Alpharetta Family Chiropractic, LLC

9570 Nesbit Ferry Road ♦ Suite 101 ♦Alpharetta, Georgia 30022
(770) 641-0029 Office ♦ (770) 643-7845 FAX
www.alpharetta familychiropractic.com

Welcome! We'd like to get to know you!

DATE: _____

About You...

Patient Name: _____
Last *First* *Middle Initial*
Name Preference: _____ □ *Male* □ *Female*
DOB: ____/____/____ **Age:** _____ **Social Security #:** _____
Mailing Address: _____ **Apt. #:** _____
City: _____ **State:** _____ **Zip:** _____
Home Phone #: _____ **Mobile Phone #:** _____
Work/Alt. Phone #: _____ Ext: _____
E-Mail Address: _____
Status: □ *Minor* □ *Single* □ *Married* □ *Separated* □ *Divorced* □ *Widowed*
If married, spouse's name: _____
Children: □ Yes □ No *(If "Yes," how many?* _____*)*

Employer: _____
Employer's Address: _____
City: _____ **State:** _____ **Zip:** _____
Occupation: _____ **How Long?** _____
Referred by: _____

In the Event of an Emergency....

Whom should we contact? _____ **Contact's Phone #:** _____
Relationship: □ *Spouse* □ *Parent* □ *Sibling* □ *Son* □ *Daughter* □ *Friend*
Who is your Medical Doctor/PCP? _____ **Phone #:** _____

Account Information...

Person ultimately responsible for account ***(Full Name, please.)*****:** _____
Relationship: □ *Self* □ *Spouse* □ *Parent* □ *Sibling* □ *Son* □ *Daughter* □ *Friend*
Billing Address: _____
City: _____ **State:** _____ **Zip:** _____ **Home Phone #:** _____
Work/Alt. Phone #: _____ **S.S. #:** _____

_____ ***"I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office)."***

PLEASE CONTINUE ON BACK ----------→

Patient Name (continued): _____

REASON FOR VISIT

Please explain the reason for this visit: _____

_____

Please describe the pain and its location: _____

_____

When did current condition begin? ____/____/____ **Is this condition getting worse?** □ Yes □ No
Duration: □ Constant □ Comes & Goes
Is this condition interfering with (*Please check all that apply.*): □ Work? □ Sleep? □ Daily Routine?
If so, please explain: _____

_____

HEALTH HISTORY

Are you taking any of the following medications? □ Nerve Pills □ Pain Killers □ Muscle Relaxants
□ Stimulants □ Blood Thinners □ Tranquilizers □ Insulin □ Other(s): _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	Y N Heart Murmur	Y N Anemia
Y N Heart Surg./Pacemaker	Y N Artificial Valves	Y N Rheumatic Fever
Y N Congenital Heart Defect	Y N Hepatitis	Y N Ulcers/Colitis
Y N Mitral Valve Prolapse	Y N Cancer	Y N Asthma
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Chemotherapy
Y N HIV+/Aids	Y N Shingles	Y N Arthritis
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Diabetes/Tuberculosis
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Lower Back Problems
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Difficulty Breathing
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Artificial Bones/Joints

Please list any other serious medical condition(s) you have or ever had: _____

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any past serious accidents with dates: _____
Family Health History: _____

_____

DO YOU: □ Take Vitamins/Supplements? □ Exercise? / How often? _____ □ Smoke? / How much? _____
Are you on a special diet? □ Yes □ No (Since ____/____/____) **Age of your mattress?** _____
Is it comfortable? □ Yes □ No **Are you wearing:** □ Heel Lifts? □ Sole Lifts? □ Inner Soles? □ Arch Supports?
FOR WOMEN, are you: □ Taking birth-control pills? □ Pregnant? / How far along? _____ □ Nursing?

