Welcome to Atlas Chiropractic

PATIENT INFORMATION:

Last Name:_____ First Name:_____ M.I._____
Gender: M F Date of Birth: ____/_____/_____ SS#_____ Marital Status:_____
Home Address:_____Apt #:_____
City:_____State:_____Zip:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Employer Name:_____Occupation:_____

SPOUSE OR GUARDIAN:

Last Name:_____ First Name:_____ M.I._____
Employer Name:_____ Work Phone:_____
Cell Phone:_____ Date of Birth: ____/_____/_____ SS#_____
Family Physician:_____ Referred by:_____

INSURANCE INFORMATION: ***(Please Present Card)***

Insurance Company:_____Phone:_____
Insured's Name:_____ ID/Policy #_____
Group #_____ Work Comp/Auto Accident:_____
Phone:_____ Claim #_____

MEDICAL HISTORY INFORMATION:

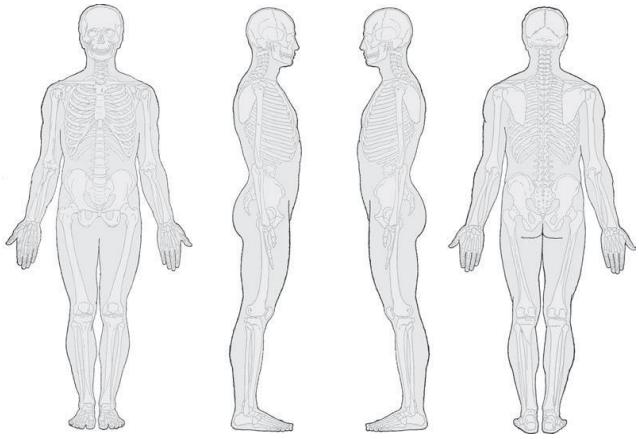
Present Complaint:_____
Is Injury do to Work?_____ Auto?_____ Other?_____
Date of Injury:_____ Brief Description of Accident:_____
_____
In the past have you had anything similar to this? YES NO Please Explain:_____
_____
Past Chiropractic Care? YES NO If yes, date of last adjustment:_____
For your present complaint have you seen any other doctors? YES NO If yes, who?_____
What treatment?_____
Have you had any X-RAY, MRI, CT scan or other imaging? YES NO If so when:_____

Please describe the character of your current pain: (you may check one or more answers)
☐Sharp ☐Stabbing ☐Burning ☐Shooting ☐Aches ☐Soreness ☐Weakness ☐Throbbing ☐Numbness ☐Dull
☐Constricting ☐Other_____

How often are the complaints present? ☐ Constant/100% of the time ☐ Frequent/75% of the time
☐ Intermittent/50% of the time ☐Occasional/25% of the time Comments:_____

Is the Pain: ☐ Increasing ☐ Decreasing ☐ Not Changing
Pain is aggravated by: ☐Walking ☐Sitting ☐Standing ☐Riding in a Car ☐Lifting ☐Bending
☐Stretching ☐Twisting ☐Other_____

Pain is reduced by: Medicine, Exercise, Rest, Adjustments, Therapy_____
Are your complaints affecting your ability to work or be active?
☐ No effect ☐ Some physical restrictions ☐Unable to perform regular duties
Is there any dizziness associated with problems? YES NO _____
Any fever or chills? YES NO _____
Any change in bowel or bladder (bathroom) function? YES NO _____
Are your complaints affecting your ability to sleep? YES NO _____
Have you missed any of days of work or school due to complaints? YES NO Dates: _____



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

*Please place the following applicable letters on the figures to the left indicating areas of pain.

O = Pain TT = Taunt/Tender

S = Spasm N = Numbness

PAST MEDICAL and SOCIAL HISTORY:

Check any of the following conditions you have had:

☐AIDS/HIV	☐Ear ringing	☐Neck Pain
☐Allergies	☐Epilepsy	☐Osteoporosis
☐Anxiety/Depression	☐Headaches	☐Poor Circulation
☐Arm/Shoulder Pain	☐Headaches – Migraine	☐Prostate Problems
☐Arthritis	☐Heart Disease	☐Rheumatoid Arthritis
☐Asthma	☐Hemorrhoids	☐Sciatica
☐Bladder Problems	☐Herniated Disk	☐Shingles
☐Cancer	☐High Blood Pressure	☐Sinus Infection
☐Chronic Fatigue	☐Insomnia	☐Stroke
☐Deafness	☐Irregular Cycle	☐Thyroid Problems
☐Diabetes	☐Kidney Problems	☐TMJ
☐Digestion Problems	☐Leg Pain	☐Venereal Disease
☐Earache	☐Low Back Pain	☐Vertigo/Dizziness

