Date: ______________
Patient # ______________

CONFIDENTIAL PATIENT HISTORY

Last ______________ First ______________ Middle Initial ______ Birth Date ______________ Age ______

Address ______________ City ______________ ST ______ Zip ______________

Phone (H) ______________ (W) ______________ (C) ______________

Email ______________ May we send you our online newsletter? ☐yes ☐no

Occupation ______________ Employer ______________

Spouse's Name ______________ D.O.B ______________ Spouse Ph ______________ Employer ______________

Children's Name & Ages ______________

Have you had previous Chiropractic care? ☐yes ☐no Whom? ______________

Who may we thank for referring you to our office? ______________ ☐Walk In ☐Advertisement ☐Promotion ☐Yellow Pages

Who is your primary care physician? ______________ Address: ______________

Phone: ______________ Date of last physical/exam? ______________ With Whom? ______________

When doctors work together, it benefits you. May we update your medical doctor regarding your treatment in our office? ☐yes ☐no

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: ______________

Date when symptom first appeared ______________ How Did it begin: ______________

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare10%

Have you ever experienced the same or similar symptoms? ☐yes ☐no When? ______________

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? ______________

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have Numbness or Tingling? ☐yes ☐no Where? ______________

Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other ______________ ☐Does not radiate

What makes the symptoms increase? ______________ What relieves the symptoms? ______________

Drugs you now take: ☐Nerve Pills ☐Pain Pills ☐Muscle Relaxer ☐Blood Pressure ☐Other: ______________

Do any family members suffer from the same complaint? If so, who? ______________

SECONDARY COMPLAINT: ______________

Date when symptom first appeared ______________ How Did it begin: ______________

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare10%

Have you ever experienced the same or similar symptoms ☐yes ☐no When? ______________

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? ______________

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have Numbness or Tingling? ☐yes ☐no Where? ______________

Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other ______________ ☐Does not radiate

What makes the symptoms increase? ______________ What relieves the symptoms? ______________

Age of Mattress ______________ ☐Comfortable ☐Uncomfortable

Have you ever been in an auto accident? ☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never

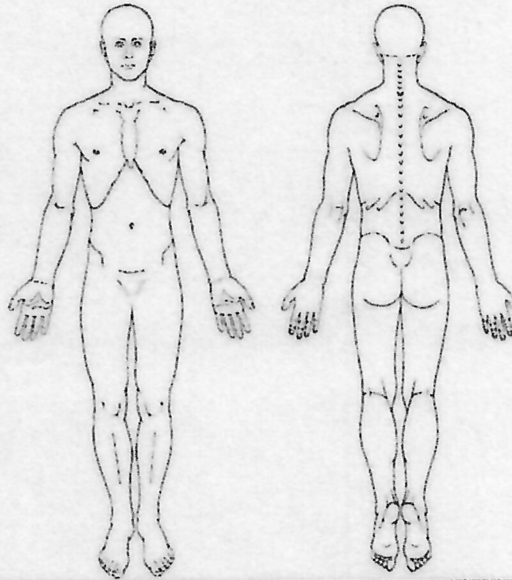
Please describe: ______________

Please list all surgeries, injuries, accidents, falls, etc: ______________

____

Please mark off all areas of complaint on the diagrams with the following indicators:

AAA=ache
DDD=dull
NNN = numbness
TTT= tingling
BBB= burning
SSS=sharp/stabbing
XXX = other



Please list any medications or vitamins you are currently taking (including dosage).

____
____
____
____
____
____
____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0◊◊◊1◊◊◊2◊◊◊3◊◊◊4◊◊◊5◊◊◊6◊◊◊7◊◊◊8◊◊◊9◊◊◊10

Do you smoke? ☐yes ☐no If yes, how many packs per week?_____ **Have you ever smoked in the past?** ☐yes ☐no When did you quit?_______
Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? ________________
Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? ________________
Do you exercise? ☐yes ☐no If yes, how many times per week and what type? ________________
Do you have a high stress level? ☐yes ☐no If yes, list reasons:________________

Is there any possibility that you may be pregnant? ☐yes ☐no **Date of Last Menstrual Cycle** ________________

Please check if you have had any of the following:

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Arthritis	☐ Disc Degeneration	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Fibromyalgia	☐ Asthma	☐ Numbness/Tingling
☐ Allergies	☐ High Cholesterol	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Glaucoma	☐ Diabetes	☐ High Blood Pressure
☐ Cancer	☐ Nervousness	☐ AIDS/HIV	☐ Osteoporosis	☐ Heart Disease/Problems
☐ Paralysis	☐ Parkinson's Disease	☐ Kidney Disease	☐ PMS/Cramps	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Sciatica	☐ Sinus Pain	☐ Pacemaker	☐ Stroke
☐ Thyroid Problems	☐ Tumors/Growths	☐ Urinary Problems	☐ Vascular Disease	☐ Vision Problems
☐ Other:				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Discover Chiropractic* will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Discover Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: ______________________ Date: ______________

Guardian's Signature: ______________________ Date: ______________

RELIEF AND REHAB CENTER OF ATLANTA, LLC

Informed Consent to Chiropractic Treatment and Care

I hereby request and consent to the performance of chiropractic adjustments, including various modes of physio-therapy by the doctor named below and/or in his/her clinic authorized by the doctor listed below. I have had an opportunity to discuss with the doctor listed below and/or other office or clinic personnel, the nature and purpose of the chiropractic adjustment and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risk of treatment, including, but not limited to muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor considers at the time, based upon the facts then known, and is in my best interests.

I have been informed that it is not uncommon for the patient to have some increased discomfort after and adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms I can call the clinic where I am being seen during office hours for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room. If any test were performed outside of this office (laboratory, MRI, X-rays or any other diagnostic procedures). I understand that the Doctor will review with me the results at my next schedules appointment in the office.

I give RELIEF AND REHAB CENTER OF ATLANTA, LLC**, and permission to perform my therapies in an open room, where other patients are also being treated. The doctors and staff of RELIEF AND REHAB CENTER OF ATLANTA, LLC,** will do all that is in their power to protect my personal health information, but due to the physical conditions, 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 a doctor at any time in private, the doctor will provide a room for these conversations. **(OPEN ROOM AUTHORIZATION – OPTIONAL)**

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient's Name: ________________________________ Date: ____________

Patient's Signature: ______________________________ Date: ____________

Doctor's Signature: ______________________________ Date: ____________

Relief and Rehab Center of Atlanta, LLC

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:____/____/____

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

RELIEF AND REHAB CENTER OF ATLANTA
PAYMENT POLICY

Thank you for choosing RELIEF AND REHAB CENTER OF ATLANTA as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We participate in BCBS, AETNA, CIGNA, UNITED, AND ASH NETWORK. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. CONVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. MISSED APPOINTMENT. Our policy is to charge $25.00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment**.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

______________________________ ______________

Signature of patient or responsible party **Date**