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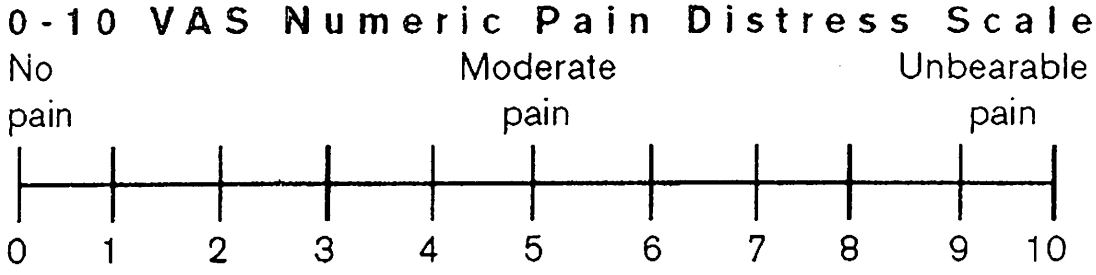
*We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. **Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager.** If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account.

* **"I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed-care organization, to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and I understand it is my responsibility to inform this office of any changes to the information I have provided."**

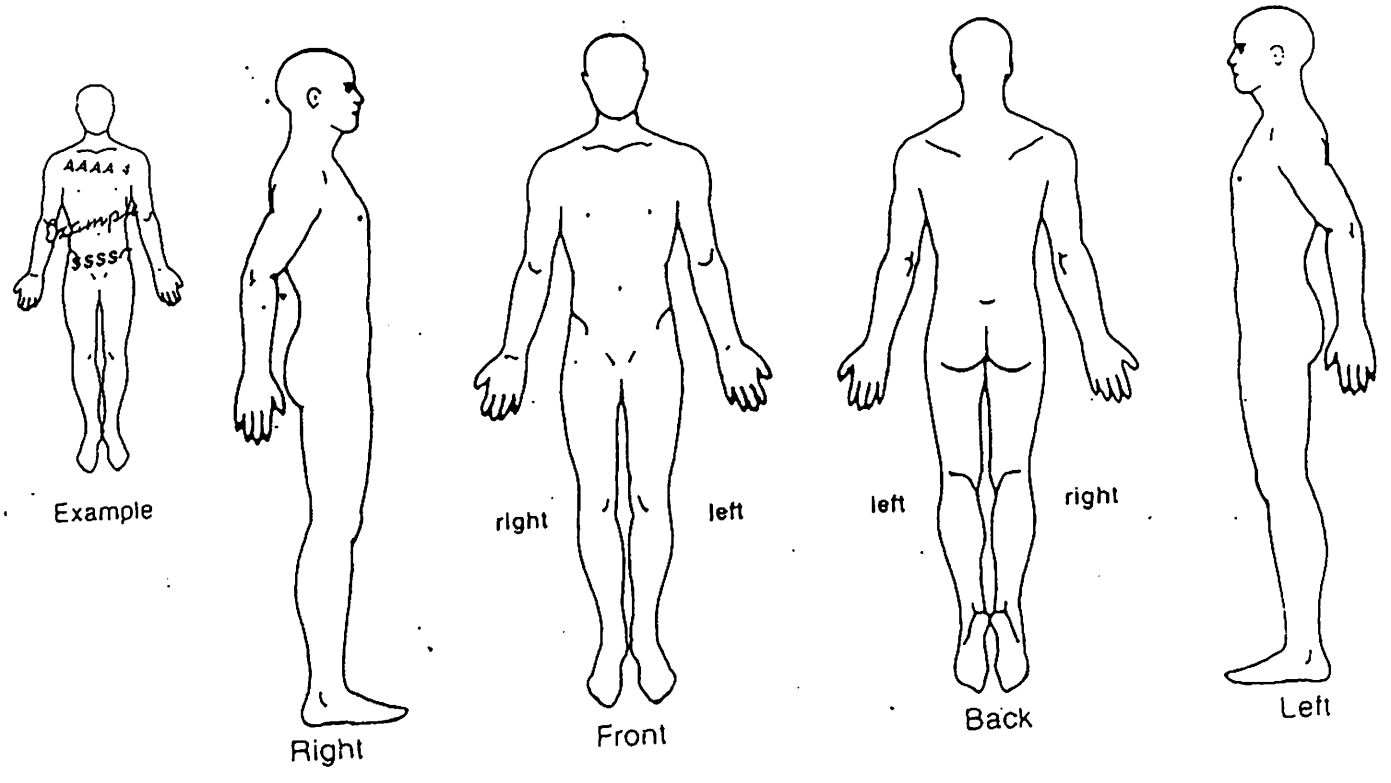
Signature _____ **Date** ____/____/____
Adult Patient _____ Parent or Guardian _____ Spouse _____

