

Patient Information

Name _____ Birth Date _____ Age _____
Address _____ Cell # _____
City _____ Home # _____
Insurance Co. _____ Social Security # _____
Sex [M F] Employer's Name _____
Marital Status [M W D S] Spouse's Name _____
Children's Name/s _____

Have you had chiropractic care before? [Y N] When? _____

What is your current complaint? _____

Is this condition due to: []Auto Accident []Work Injury []Other Accident []Unknown []Illness

Date symptoms appeared? _____ **If accident, please describe what happened?**

What aggravates your condition? []Standing []Twisting []Bending []Sitting []Lying []Walking
[]Walking []Coughing []Lifting

Are your symptoms:	List all surgical operations (107):	List all <u>non-prescription</u> drugs you now take (109):
[]Improving (101)	_____	_____
[]About the same (102)	_____	_____
[]Getting Worse (103)	_____	_____
[]Intermittent (104)	_____	_____

Have you had these symptoms before? (105)	List all <u>prescription</u> drugs you now take? (108)	Check if you have a <u>family</u> history of:
[]No	_____	[]Arthritis (110)
[]Yes When? _____	_____	[]Cardiovascular Disease (111)
	_____	[]Diabetes (112)
	_____	[]Cancer (113)

Who is your family Dr.? (106)
Dr. _____

Social Habits: (114) []Tobacco []Alcohol []Coffee

Exercise Activity: (115) []None []Light []Moderate []Strenuous

Stress Levels: (116) []Little or none []Minimal []Moderate []Greatly Stressed

Physical Activity: (117) []Sitting 50% or more []Light labor []Manual Labor
[]Heavy Labor []Repeated Motion

Are you Pregnant? Y N **Date of Last Menstrual Period:** _____

Patient Information (Cont'd)

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU MAY HAVE HAD: (118)

- | | | |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastric Ulcers |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Colitis/Spastic Colon |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sinus/Allergies | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Premenstrual Pains |
| <input type="checkbox"/> Joint Pains | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Stroke or Heart Attack | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> HIV+/AIDS |

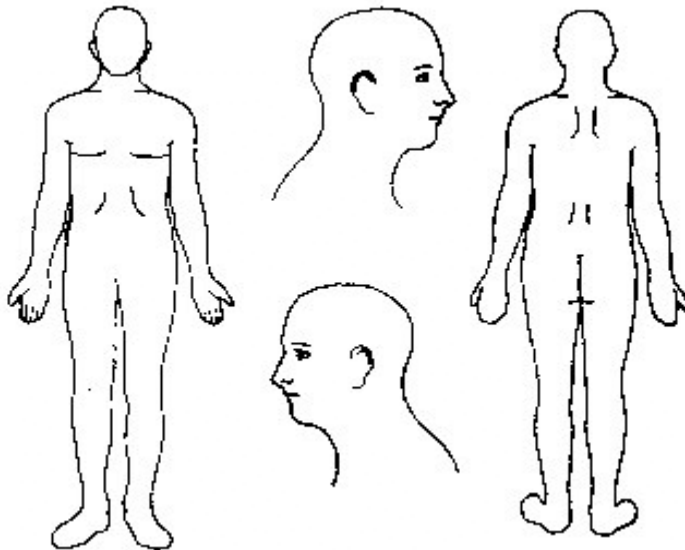
Place an "X" on the drawing below on areas causing you pain and a letter describing it:

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS AND 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



Would you like us to send a report to your family doctor? Yes No

The above information is true and accurate to the best of my knowledge.

Signature: _____

Date: _____

**COMPLETE CHIROPRACTIC CARE, LLC
HEALTH CARE AUTHORIZATION FORM**

Patient's Name: _____

Patient's SS#: _____

Date of Birth: _____

THE PATIENT ABOVE AUTHORIZES **COMPLETE CHIROPRACTIC CARE** TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

____ I give permission to Complete Chiropractic Care 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 Complete Chiropractic Care contacts me by phone; I give them permission to leave a phone message on my answering machine or voicemail.

____ I give Complete Chiropractic Care permission to disclose protected health information in the presence of anyone accompanying me into the treatment room or consultation room by my request.

____ By signing this form you are giving Complete Chiropractic Care permission to use and to disclose your protected health information in accordance with the directives listed above.

EXPIRATION: The authorization shall expire on the following date: _____

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 on the reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Complete Chiropractic Care. The written notice must contain the following information: Your name, SS# 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 Complete Chiropractic Care 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, Complete Chiropractic Care will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

A copy of the signed authorization will be provided to you

Signature of Patient: _____

Date: _____

Signature of Personnel Representative: _____

Description of the Representative's Authority to Act for Patient: _____

COMPLETE CHIROPRACTIC CARE PAYMENT POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your cooperation, and your understanding of our payment policy.

1. Payment is expected at the time services are rendered unless other arrangements are made in advance.
2. We will be happy to process your insurance for payment. The percentage that you owe is due at the time of services.
3. We must emphasize that as your health care provider, our relationship is with you and not your insurance company. The filing of insurance claims is a courtesy that we extend to our patients. All charges are your responsibility and due 30 days after the date the insurance is filed.
4. Balances carried past 30 days will have a late charge of 1 ½% per month, which is an annual rate of 18% with a minimum charge of \$1.00.
5. A charge limit is \$200.00. if your balance is \$200.00 you will be required to pay each visit plus a minimum of \$5.00 to be subtracted from your previous balance.
6. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact this office promptly for assistance in the management of your account.

If you have any questions about the information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We are here to help you.

I HAVE READ AND UNDERSTAND THE ABOVE COMPLETE CHIROPRACTIC CARE POLICY.

Patient Signature

Date

FINANCIAL AGREEMENT

COMPLETE CHIROPRACTIC CARE, LLC
4580 W. HWY. 136
(706) 657-4777

We welcome you to our office and assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policies of our office, I would like to explain how your medical bills will be handled.

Our fees are as follows:

- Adjustments: \$33 - \$40
- Therapy (each): \$20 - \$25 (Roller Table, Inversion Table, Posture Pump)
- X-ray per view: \$30
- Exams: \$40 - \$50
- Extremity Adjustments: \$20
- Exercise Handouts: \$25

Payment is expected at the time of services are rendered unless other arrangements have been made in advance.

We will be happy to submit your medical bills for payment to your insurance company. Your deductible/coinsurance/co-pay is due at the time of service.

If your insurance stops paying, you are responsible for any visits not covered. We will notify you should your insurance company discontinue payment.

All services that are rendered in this office will be charged directly to you, and ultimately you will be personally responsible for payment of these bills regardless of your insurance coverage.

If you have any questions regarding your insurance coverage, please do not hesitate to ask. We are here to help you.

I have read and agree to the above. I further agree that if this account has to be placed in the hands of a collection agency or an attorney for collections, all will be responsible for all reasonable attorney fees and court costs.

Patient Signature

Date

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this office:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distant science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the "law of this jurisdiction" involves the application of a specific directional thrust (called an adjustment) to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments called subluxations. Adjustments are a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone by doctors of chiropractic.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

(Signature)

Date _____