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?

***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** _____

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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. We **do not** file secondary or supplemental insurance. We will file with your primary carrier but you will be responsible for filing with the other carrier. The balance on the account after the primary carrier has paid is the patient's responsibility. The only exception is when a Medicare patient has an automatic rollover from Medicare to the secondary or supplemental carrier and they pay us directly. The arrangement for the automatic rollover is the patient's responsibility.

8. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

9. This office will resubmit a claim **twice**. We will not enter into 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.

10. 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.**

11. 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.

12. 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.

13. If your case is a Personal Injury or Workmen's Compensation claim, regardless of your settlement from the insurance company, you are responsible for the account balance.

14. This office accepts MasterCard, Visa, Discover and personal checks. There will be a service charge of $30.00 for returned checks.

15. 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**

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Health Insurance Claim Form-1500

ASSIGNMENT OF BENEFITS
&
RELEASE OF INFORMATION STATEMENTS

BOX 2: Patient's *Printed* Name (Last Name, First Name, Middle Initial):

_____,_____

LAST *FIRST* *M.I.*

BOX 12: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: "I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party, who accepts assignment."

_____ _____

Patient's/Authorized Person's Signature *Date*

BOX 13: INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: "I authorize payment of medical benefits to the undersigned-physician or -supplier for services described below."

_____

Patient's/Authorized Person's Signature

Alpharetta Family Chiropractic, LLC
9570 Nesbit Ferry Road, Ste. 101
Alpharetta, Georgia 30022

(770) 641-0029

Notice of Patient Privacy Policy

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Halee Nicholson.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.alpharettafamilychiropractic.com` , calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent
Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

  For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We do not have open therapy/adjusting areas.

  We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

  We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *disclosures of psychotherapy notes*
- *uses and disclosures of Protected Health Information for marketing purposes;*
- *disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office*. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

  Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- ***You have the right to be notified by our office of any breech of privacy of your Protected Health Information.***

  You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:*

http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Halee Nicholson; you may contact our Privacy Officer, or any staff member, including Dr. Ashley Goodman, at the following phone number: (770) 641-0029, or our website, at www.alpharettafamilychiropractic.com for further information about the complaint process.

This notice was published and becomes effective on February 5, 2021.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Alpharetta Family Chiropractic, LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

_____ _____

Date **Signature**

_____

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

___ Patient Unavailable

___ Patient Physically Unable

___ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

___ Personally ___ Mail ___ Phone Follow Up

___ Other: _____

_____ _____

Date Signature

_____

Print Name of Physician

Alpharetta Family Chiropractic, LLC

Name of Practice