a message? ❑ Yes ❑ N

Sex: ❑ Male ❑ Female 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: _____

Emergency contact: _____Relation: _____ Phone #: _____

**PLEASE PROVIDE A COPY OF YOUR DRIVERS LICENSE AND INSURANCE CARD(S)**

## PATIENTS CHOOSING TO FILE INSURANCE

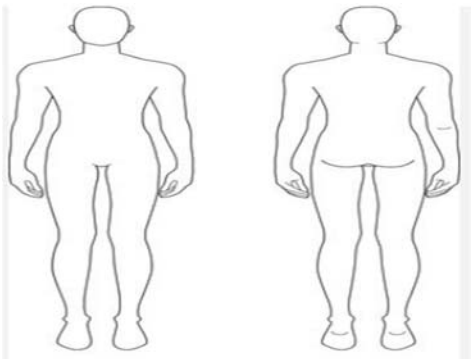
I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid 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:** _____ **DATE** _____

## PATIENTS CHOOSING TO BE SELF-PAY

I _____ have made an independent request to Atlas Chiropractic that I wish to become self-pay. It has been made abundantly clear to me under **NO** circumstances will I be able to submit chiropractic care fees to insurance of any kind, whether it be for primary, secondary, shared accounts, health benefit accounts, and auto accident companies and attorneys. **ANY REQUESTS WILL VOID ALL DISCOUNTS GIVEN.**

**SIGNATURE:** _____ **DATE:** _____



Place an "X" on the drawing 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:_____
_____
Allergies:_____
_____

Patient Signature: _____ Date:_____

## REASON FOR VISIT

**What is the reason for your visit today?** □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

**What caused this complaint(s)?**_____

**When did this complaint begin?** _____/_____/_____ **Is it getting worse?** □ Yes □ No □ Constant □ Comes and goes

**Have you had this or similar complaint in the past?** □ Yes □ No If "Yes", when?_____

Other physicians consulted in past 12 months: _____

NAME DIAGNOSIS

Accidents and/or injuries related to current symptoms:

_____

ACCIDENT OR INJURY DATE OTHER IMPORTANT INFO. REGARDING INJURY

**(IF AN AUTO, WORK OR PERSONAL INJURY, PLEASE REQUEST INSURANCE FORMS FROM FRONT DESK)**

**Height: _____ Weight: _____ Most recent blood pressure (if known): _____**

## HEALTH HISTORY

| Please check **ALL** of the health conditions below that apply to **you** currently or in the past. | | | | **Family History** Relationship: Mark **ALL** conditions that run in your family (Father,Mother,Sister,Brother) | | |
|---|---|---|---|---|---|---|
| □ | Osteoarthritis/Degenerative Joint Disease | □ | Whiplash Injury *Date of injury:* | □ | Cancer *Type:* | |
| □ | Asthma | □ | Headaches | □ | Anemia | |
| □ | Diabetes □ Type I □ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? □ Yes □ No □ Not Sure | □ | Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____ | □ | Diabetes (check one) □Type I □ Type II | |
| □ | Anemia | □ | Migraines | □ | Heart Problems / Stroke | |
| □ | Cancer/Tumor | □ | Osteoporosis /Osteopenia | □ | High Blood Pressure | |
| □ | Rheumatoid Arthritis | □ | Epilepsy / Seizures | □ | Genetic Disorders | |
| □ | Depression/ Anxiety | □ | Fibromyalgia / Chronic Fatigue | □ | Rheumatoid Arthritis | |
| □ | Disc Herniation | □ | Genetic Disorders | □ | Other (List): | |
| □ | High Blood Pressure /Hypertension | □ | Please list any other medical conditions: | | | |
| □ | Heart Disease / Stroke | | | | | |

**WOMEN ONLY:** Currently Pregnant? □ Yes □ No Painful /Abnormal Menstrual Cycle? □ Yes □ No
Do you have children? □ Yes □ No If "Yes", Any birth difficulties? _____

## SOCIAL HISTORY

| |
|---|
| **Do you exercise?** □ Yes □ No **Times per week?** **Intensity?** □ Light □ Moderate □ Strenuous Type?: |
| **Do you currently smoke tobacco of any kind?** □ Yes □ Former smoker □ Never been a smoker |
| **If "Yes"**, how often do you smoke: □ Current every day smoker □ Current sometimes smoker **Circle level below ↓:** |
| **If "Yes"**, what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10** |
| **Do you drink alcohol?** □ Yes □ No How many drinks per week? For how many years? |
| **Do you drink caffeine?** □ Yes □ No How many drinks per day? What type? □ Coffee □ Tea □ Soft Drinks □ Energy Drinks |
| **Do you take pain killers?** □ Yes □ No How often? □ Daily □ Weekly □ Monthly □ Rarely |
| **What type?** □ Aspirin □ Ibuprofen □ Tylenol □ Other_____ |
| **What do your work duties include?** □ Sitting □ Standing □ Light Labor □ Heavy Labor □ Other: |
| **Please describe your overall health right now?** □ Excellent □ Very Good □ Good □ Fair □ Poor |
| **What is your current stress level?** □ Mild □ Moderate □ High |
| **Have you seen a chiropractor in the past?** □ Yes □ No |
| **What are your hobbies?** |

# Atlas Chiropractic

## HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINICS

## 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 utilizes text messaging to remind you of your upcoming appointment. Our office considers a missed appointment to be a cancellation that is with less than 4 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 4 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 $35.00 payable by YOU**. 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.

**PATIENT/LEGAL GUARDIAN INITIALS:** _____

### 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.

**PATIENT/LEGAL GUARDIAN INITIALS:** _____

### 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. **ALL ACOUNTS TURNED OVER TO THE COLLECTION AGENCY WILL ALSO BE RESPONSIBLE FOR THE COLLECTIONS AGENCY FEES OF 40% OF THE BALANCE OWED.**

**PATIENT/LEGAL GUARDIAN INITIALS:** _____

### 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.

**PATIENT/LEGAL GUARDIAN INITIALS:** _____

### RETURN CHECKS

There will be a **$50.00** 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.

**PATIENT/LEGAL GUARDIAN INITIALS:** _____

### 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.

**PATIENT/LEGAL GUARDIAN INITIALS:** _____

**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 CLINICS

## 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

# Atlas Chiropractic

**HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINICS**

**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**

**Date Signed ____/____/____ Witness:** _____

## Consent for Treatment

I have been informed that diagnostic x-rays are advisable in my care so that a complete analysis can be made of my present musculoskeletal problem (or illness).

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