DULUTH CHIROPRACTIC
& WELLNESS CENTER

Steven M. Sommer, DC - Mayan Orgel, DC
3499 Duluth Park Lane, Suite 110 | Duluth, GA 30096
phone 770-623-9291 | *fax* 770-623-1308 | *web* www.duluthchiropractic.com

Date_____

First Name_____ Last Name_____

Phone Number (Cell)_____ (Home)_____ Email_____

Street_____ City,ST_____ Zip _____

Age_____ Gender_____ Date of Birth_____ Driver's License #_____

Name of Spouse_____ Contact#_____

Employer_____ Medical Physician_____

Referred to this office by: ❑ Google ❑ Yelp ❑ Insurance Company ❑ Friend or Family ❑ Zoc Doc ❑ Other

INSURANCE INFORMATION

Please check the following insurance you will be using in our office:

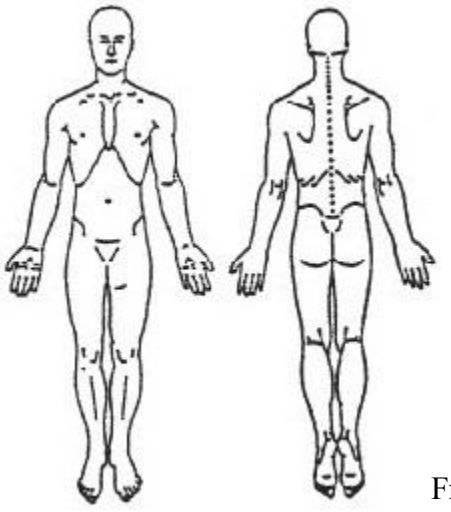
❑ No Insurance ❑ Major Medical (Health Insurance) ❑ Automobile Insurance (Auto Accident)

Patient Relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

In the diagram below, please mark the area(s) where your pain/symptoms are located using The following symbols: X = Pain, /// = Pins & Needles, O = numbness, ^^^ = Shooting Pain.

LIST AREAS OF PAIN

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____



Frequency of Pain: ❑ Constant ❑ On & Off

If an auto accident, what was the date of the accident?_____

How did this problem start this time? (What caused it? How did it start?)_____

_____

When did your problem start this time? (Date)_____

What makes it worse? _____

What makes it better? _____

Does coughing and sneezing increase the pain? ❑ Yes ❑ No

Any bowel or bladder problem now? ❑ Yes ❑ No If yes, please

explain:_____

_____

What is your occupation? _____

What physical activities does it require?_____

Please list all Doctors seen for this problem:

	Name of Doctor	Diagnosis	Treatment	Date Last Seen
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Please list all previous falls, broken bones and injuries:

1. _____
2. _____

Please list all past surgeries you have had in your life:

	Type of Surgery	Reason Why	Date Performed
1.	_____	_____	_____
2.	_____	_____	_____

Please list all medications you are taking for this problem and all others:

	Name of Medication	Reason for Taking
1.	_____	_____
2.	_____	_____

If female, by signing this form, I state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

Fees are payable at the time x-rays, examinations and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while the opportunity to ask questions regarding any treatment I receive and by signing belowI agree this form will act as consent for my present condition and for future conditions for which I will seek treatment.

If you are seeking treatment for injuries you sustained in an auto accident, please discuss all details with the doctor and staff. Office policy is that we do not accept Health Insurance as a form of payment for your treatment of these types of injuries. Please speak with staff to review our Personal Injury Checklist.

Health and accident policies are an arrangement between the carrier and the patient which are designed to offset a large portion of the total cost. This office will prepare any necessary reports and forms to assist in making collections from the insurance company. Any amount authorized to be paid directly to this office will be credited to the patient's account. It should be understood that all services furnished are charged directly to the patient who is personally responsible for payment. Payment is expected at time of visit unless your insurance is confirmed and assignment is accepted by our office.

Patient or Legal Guardian Signature:_____ Date_____

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HIPAA HEALTH CARE AUTHORIZATION FORM

Patient's Name_____

Patient's Date of Birth_____

The Patient identified above authorizes Duluth Chiropractic and Wellness Center to use and/or disclose protected health information with the following:

SPECIFIC AUTHORIZATIONS

_____ I give permission to Duluth Chiropractic and Wellness Center to use my address, phone number, email address, 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 Duluth Chiropractic and Wellness Center contacts me by telephone, I give them permission to leave a telephone message on my answering machine or voicemail.

