Mitchell Chiropractic
2098 Teron Trace, Suite 300
Dacula, GA 30019

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:___________________________ M.I.___ **Last Name**:___________________________

Email address: __________________@__________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____________________

Current Address: ____ **City:** ________________________________

State: _____ **Zip:** ___________ **SS#:** ____________________________ **Home #:** _____________________________

Cell #: ________________________ **Employer:** _______________________ **Occupation:** _____________________

Work #: _____________________ **Marital Status:** _______________ **Spouse's Name:** ______________________

Spouse Phone #: _____________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): ___________________

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications?	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Medication	Reaction

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

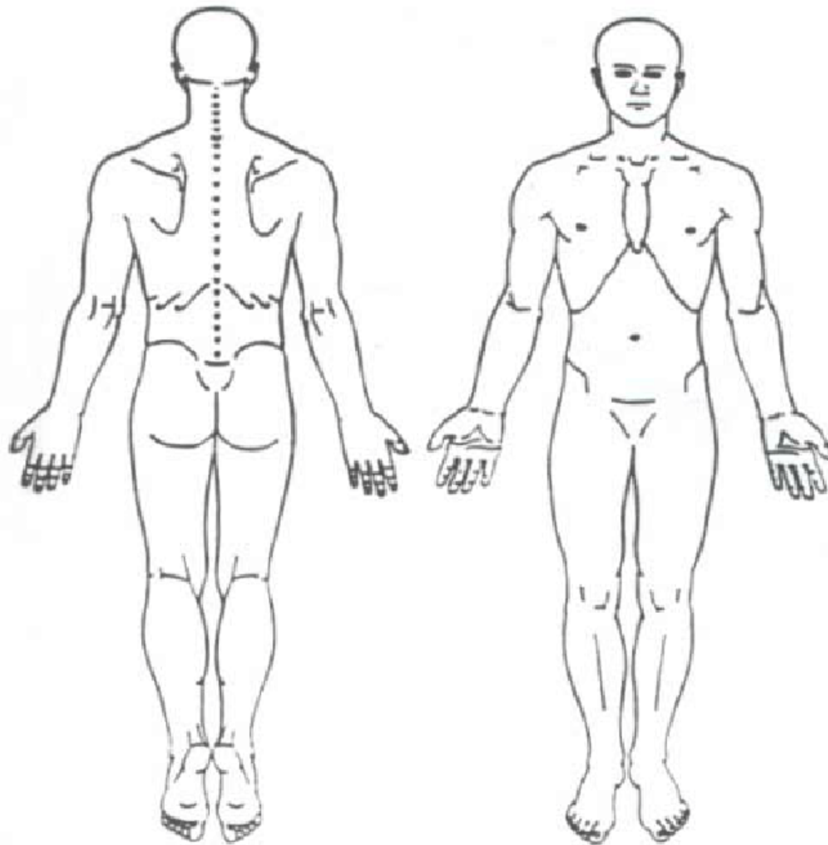
Present Health

My present symptoms are: ____
____
Purpose of this appointment: ____
Job Related: _____ Auto Related: _____ Date of Accident: ____________________
List any major traumas: ____
List any surgeries: ____
List any medical conditions/ issues: ____
____
If applicable, are you pregnant: _____ Yes _____ No
Describe your current exercise regimen: ____
____

Please Circle Any of Following Conditions You Have

Neck Pain	Emphysema	Seizures
Back Pain	Difficulty Breathing	Paralysis
Lower Back Pain	Shortness of Breath	Muscle Weakness
Chest Pain	Heart Disease	Depression
Extremity Pain	Angina	Coordination Difficulties
R/L Arm Pain/ Tingling	High Blood Pressure	Cataracts
R/L Leg Pain/Tingling	Fasciotomy	Pneumonia
R/L Foot Pain/Tingling	Edema	Bronchitis
R/L Hand Pain/Tingling	Arthroplasty	Asthma
Fingers/Toes Pain/Tingling	Nausea	Spit Up Blood
Spasms	Vomiting	Cough
Dizziness	Constipation	Postnasal Drip
Vision Disturbance	Blood In Stool	Sinusitis
Motion Restriction	Gas/ Bloating	Frequent Colds
Radiating Symptom	Liver Disease	Ear Ringing Earaches
Sleep Disruption	Hemorrhoids	Impaired Hearing
Anxiety	Abdominal Pain	Change in Taste Goiter
Night Sweats	Peptic Ulcer	Double Vision
Headaches	Gallbladder Disease	Fainting
Head Injury	Pain on Urination	Kidney Stones
Impaired Vision	Ligament/Tendon Repair	Tearing/Dryness
Corrected Vision	Muscle Spasms	Deep Leg Pain