On the scale, below, please rate your pain-level—



Mark area(s), at which your symptoms are located, using the following description(s)—

Aching = AAAA Burning = BBBB Stabbing = SSSS Numbness = NNNN Pins & Needles = PPPP



Signature: _____ Date: _____

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FINANCIAL OFFICE POLICY

1. **All patients are on a cash basis until their respective insurance coverage and deductibles are verified.**
2. **If the deductible has not been met, you will be on a cash basis until the deductible has been met.**
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the Insured/Patient signs an assignment of benefits and/or lien (authorizing payment to be sent to the doctor).
4. Filing insurance claims and waiting for insurance payment is a **courtesy**.
5. As a patient, it is your responsibility to take care of the co-payment and any non-covered services on a weekly basis. This office may make payment plan arrangements on an individual basis.
6. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. **Insurance policies are an arrangement between an insurance carrier and a patient or insured.**
7. **Any services not covered or coverage reductions by your insurance will be the patient's responsibility.**
8. This office will resubmit a claim twice. We will not enter any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. Any denied or disputed claims will be treated as uncovered services, and you will be expected to pay such charges on a timely basis.
9. All insurance payments are applied to your account as long as any balance is due. This means refunds are made only after your balance is completely cleared with this office.
10. If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is on assignment to this office.
11. If there is a change of insurance company, employers, or insurance coverage, it is your responsibility to provide this office with the current information immediately.
12. If your case if a personal injury or workers compensation claim, regardless or your settlement from the insurance company, you are responsible for the account balance.
13. This office accepts, American Express, Visa, Mastercard, checks, Care Credit and HSA cards.
14. If you have questions concerning this or any other matter, please speak with us prior to seeing the Doctor.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient Signature (or Responsible Party) **Date**

Account Information

Initial:_____I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initial:_____I authorize the charge of my credit card if my appointment is cancelled missed or rescheduled with less than 24 business hours of notice before scheduled appointment time as follows: $25.00 for regular appointments, $100.00 for Softwave Therapy and $75.00 for exam/x-rays.

1. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

2. Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If account is not paid within 30 days of the date of service and no financial arrangements have been made, I authorize you to charge the credit card for all portions of my balance/fees. These fees can include legal fees, collection agency fee, and any other expenses incurred in collecting your account.

3. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient Signature (or Responsible Party) **Date**

Alpharetta Family
CHIROPRACTIC

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alpharettafamily.chiro@gmail.com
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No-Show/Cancellation Agreement

To Our Valued Patients:

Our mission is to serve and assist as many patients as possible to attain great health and wellbeing for themselves. We fill and reserve our appointment timeslots each day and make sure that none go unused. When patients call our office in need of a last-minute appointment, we do our best to get them in as soon as possible.

We certainly understand that emergencies and life circumstances happen that could get in the way of making it to an appointment. So that we can let another patient take your timeslot, please text or call us at **770-641-0029** within 24 hours ahead of your appointment time to cancel and reschedule. You can also leave a message on our answering machine and Halee will gladly reschedule your appointment for you.

If you miss your appointment, and do not call or text us ahead to cancel or re-schedule (NO CALL/NO SHOW), a $25 Missed Appointment Fee will be charged.

Missed Appointment / No-Show Agreement

First occurrence – Not charged

After first occurrence - $25 each time

Thank you,

Dr. Goodman , Alpharetta Family Chiropractic

Printed Name:_____

Signature:_____

HIPPA Compliance Patient Content Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By Signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. The patient has the right to revoke this content receipt of treatment upon execution of this content.

May we discuss your medical condition with any member of your family? Yes NO

If yes, please name the members allowed: _____

This consent was signed by _____

(Print Name Please)

Signature: _____ Date: _____