OPEN ROOM AUTHORIZATION

_____ I give Duluth Chiropractic and Wellness Center permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak to the doctor at any time in private, he will provide a room for these conversations.

_____ By signing this form, I am giving Duluth Chiropractic and Wellness Center permission to use and disclose protected health information in accordance with the directives listed above.

EXPIRATION

This Authorization shall expire upon patient written request.

Patient or Legal Guardian Signature:_____ Date_____

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RIGHT TO REVOKE HIPAA AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your write request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Duluth Chiropractic and Wellness Center. The written notice must contain the following information:

- ➢Your name, social security number, and date of birth
- ➢A clear statement of your intent to revoke this AUTHORIZATION
- ➢The date of your request
- ➢Your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Duluth Chiropractic and Wellness Center for its own use/disclosure of PHI (Protected Health Information). (*Minimum necessary standards apply*)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Duluth Chiropractic and Wellness Center 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****

_____ _____

Print Name of Patient **Signature of Patient**

_____ _____

Date of Signature **Signature of Representative**

Description of Representative's Authority To Act For The Patient:_____

_____

_____

_____

Witness

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OFFICE POLICY

Thank you for trusting us with your health. We are committed to providing you with the best possible care. Understanding our office policies and fees is essential.

Please initial any of the below that apply to <u>your</u> visits with us:

_____ ***I have health insurance***. We accept many major medical insurance companies. You are responsible for the payment of your deductible, co-payment or co-insurance on all visits as well as any and all fees associated with the collection of these payments. Any procedures deemed by insurance "non-covered/patient responsibility" may be billed to you. We accept **CASH/CHECK/MASTERCARD and VISA**

_____ ***I have health savings I will use to pay for my care.*** FSA/HRA/HSA reimbursement accounts: Funds available: $_____. Let our staff know if you have a plan-issued debit card or checks, or if payments come to us directly from your plan. If the plan is responsible to send payments to us from these funds, you may be asked to leave a credit card on file with us should the available amount be depleted before your deductible, co-payment, or co-insurance can be settled.

_____ ***I have been in an auto accident. Date of accident _____.*** If you were involved in an automobile accident, we must have copies of your auto insurance card (to verify Medical Payments Coverage), police report, and the at-fault party's information including the claim number and adjustor's name. Medical Payments Coverage (should your policy carry it) is considered as the primary payer. We **DO NOT** bill Medical Insurance carriers as they will expect repayment of funds from our patients for services rendered so it is our policy not to accept Health Insurance for car accidents.

___ ***I do not have health insurance.*** I will be considered a SELF PAY patient.

Following is a list of our standard fees:

Examinations……..	$200-$375
XRays (including radiographic diagnostic analysis).....	$130-$250
Spinal Manipulation……	$75-$80
Therapies (includes: ice, laser, percussor, etc.).....	$45-$75
No-Show(fee to be charged due to canceling without notice/no-show)…….	$15-$20

As mentioned, some of the charges listed above may not be covered by insurance. Charges for these services, if they are provided to you during your visit, may be your responsibility. Signing this form acknowledges that you understand the policies outlined here. If you have any questions and/or concerns, please feel free to ask.

_____ _____
Patient Signature Witness

_____
Date

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LATE TO APPOINTMENT POLICY

If you are an **established** patient and you arrive to your scheduled appointment 10 minutes or more late, you will likely be asked to reschedule your appointment unless the Doctor's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between those patients. This may mean that you will have a wait time in the clinic. If this is not convenient for you, you may choose to reschedule. It is always our goal to see all of our patients as close to their appointment time as possible.

Likewise, if you are a new patient and you arrive **AT** the scheduled appointment time and not 15 minutes before your appointment to complete necessary paperwork as requested by our front office staff, or have not completed our registration paperwork you too may also be asked to reschedule.

MISSED APPOINTMENT OR "NO-SHOW" POLICY

While we make every effort to provide our reminder texting system **24hrs** before your appointment it then becomes **your** responsibility to remember that appointment. **If you do not show up or call to reschedule your appointment, we will enforce the following rule:**

- ➢ Arriving late may require you to be seen by another doctor than originally scheduled.
- ➢ **1st** infraction we will issue you a warning.
- ➢ **2nd** infraction you will be charged a **$15** missed appointment fee.
- ➢ **3rd** infraction the fee will increase to **$20** and will be charged prior to your next visit.

We ask that you please be courteous of the Doctors' valuable time and attention. This courtesy will also be afforded to the office staff as well as your fellow patients.

THANK YOU

_____ _____

Patient Signature **Date**