DULUTH CHIROPRACTIC
& WELLNESS CENTER

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

Date _____

Please check the type of care desired: ❑ Temporary Relief ❑ Lasting Correction
❑ Check here if you want the Doctor to select the type of care he feels is best for you.

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? _____

❑ Phonebook ❑ Newspaper ❑ Television ❑ Sign ❑ Other

INSURANCE INFORMATION

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

❑ No Insurance
❑ Automobile Insurance (Auto Accident)
❑ Workman's Compensation (On The Job Injury)
❑ Major Medical (Health Insurance)

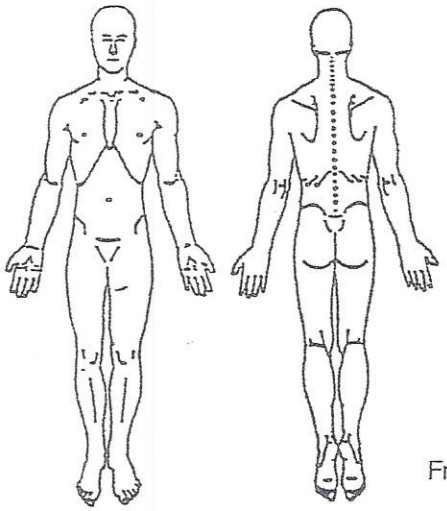
Patient Relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Please mark the exact location of your pain on the diagram below.

COMPLETE THESE DIAGRAMS

MAJOR COMPLAINT
(Please describe only
your major problem)

_____
_____
_____
_____
_____



Frequency of Pain: ❑ Constant ❑ On & Off

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.				

Do you have a history of cancer? ❑ Yes ❑ No

If yes, please explain: _____

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.				❑ Yes ❑ No
2.				❑ Yes ❑ No

Please list all supplements or vitamins you are currently taking:

Would you be interested in discussing vitamin recommendations with the doctor? ❑ Yes ❑ 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.

If treatment is to be rendered, I hereby authorize and give consent to the clinic to administer care and treatment as they so deem necessary.

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.

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 _____

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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. Martin or 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.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written 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 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 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_____

Signature of Personal 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:

___ As a courtesy to our patients, this office will verify insurance benefits. If insurance benefits cannot be verified while you are here, you will be asked to pay in full for your initial visit. ***I will be making payment for today's services with:***

☐CASH ☐CHECK ☐ MASTERCARD ☐ VISA ☐ CARE CREDIT

___ ***I have health insurance.*** We accept many major medical insurance companies, including Aetna, BCBS, Cigna, Coventry, Kaiser, Medicare, UHC and others. 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.

___ ***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 would like to apply for Care Credit.*** Ask for information about interest-free financing options.

___ ***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), health insurance card, 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 by your health insurance company as the primary payer and health insurance is the secondary payer.

___ ***I was hurt at work.*** If this is a work related injury, we must have written authorization from your employer in order to provide treatment.

Following is a list of our standard chiropractic fees:

Examination	$115.00 - $375.00
XRays (including radiographic diagnostic analysis)	$130.00 - $200.00
Spinal Manipulation	$70.00 - $80.00
Therapies (includes: ice, laser, percussor, etc.)	$ 45.00 - $75.00
Wellness Protocol	$ 65.00
Detoxification Footbaths	$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