Perkins Chiropractic Clinic

3232 Krisam Creek Drive, Suite 200, Loganville, GA 30052 | 678-957-6808

Date _____

Name_____

Address_____

City_____State_____Zip_____

◯ Male ◯ Female Age_____

Birthdate _____/_____/_____ SSN#_____/_____/_____

Home (_____)_____

Work/Cell (_____)_____ ext. _____

Occupation_____

Employer_____

Employer Address_____

_____

Employer Phone (____)_____

◯ Single ◯ Married

Spouse's Name_____

Spouse's Employer_____

How did you hear about us or who referred you?

_____

E-Mail Address_____

Health Insurance_____

Policy #_____

In case of an emergency, contact:

Name_____

Relationship_____

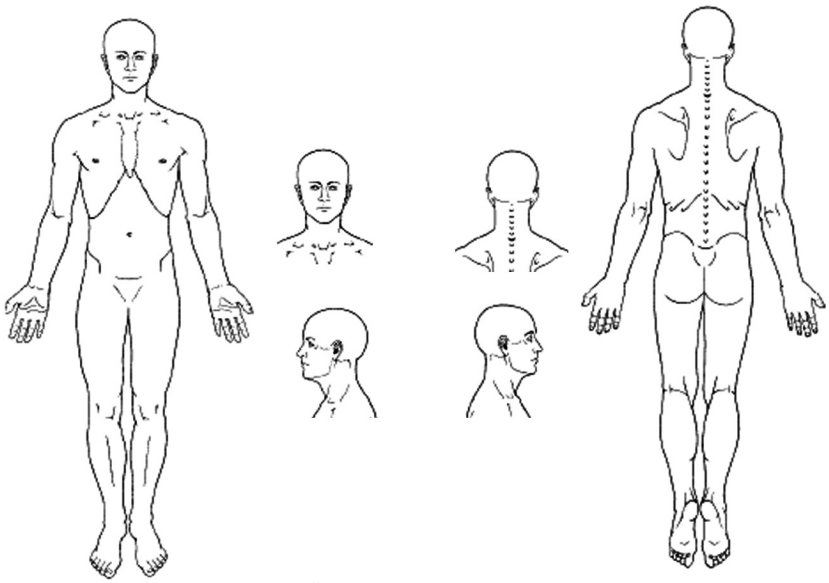
Home (_____)_____

Mark the diagram with the following:

X Pain

O Burning

● Numbness or Tingling



_____

_____

_____

_____

HEIGHT:_____ WEIGHT:_____

What is your major complaint?_____

How long have you had this condition?_____

Did it begin ◯ Gradually ◯ Suddenly ◯ Progressive over time

Have you had this or anything similar to this before?_____

Do any positions make it feel better? Describe how_____

Do any positions make it feel worse? Describe how_____

Type of pain ◯ Sharp ◯ Dull ◯ Ache ◯ Burn ◯ Throb

Does the pain radiate in to your ◯ Arm ◯ Leg ◯ Does not radiate

Is this condition interfering with your ◯ Work ◯ Sleep ◯ Daily Routine ◯ Other

Do you have numbness or tingling? ◯ No ◯ Yes

How often do you experience these symptoms ◯ 100% ◯ 75% ◯ 50% ◯ 25% ◯ 10%

What do you think caused this condition?_____

Do you have any family members who suffer from the same complaint? _____ If so, who?_____

Is the condition due to an accident? ◯ No ◯ Yes Date_____ Was it due to: ◯ Auto ◯ Work ◯ Home ◯ Other

Rate the severity of your pain on a scale of 1 (least painful) to 10 (severe pain)_____

Are there any other doctors that you have seen for this problem? The date(s)_____

_____

Who is your primary care doctor?_____

Mark the box next to any condition you have or have had in the past.

- ◯ Allergies
- ◯ Arthritis
- ◯ Cancer
- ◯ Dizziness
- ◯ Diabetes
- ◯ Digestive Problems
- ◯ Kidney Problems
- ◯ Heart Conditions
- ◯ Reproductive Problems
- ◯ Migraine/Headaches
- ◯ Stroke
- ◯ Sinus Problems

Please list any other conditions or symptoms that are not listed above concerning your health history.

_____

_____

EXCERCISE	WORK ACTIVITY	HABITS
◯ None	◯ Sitting	◯ Smoking_____Packs/Day
◯ Moderate Type _____	◯ Standing	◯ Alcohol _____Drinks/Week
◯ Daily Duration_____	◯ Light Labor	◯ Coffee/Caffeine_____Cups/Day
◯ Heavy	◯ Heavy Labor	◯ High Stress Level_____

Have you ever been treated by a chiropractor ◯ Yes ◯ No Name _____Date_____

Are you pregnant? ◯ Yes ◯ No Due Date_____

Injuries/Surgeries you have had

	Date	Description
Auto Accidents	_____	_____
Surgeries	_____	_____
Hospitalization	_____	_____
Falls	_____	_____
Broken Bones	_____	_____

Are you currently taking any medications ◯ Yes ◯ No Type_____

I hereby consent to the performance of the chiropractic adjustment and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays. I further understand that in all healthcare, there are some risks involved. However, in chiropractic care the risks are minimal. I understand that at any point in my care I have the opportunity to discuss my care with the doctor. I understand that results are not guaranteed.

I assign Advanced Chiropractic Clinic P.C. direct payment of all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information neccessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship or authority if not signed By patient

_____

Witness

PERKINS CHIROPRACTIC CLINIC
3232 KRISAM CREEK DR STE 200

Perkins Chiropractic & Rehab

3232 Krisam Creek Suite 200
Loganville, GA 30052
(678) 957-6808
www.perkinschiropractic.net

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out It's health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
    a) A postcard mailed to me at the address provided by me; and
    b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for *seven years*. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative* Relationship Date Signed ____/____/____

Witness: _____*Attorney-In-Fact, Guardian, Parent if a minor

PERKINS CHIROPRACTIC
FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:**
All payments are expected at the time of service.

2. **If You Have Insurance:**
All deductibles and co-payments are expected at the time of service or by an authorized payment plan You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for some insurance assignment (i.e., Medicare). Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Should your account be placed with collection services, you will be charged a fee of 33% of your total outstanding balance at the time the account is placed.

By signing below you are acknowledging that you have read and understand our financial policy.

Patient's Printed Name: _____

Signature: _____ Date: _____

Witness: _____