Alternative Health Chiropractic Center

Phone: (678) 344-4533 Fax: (678) 344-4548

2164 North Rd. Snellville, GA 30078

Patient Health Assessment

General Information

Patient Name:		Date:
Provider Name:		
Primary Care Physician's Name:		
Patient Sex: **M F** Date of Birth:	Social Security #:	
Patient Address:	City:	Zip:
Home Phone:	Work Phone:	
Patient Employer:	Patient Occupation:	
Subscriber Name:	Relation to Patient:	
Subscriber Employer:	Subscriber SSN:	
Referred for Treatment by:		
Health Insurance Plan:	Group #:	Member#:

Complaint History

1. Describe your current complaint and how the problem began: _____

   _____

   How long have you had this condition? _____ Date of Onset: _____

2. How would you describe the pain?

   ☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness

   ☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

3. How would you rate the intensity of your pain? (Circle the appropriate number)

   0 1 2 3 4 5 6 7 8 9 10

   (no pain) (moderate pain) (terrible/unbearable pain)

4. How often is the pain present?

   ☐ Constant(81-100%) ☐ Frequent(51-80%) ☐ Occasional(26-50%) ☐ Intermittent(25% or less)

5. Since your problem began is the pain:

   ☐ Getting worse ☐ Getting better ☐ Staying the same

6. How did your problem begin?

   ☐ An auto accident ☐ Work related accident ☐ Other type of accident Explain: _____

   ☐ Gradual ☐ Sudden ☐ No specific reason _____

7. What makes your problem better?

   ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/exercise ☐ Lying down ☐ Inactivity

8. What makes your problem worse?

   ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/exercise ☐ Lying down ☐ Inactivity

9. Are you currently taking any medications? ☐ Yes ☐ No

   If yes, please describe _____

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Patient Health Assessment (Cont)

10. Were you previously treated for an earlier occurrence of this same condition? ☐ Yes ☐ No

If yes, by whom? ☐ MD ☐ Chiropractor ☐ Physical therapist ☐ Other _____

What were the approximate dates, type of treatment, and the results? _____

_____

11. What is your physical activity at work?

☐ Mostly sitting ☐ Light manual labor ☐ Moderate manual labor ☐ Heavy manual labor

12. Do you exercise?

☐ No regular exercise ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5-7 times a week ☐ Cardiovascular

☐ Stretching ☐ Weight Machine ☐ Free Weights ☐ Sports (list type) _____

13. What is your present general stress level:

☐ No stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?

☐ No effect ☐ Have some limited physical restrictions, but can function

☐ Need some assistance with daily activities ☐ Cannot work

Past or Present Symptoms, Conditions or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck Pain	☐	☐	High blood pressure	☐	☐
Shoulder pain	☐	☐	Heart condition	☐	☐
Arm/elbow pain	☐	☐	Respiratory condition	☐	☐
Hand pain	☐	☐	Digestive problems	☐	☐
Upper back pain	☐	☐	Kidney/bladder problem	☐	☐
Lower back pain	☐	☐	Menstrual problems	☐	☐
Pain in upper leg or hip	☐	☐	Breast soreness/lump	☐	☐
Pain in lower leg or knee	☐	☐	Sinus conditions	☐	☐
Pain in ankle or foot	☐	☐	Allergies/asthma	☐	☐
Jaw pain	☐	☐	Cancer	☐	☐
Swelling/stiffness of joints	☐	☐	Stroke	☐	☐
Headaches	☐	☐	Excessive weight loss/gain	☐	☐
Dizziness	☐	☐	Skin condition	☐	☐
Fainting Spells	☐	☐	Arthritis	☐	☐
Convulsions	☐	☐	Diabetes	☐	☐
General prolonged fatigue	☐	☐	Prostate condition	☐	☐
Condition of uterus/ovaries	☐	☐			

Tobacco use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

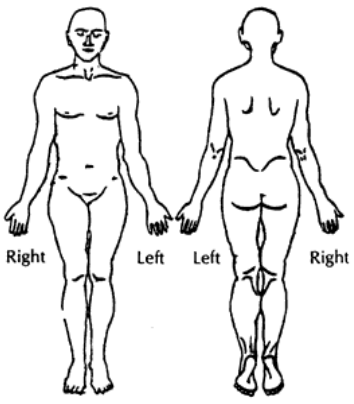
Alcohol use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Caffeine use: (coffee, tea, soft drinks)
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Pregnancy:
☐ Past ☐ Present

Surgical Procedure:
☐ Past ☐ Present

Please list:



Please shade in the figures to the left where you have pain, or other symptoms.

