Alpharetta Family CHIROPRACTIC

5755 North Point Pkwy, Suite 53, Alpharetta, Ga 30022
Phone 770-641-0029 Fax: 770-643-7845
www.alpharettafamilychiropractic.com

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

Date: _____

About You…

Patient Name: _____
Last *First* *Middle*

Sex/Preferred Pronoun ☐ **Male** ☐ **Female** _____
DOB: _____ **Age:** _____
Mailing Address: _____ **Apt #:** _____
City: _____ **State:** ____ **Zip:** _____
Home Phone #: _____ **Mobile Phone #:** _____
Email Address: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
If Married or Partnership, Spouse's Name: _____
Children: ☐ **Yes** ☐ **No** **How many:** _____
Employer: _____
Employer's Address: _____
City: _____ **State:** ____ **Zip:** _____
Occupation: _____

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? _____

_____**"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."**

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: _____

_____

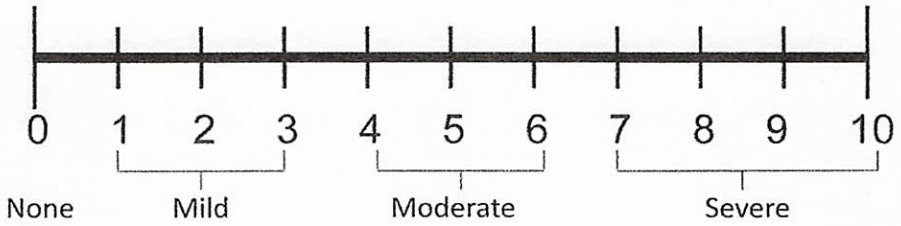
DO YOU: □ Take Vitamins/Supplements? □ Exercise? / How often? _____ □ Smoke? / How much? _____
Are you on a special diet? □ Yes □ No (Since _____/_____/_____) **Age of your mattress?** _____
Is it comfortable? □ Yes □ No **Are you wearing:** □ Heel Lifts? □ Sole Lifts? □ Inner Soles? □ Arch Supports?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

***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

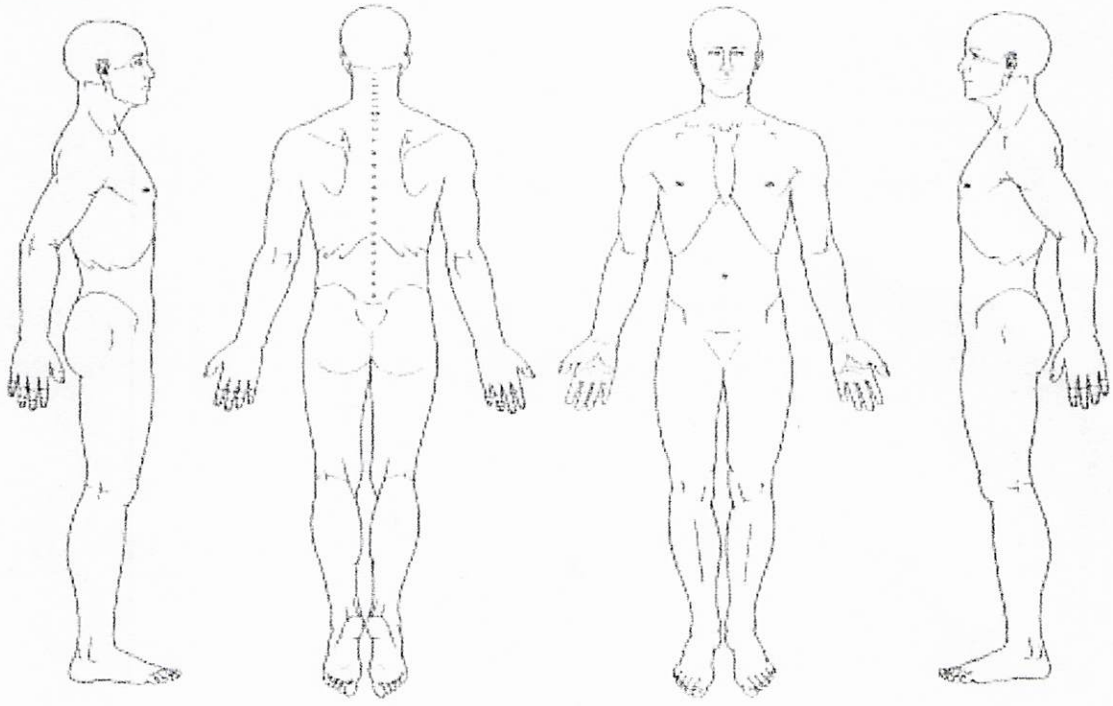


Mark area's that you're having symptoms, use the following descriptions.

Aching = AAA, Buring = BBB, Stabbing = SSS,

Numbness = NNN, Pins & Needles = PPP

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



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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. We do our best to have availability to take same day appointments while honoring prebooked appointments.

Please text or call us at 770-641-0029 within **24 hours ahead of your appointment time** to cancel and reschedule your appointment. Please leave a message or text us so we can confirm the cancellation. This ensures the ability to be able to serve our patients well by maintaining the daily appointment capacity. You can also use The Scheduling App or our website to make and change your appointment day and time. Ask us about The Scheduling App.

There will be a **$25 fee for no call/no show missed appointments**. We appreciate your understanding and working with us to provide the best care possible.

Missed Appointment / No-Show Agreement
First occurrence – Not charged
After first occurrence - $25 each time

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

1. 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.

I have read and understand the Cancellation/Credit Card Policy and agree to abide by these terms.

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

Credit Card Authorization for Card on File

_____ **I authorize Alpharetta Family Chiropractic to hold my credit care on file. We can keep your card safe on your file and charge the same card for your appointments.**

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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**

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: _____