STRESSORS:

☐Smoking	Packs/Day _____
☐Alcohol	Drinks/Wk _____
☐Coffee/Caffeine Drinks	Cups/Day _____
☐High Stress Level	Reason _____

EXERCISE:

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Have you had any:	**Description**	**Date**
Automobile accidents	_____	_____
Surgeries	_____	_____
Broken Bones	_____	_____
Falls/Head Injuries	_____	_____

Females: Are you pregnant? YES NO # of pregnancies:_____ Date of last menstrual cycle:_____

List any medications you are taking:_____

_____

_____

Vitamins/Herbs/Minerals:_____

Any other health concerns:_____

PAYMENT METHOD: ☐Cash ☐Check ☐Credit Card ☐ACH auto payment (see attached financial policy)

I certify that the above information in correct. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation. I authorize Atlas Chiropractic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek services of another health care provider.

Signature of Patient, Parent, Legal Guardian Date

Atlas Chiropractic

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Please read so that you understand the quality care you will agree to receive.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seed the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print Name)

All question regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission form child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of the last menstrual period: _____

_____ _____
(Signature) (Date)

FINANCIAL POLICY
We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy.

PATIENTS WITH INSURANCE
While the filing of insurance claims is a courtesy that we extend to our patients, ***all charges not covered by your insurance company are your responsibility.*** If you have insurance, we will do our best to help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. When possible, we will call your insurance company to verify your benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Our office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than supply factual information as necessary. You are responsible for the items listed above as well as any services considered "not medically necessary" by your insurance company. We participate with most insurance companies; however, if we do not participate with your insurance company, you are responsible for all out of network deductibles and co pays. We are legally and contractually obligated to collect ***ALL CO-PAYS AT TIME OF SERVICE***.

MEDICARE
We do accept assignment from Medicare. Medicare pays 80% of the allowable fee after your deductible has been met. **Medicare will cover the chiropractic adjustment only and for active conditions only.** Medicare for seniors does not cover or pay for initial exams! Medicare does not cover or pay for x-rays! But Medicare DOES REQUIRE by law that these procedures are performed prior to the beginning of care. As a courtesy and out of respect our office does offer a senior discount of $10.00 off the cost of these services. Medicare supplemental policies will cover only those charges that Medicare also allows. You are responsible for your Medicare deductible and all coinsurance.

PATIENTS WITHOUT INSURANCE
We require that 100% of the examination and x-ray exam be paid at the time of the visit, unless other arrangements have been made. To qualify for our Time of Service Reduction in fees you must pay on the day the service was performed. We are happy to accept cash, check, Master Card, Visa, or Discover.

WORKERS COMPENSATION
If you are injured on the job, your care may be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of their insurance carrier. If your claim is not allowed, you will be responsible for all charges accrued during your care. Additionally, please let us know if you are currently working with an attorney.

PERSONAL INJURY
Please notify your auto insurance of your visit to our office immediately. Although you are ultimately responsible for any charges accrued during your care, we will wait for a settlement of your claim for up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care all fees for services are due immediately. Additionally, please let us know if you are currently working with an attorney.

*Accounts past 30 days old with no attempt at payment will be charged an 18% annual finance charge, which will be added monthly to that account until the balance is paid in full. A $25 service fee will be charged for any returned checks.

*Patients with an outstanding balance more than 60 days overdue must make arrangements for payment prior to scheduling appointments.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY ATLAS CHIROPRACTIC. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE. I GRANT PERMISSION TO MY INSURANCE COMPANY TO PAY ATLAS CHIROPRACTIC DIRECTLY FOR SERVICES RENDERED. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR.

***Patient/Guardian Signature*_____ *Date*_____**

Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying you bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Your health is priceless, and we are committed to helping you get the best results in the shortest amount of time at an affordable rate.

ATLAS CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

Atlas Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Atlas Chiropractic is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. HIPAA requires a chiropractic practice to make a good faith effort to obtain a signed acknowledgement from the patient at the time that it provides the HIPAA Notice of Privacy Practices to the patient. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

I acknowledge that Atlas Chiropractic staff provided me with a copy of their Privacy Practices Notice to review. I understand that I have a right to receive a copy of this Privacy Practices Notice if I request it.

_____
Patient's Name (print)

_____
Patient's Signature