Relief and Rehab Center of Atlanta, LLC

INTAKE QUESTIONNAIRE

DATE_____ PATIENT ID #:_____

NAME AS IT APPEARS ON D/L OR FORMAL ID_____ (MALE/FEMALE)

SOCIAL SECURITY # _____ DATE OF BIRTH_____ AGE_____

STREET ADDRESS_____

CITY_____STATE_____ZIP CODE_____

TEL #_____CELL# _____ EMAIL ADDRESS_____

OCCUPATION_____ARE YOU NOW WORKING? YES NO IF NO, STOP DATE_____

EMPLOYER_____EMPLOYER TEL # _____

HOBBIES? _____

IN CASE OF EMERGENCY, WHO TO CONTACT? NAME_____TEL # _____

DO YOU HAVE AN ATTORNEY REPRESENTING YOU IN THIS ACCIDENT? YES NO

ATTORNEY NAME_____ ATTORNEY TEL:_____

ATTORNEY ADDRESS_____CITY_____STATE_____ZIP_____

DESCRIPTION OF ACCIDENT

DATE OF ACCIDENT_____TIME OF ACCIDENT_____MVA___WC___S/F___OTHER___

LOCATION OF ACCIDENT_____

WERE YOU: ( ) DRIVER () PASSENGER SEATED: ( ) FRONT ( ) BACK ARE YOU: RIGHT OR LEFT HANDED?

NUMBER OF PEOPLE IN VEHICLE:_____ NUMBER OF VEHICLES INVOLVED IN THE MVA _____

WAS YOUR VEHICLE MOVING OR SITTING STILL AT IMPACT ? _____

DID THE OTHER VEHICLE HIT YOUR VEHICLE? YES NO _____

WERE YOU STRUCK FROM: () BEHIND () FRONT () DRIVER SIDE () PASSENGER SIDE

AFTER THE INITIAL IMPACT DID YOUR VEHICLE STRIKE ANY OTHER VEHICLES/OBJECTS? YES NO

DID YOU ANTICIPATE THE ACCIDENT? YES NO

WERE YOU WEARING A SEAT BELT? YES NO

DID YOU RECEIVE ANY INJURY OR BRUISE FROM THE SEATBELT? YES NO _____

DID YOUR AIRBAGS DEPLOY? YES NO

DID ANY PART OF YOUR BODY STRIKE THE INSIDE OF THE VEHICLE? YES NO _____

ANY CUTS, BRUISES. SPASMS, OR LACERATIONS? _____DID YOU LOSE CONSCIOUSNESS? YES NO

DID THE POLICE COME TO THE ACCIDENT SCENE? YES NO IS THERE A POLICE REPORT? YES NO

DO YOU KNOW IF ANY TICKETS/CITATIONS ISSUED? (YES) (NO) (I DON'T KNOW) WHO GOT THE TICKET? _____

DID YOU EXPERIENCE PAIN IMMEDIATELY OR SLOWELY AFTER? _____

SINCE THE ACCIDENT HAS THE PAIN BEEN BETTER , WORSE , OR STAYING THE SAME? _____

IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT:_____

_____

PATIENT SIGNATURE: _____ DATE: _____

STAFF NAME: _____ STAFF SIGNATURE: _____

Relief and Rehab Center of Atlanta, LLC 3433 B Main Street, College Park, Ga 30337
404-766-0676

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CURRENT HEALTH CONDITION

PATIENT NAME:_____ DATE:_____ ID#_____

DID YOU GO TO THE HOSPITAL/DOCTOR FOR THIS ACCIDENT? YES NO

IF SO, WHERE?_____

HOW DID YOU GET THERE? _____

WHAT TYPE OF TREATMENT WAS DONE (X-RAYS, MEDICATION - HOW MANY DAYS SUPPLY? _____ FILLED? YES NO HELPING? YES NO STILL TAKING? YES NO) , COLLARS, SPLINTS ETC?)