I have reviewed the information contained on this form with the patient.

_____
Patient Name

_____ _____
Provider Initials Date

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Patient Health Assessment

NAME_____ **CASE#** _____

Consent for Treatment

I, the undersigned, hereby authorize Dr._____ and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account.

HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature_____ **Date**___/___/___ **Witness**_____

Authorization to Release Medical Information

I authorize Dr._____ to release any medical information pertinent to my treatment plan to my primary care physician or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient's Signature_____ **Date**___/___/___ **Witness**_____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to ALTERNATIVE HEALTH CHIROPRACTIC CENTER the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature_____ **Date**___/___/___ **Witness**_____

Attorney Representation and Protection of Balance

I, the undersigned patient am directing my attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, will require me to make payment on a current status.

Patient's Signature_____ **Date**___/___/___ **Witness**_____

Consent for Treatment of Minor

I hereby authorize Dr._____ and whomever he/she may designate as his/her assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my (indicate relationship of child) _____ (child's name) _____

Guardian's Signature_____ Date___/___/___ Witness_____

X-Ray/Medical Records Release

I have requested the release of records of (patient's name)_____ which are a part of the records at (facility)_____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostastic copies, abstract or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning that I may have had in the past, now have, or may have in the future. Please forward this to Alternative Health Chiropractic Center 2164 North Road Snellville GA, 30078

Patient's Signature_____ Date___/___/___ Witness_____

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Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment. The following is a statement of our financial policy, which we require you read and sign prior to any treatment. The staff and employees of this facility are not authorized to deviate from the stated options in this policy. Any request for deviation will be taken under advisement and reviewed according to individual merit.

All patients must complete our information and insurance form before seeing the doctor. FULL PAYMENT IS DUE AT TIME OF SERVICE, unless insurance has been verified. Any co-pays or deductibles will be due at time of service. We accept CASH, CHECKS, VISA, MASTER CARD OR DISCOVER. We offer a discount program on certain services, if patient pays for each visit at time of service, maintains a zero balance and files their own insurance (separate policy for this service).

INSURANCE OPTIONS

We will be happy to accept assignment of benefits according to the terms of your policy, provided the plan includes chiropractic care. We do require your co-payment, deductibles and non-covered services be paid at time of service. We will set up your account according to the insurance company's verification. However, please keep in mind that this is strictly a verification of benefits and does not guarantee payment. You will be responsible for any balance not covered by your insurance.

In the case of **Worker's Compensation**, we must have all necessary information to verify coverage prior to administering treatment. The person authorizing treatment must warrant that he/she is qualified and sanctioned by the employer to give such endorsement or this clinic must appear as pre-authorized on the required "Panel of Physicians" on file in the appropriate place in your work place.

In the instance of a **motor vehicle accident**, be aware that you are ultimately responsible for payment in full, no matter who or what caused your accident, regardless of insurance coverage and any litigation. We do not accept attorney's liens in lieu of payment. Normally the "At Fault" persons insurance will not pay during the treatment phase, but rather wait for you to settle. This settlement usually occurs once you are released from care. In the interim, you have several options to consider. 1. We can file with your auto insurance provided you have MED PAY on your plan (it is your responsibility to report the accident to have a claim number assigned). This coverage in considered primary in the State of Georgia. 2. If you do not have MED PAY then we can file with your health insurance carrier. 3. If you do not have any of these options available to you, we will set you up on a monthly payment plan (remaining balance will be due 60 days from release date). 4. Discount program on certain services is offered if patient pays for each visit at time of service, maintains a zero balance and files their own insurance (separate policy for this service).

The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with complete and current information. If your insurance company has not paid your account within 60 days, the balance will be automatically transferred to patient responsibility and the bill will be due upon receipt. Our practice makes every effort to bill your insurance company within 48 hours of treatment. Unfortunately, all insurance companies do not pay for service in the same manner. Coverage that cannot be verified, for any reason, will be treated as a cash account until verified.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and our fees are based upon what is usual and customary for this area. You are responsible regardless of any insurance company's arbitrary determination of usual and customary rates.

I agree that if outside collection and/or legal action against me for collection of my account(s) becomes necessary, the clinic is authorized to add to my account(s) any charges encountered including: legal, filing, collection or other fee appropriate to collection of the account(s).

_____ _____

Signature (Parent/Guardian if minor) Date