

Date _____

First Name _____ Last Name _____

Phone Number (Home) _____ (Work) _____ Email _____

Street _____ City _____ Zip _____

Age _____ Sex _____ Date of Birth _____

Driver's License No. _____ Medical Physician _____

Employer _____ Employer's Address _____

Name of Spouse _____

Date of Last Physical _____

Referred to this office by:

☐ Another Doctor - Who? _____

☐ A friend or family - Who? _____

☐ Google ☐ Yelp ☐ Insurance Company

INSURANCE INFORMATION

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

☐ No Insurance

☐ Major Medical (Health Insurance)

☐ Automobile Insurance (Auto Accident)

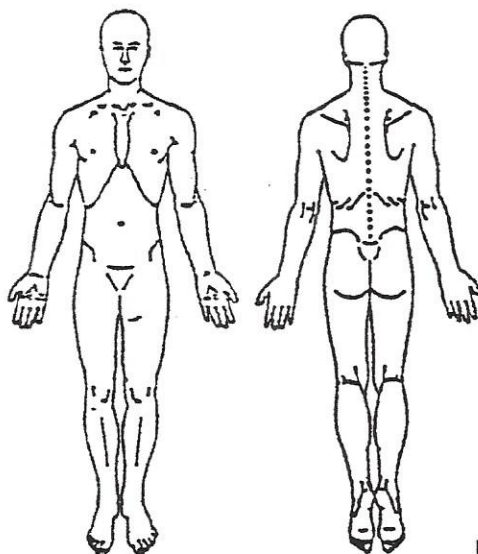
Patient Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Please mark the exact location of your pain with an "X" on the diagram below.

COMPLETE THESE DIAGRAMMS

LIST ALL AREAS OF PAIN

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



Frequency of Pain: ☐ Constant ☐ On & Off

If auto accident, what was date of accident? _____

Have you ever had this problem or similar problems before? If yes, please explain: _____

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 type of 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, accidents, broken bones and injuries:

	Type of Accident	Diagnosis	Date of Accident
1.	_____	_____	_____
2.	_____	_____	_____

Please list all past surgery 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	Name of the Doctor who prescribed Medication	Does it Help?
1.	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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 employed by, are associated with, or are serving as back up for the doctor of chiropractic named above. I understand I have the opportunity to ask questions regarding any treatment I receive and by signing below I 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 insurance 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 _____



Steven M. Sommer, DC

3499 Duluth Park Lane, Suite 110 | Duluth GA 30096

phone 770 623 9291 | fax 770 623 1308 | web www.duluthchiropractic.com

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 your 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.*** 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 (should your policy carry it) Coverage 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 chiropractic fees:

Examination.....	\$200.00 - \$375.00
XRays (including radiographic diagnostic analysis)	\$130.00 - \$250.00
Spinal Manipulation.....	\$75.00 - \$80.00
Therapies (includes: ice, laser, percussor, etc.).....	\$ 45.00 - \$75.00

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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HIPAA HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

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 voice mail.

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 with Dr. Sommer 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

The Authorization shall expire upon patient request.

**HIPAA
RIGHT TO REVOKE AUTHORIZATION**

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

You may revoke this HIPPA AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Duluth Chiropractic and Wellness Chiropractic. 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 HIPPA AUTHORIZATION
- The date of your request
- Your signature

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

This HIPPA 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 HIPPA 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 _____

Signature of Personal Representative _____

Description of Representative's Authority to Act For The Patient:

Witness: _____