_____

RESULTS: _____ FOLLOW UP INSTRUCTIONS? _____

HAVE YOU BEEN TO ANY OTHER DOCTORS/CLINICS RELATED TO THIS INJURY/ACCIDENT? YES NO

IF SO, WHERE? _____DATE_____PHONE #_____

DID THEY TAKE X-RAYS / CT / MRI?_____WHAT AREAS? _____

TEST RESULTS? _____ ARE YOU ON ANY MEDICATION? YES NO

IF YES, WHAT DO YOU TAKE? _____

REASON FOR TAKING THIS MEDICATION? _____

DO YOU HAVE A PRIMARY MEDICAL PHYSICIAN? YES NO (IF YES) DR NAME _____

PAST HEALTH HISTORY:

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS? (IE: STROKE, PACEMAKER, OSTEOPOROSIS, DIABETIC, BLOOD PRESSURE, HEART DISEASE, LUNGS, LIVER, KIDNEY DISEASE) IF SO, CIRCLE AND EXPLAIN: _____

_____

HAVE YOU EVER HAD ANY MAJOR SURGERY OR OPERATIONS? YES NO IF YES, PLEASE DESCRIBE (INCLUDE DATE)_____

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT OR WORK RELATED ACCIDENT? YES NO
IF YES, PLEASE DESCRIBE (INCLUDE DATE, TREATING DOCTOR, ATTORNEY AND INJURIES)

_____

_____

OCCUPATIONAL INFORMATION:

WHAT DOES YOUR JOB INVOLVE? CIRCLE (SITTING , STANDING) HOW LONG? _____

LIFTING? HOW MUCH? _____ BENDING , TWISTING , TURNING , STOOPING

HOW MUCH PHYSICAL ACTIVITY AT WORK? (CIRCLE) SEDITARY , LIGHT MANUAL LABOR , HEAVY MANUEL LABOR

HAVE YOU MISSED ANY TIME FROM WORK AS A RESULT OF THIS ACCIDENT? YES NO (IF YES) WHAT DATES _____

ARE YOUR WORK ACTIVITES RESTRICTED AS A RESULT OF THIS ACCIDENT? YES NO _____

DO ANY OF YOUR WORK ACTIVITIES AGGREVATE YOUR PRESENT MAIN COMPAINTS? YES NO (IF YES, EXPLAIN)

_____

I CERTIFY THAT I HAVE READ AND UNDERSTAND AND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE FOLLOWING QUESTIONS HAVE BEEN ANSWERED TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I HEREBY AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO GEORGIA TOTAL CARE, LLC. THE OFFICE WILL COMPLETE ALL INSURANCE FORMS FOR MY CLAIM. I AM RESPONSIBLE FOR MY BILL. IN THE EVENT OF DELIQUENCY, ALL COLLECTION COSTS WHICH INCLUDE, BUT IS NOT EXCLUSIVE TO, ATTORNEY FEES, COURT COSTS, AND AN ACCUMULATED MONTHLY INTEREST F 1.5% WILL BE ADDED TO THE TOTAL BALANCE OF MY MEDICAL BILLS.

