

Patient Information

Date _____

Name _____ DOB _____ Age _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (C) _____ (W) _____

Email _____

Marital Status Married Single Widowed Divorced

Number of Children _____

Emergency contact name _____ Phone _____

Occupation _____ Employer _____

Name of medical doctor _____ Phone _____

Who referred you to our office _____ ?

Have you had x-rays, MRI, CT scan No Yes Date(s) Taken _____ ?

Please Describe Your Current Problem and how and when it began:

Is this injury/condition Work related Auto Related

How often is your symptoms Present 0-25% 26-50% 51-75% 76-100%?

How long have you had this problem Days Weeks Months Years?

Current complaint (how you feel today)

0 1 2 3 4 5 6 7 8 9 10
0 means no pain 10 indicates unbearable pain

Does this interfere with personal care lifting bending pushing pulling?

walking reading driving standing sleeping hobbies sports work concentrating

family/home responsibilities eating/breathing?

Authorization and Release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use my patient health information for the purpose of treatment, payment healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my doctor and agreed upon by me, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Patient or Guardian Signature _____ Date _____

Georgia Chiropractic Neurology Center
903 Bombay Lane
Roswell, Georgia 30076
(770) 664-4288
www.healthybrainnow.com

Patient Information

Past Medical History

What doctors you have seen for this or other conditions in the past 12 months:

Date_____Describe_____

Date_____Describe_____

Date_____Describe_____

Surgeries/Operations_____

Accidents or Falls (including car accidents)_____

Fractures or Dislocations_____

Were you ever knocked unconscious or stunned? Yes No

Chronic Illnesses_____

Hospitalizations_____

Hobbies: What occupies your spare time? _____

How long has it been since you felt really good? _____

Habits: number of hours of sleep per night_____ Trouble falling asleep? Yes_____ No _____

Wake with pain? Yes No

Number of sodas per day_____ Number of alcohol drinks per day _____ per week_____

Number of meals per day_____

Patient Information

Name of medication _____ for what condition _____

Name of medication _____ for what condition _____

Name of medication _____ for what condition _____

Family History Age Health Problem or case of death

Mother _____

Father _____

Mother's Mother _____

Mother's Father _____

Father's Mother _____

Father's Father _____

Brothers _____

Sisters _____

Children _____

Cancellation Policy

I understand that if I am unable to keep an appointment that it is my responsibility to notify Choose Life Chiropractic Neurology Center via phone at least 24 hours before my appointment. Furthermore I understand and agree that if I do not give this notification that I will be charged a fee of \$25. This fee is fully my responsibility and not that of my insurance company, or any other third party payer. I understand that this fee will be due before care on my next visit.

Signature _____ Date _____

Patient Information

HIPAA Patient Authorization

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

In the course of your care as a patient at Choose Life Chiropractic Neurology we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or in worker's comp cases to your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home/work to receive an appointment reminder, a message may be left. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care however, full payment will be expected at the time of services.

Under federal law, we are also permitted or required to use or disclose your health information with your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.
- If we ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you personally at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please, advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information at an address other than home or, if you would like the information in a different form please, advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect copy or amend your health, related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. We will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notices, our privacy practices or any aspect of our privacy activities, or if you would like any additional information regarding our privacy policies, please contact our office.

This notice is effective as this date. This notice and any alterations or amendments made to hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name _____ Signature _____

Date _____

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If you are a minor, or if you are being represented by another party:

Personal Representative Name _____

Personal Representative Signature _____

Date _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Dr. Marc Ellis will prepare any necessary reports and forms to assist me in collecting from the insurance company. Any amount paid directly to Dr Marc Ellis will be credited to my account. However, I understand that all services rendered to me are charged directly to me and I am responsible for the payment.

Patient Signature

Witness

Date

I authorize the doctor and their staff named above to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to claim for payment of charges incurred by me as a result of professional services rendered and hereby release them of any consequences thereof. I agree that a Photostat copy of this agreement shall serve as the original.

Patient Signature

Witness

Date

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor named above as payment toward the total charge for professional services rendered. I agree that a Photostat copy of this agreement shall serve as the original.

Patient Signature

Witness

Date

I give permission to Dr Marc Ellis to send a report to my Physician.

Physician's name: _____ Phone: _____

Patient Signature

Witness

Date

Email is a great way to make and confirm appointments plus receive our fun and fact filled educational newsletter to keep you abreast of all the latest development in the field of Chiropractic Neurology. If you would like to added to our list, please provide your email address here:

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