PATIENT SIGNATURE: _____ DATE: _____

STAFF NAME: _____ STAFF SIGNATURE: _____

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INITIAL DIAGNOSTIC PROFILE

Name: _____ Date: _____

CHECK SYMPTOMS YOU ARE PRESENTLY EXPERIENCING

___ Headaches

___Nausea

___Dizziness

___Ringing of ears
___ Right ___Left

___Nasal Pain

___Loss of Smell

___Loss of Taste

___Jaw Pain/Clicking of Jaw
___Right ___Left

___Mouth/Lip Pain

___Tooth Pain

___Neck Pain/Stiffness

___Shoulder pain/Stiffness
___Right ___Left

___Upper Arm Pain
___Right ___Left

___Elbow Pain
___Right ___Left

___Forearm Pain
___Right ___Left

___Wrist Pain
___Right ___Left

___Hand Pain
___Right ___Left

___Finger Pain
___Right ___Left

___Collar Bone
___Right ___Left

___Chest Pain
___Right ___Left

___ Sternum Pain
___Right ___Left

___Rib Pain
___Right ___Left

___Abdomen Pain
___Right ___Left

___Back Pain/Stiffness
___Right ___Left

___Pelvic Pain
___Right ___Left

___Hip Pain
___Right ___Left

___Buttock Pain
___Right ___Left

___Coccyx Pain

___Groin Pain
___Right ___Left

___Thigh Pain/Weakness
___Right ___Left

___Knee Pain/Weakness
___Right ___Left

___Leg Pain
___Right ___Left

___Calf Pain
___Right ___Left

___Shin Pain
___Right ___Left

___Ankle Pain
___Right ___Left

___Heel Pain
___Right ___Left

___Foot Pain
___Right ___Left

___Toe Pain
___Right ___Left

___Sleep Disturbance

___Fatigue

___Fear of Driving

___Anxiety

___Depression

___Memory Loss

DO YOU FEEL PAIN, NUMBNESS, TINGLING, PINS & NEEDLES IN ANY PART OF YOUR BODY?

____YES ____NO

IF YES, WHERE?

_____

_____

ANY HISTORY OF CURRENT SYMPTOMS? _____

PERSONAL HEALTH HISTORY/MEDICAL CONDITIONS? _____

FAMILY HISTORY? _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: (Provider)_____
(Name of Doctor, Clinic, Hospital, etc.)

Fax #:_____

Patient Name: _____

D/O/B: _____

D/A: _____

I, _____ request the following information:
(Patient's name)

____X-rays ____History ____Records ____Diagnosis ____Reports ____Billing

Concerning my: ____Accident ____Injury ____Illness ____Other_____

To be released to:_____
(Name of Insurance Company, Attorney, Doctor, Hospital, Employer)

Address: _____

_____

_____

For the purpose of: DR CONSULT

Signed:_____ Date:_____

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HIPPA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard of certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest. **Your Personal Health Information (PHI) will never be given to any entity besides what is required for your treatment, payment and health care operations.**

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as radiologists that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of you PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Parent/Legal Guardian:_____

Signature: _____Signature:_____

Date:____/____/____ Date:____/____/____

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michaelthomasdc@gmail.com

Relief And Rehab Center Of Atlanta, LLC

Dr. Michael R. Thomas, D.C.

Contract and Assignment OF Benefits-Medical Lien

I_____**(client),** hereby authorize and direct you, as my attorney, to pay directly to said provider of medical services such sums as may due and owing for professional services rendered to me by reason of this accident and to hold such sums from any net settlement, judgment or verdict as may be necessary adequately to protect said provider of such medical services. I hereby agree in the event another attorney is substituted in this matter, I will instruct said attorney to comply with the terms of this agreement and to execute an agreement.

I hereby further give an assignment in contract to said provider for payment from my settlement, judgment or verdict of medical services against any and all proceeds of any net settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said provider of medical services for all professional bills submitted by them for services rendered to me and that this agreement is made solely to give said provider of medical services additional protection and in the consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict which I may eventually recover such fee.

I agree that above assignment is irrevocable and in the event that I contradict such agreement, I authorize my attorney to hold in trust said amounts until a court of equity for damages that may resolve the validity of this agreement._____**(Patient Initial)**

I further agree that I am choosing to forgo utilizing any medical insurance coverage that I may have for any services provided to me by said provider._____**(Patient Initial)**

X Patient's Signature:_____ **Date:** ____/____/_____

The undersigned being attorney of records for the above client does hereby acknowledge notice of the assignment of benefits of contract, agrees to observe all the terms of the above, agrees to withhold such items from any net settlement, judgment, or verdict as may be necessarily adequate to protect the said provider medical services named above, as the inherent duty of a fiduciary. As attorney of records, I acknowledge receipt of said assignment under contract law and the obligation imposed by the Georgia Professional Rules of Conduct1.15(l)(b).

X Attorney's Signature:_____ **Date:** ____/____/____