USE THE PICTURE BELOW TO INDICATE YOUR PROBLEM AREAS



PLEASE RATE YOUR PAIN ON A SCALE OF 1-10
1=MILD PAIN 10=THE WORSE PAIN YOU'VE EVER FELT

LOCATION PAIN RATING DESCRIBE SYMPTOM

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

MITCHELL CHIRORPRACTIC INSURANCE FORM

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: ____________________________ Phone #: ________________________

Policy #/ Subscriber ID: ____________________________________ Group # _____________________________

Relationship of insured to the patient: ___ Self ___ Spouse ___ Child ___ Other

Name of Insured Person: ______________________________ Insured Date of Birth: ______________________

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: ____________________________ Phone #: ________________________

Policy #/ Subscriber ID: ____________________________________ Group # _____________________________

Relationship of insured to the patient: ___ Self ___ Spouse ___ Child ___ Other

Name of Insured Person: ______________________________ Insured Date of Birth: ______________________

INSURANCE INFORMATION FOR PERSONAL INJURY ACCIDENTS/ WORKERS COMP:

Insurance Company Name: ____________________________ Phone #: ________________________

Claim #: ____________________________________ Adjuster Name: ____________________________

Address: ____

___ Medical Payment Claim ___ Liability Claim

Attorney Name & Phone #: ____

ATTENTION: PERSONAL INJURY CLAIMS – I HEREBY AUTHORIZE THE STAFF AT MITCHELL CHIROPRACTIC TO DISCUSS WITH THE ATTORNEY AND OR INSURANCE CO ANY INFORMATION PERTAINING TO MY AUTO CASE. INITIALS: ____

I understand that insurance is being flied as a courtesy for me. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered and that any amount authorized to be paid directly to Mitchell Chiropractic will be credited to my account upon receipt. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Co-pays, coinsurance, or any amounts applied to your deductible are due at time of service. I also understand that if suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

(Guardian) Patient's Signature: ___________________________________ Date: ____________________

Print Patient's Name: ______________________________________

MITCHELL CHIROPRACTIC

Informed Consent to Medical or Chiropractic Treatment and Care

I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment or soreness after a massage. If that happens, I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms, I can call the number listed above during office hours for an emergency appointment. If any tests were performed outside the office (laboratory or other diagnostic procedures), I understand that if available, the doctor will notify me of the results at my next appointment.

I hereby request and consent to the performance of chiropractic adjustments and other treatment procedures, including various modes of physiological therapies and, if necessary diagnostic x-rays on by my doctor. I have had an opportunity to discuss with the doctor(s), and/or with other office of clinic personnel, the nature and purpose of chiropractic and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, included but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read the above consent to chiropractic and/or medical treatment as indicated by my signature. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this form to cover the entire course of treatment for my present and for any future conditions for which I seek treatment.

(Guardian) Patient's Signature: ______________________________ Date: __________

Print Patient's Name: ____________________________ Date: __________

HIPAA Notice of Privacy Practices

Mitchell Chiropractic
2098 Teron Trace, Suite 300
Dacula, GA 30019
(770)614-4060

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEAES REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, pay or health care operations (TPO) and for other purposes or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Information

Uses and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manager your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities, employee review of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready for you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors. And Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required uses and disclosures; under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

__Your rights__
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not use or disclose any part of your protected health information for the purpose of treatment, payment of healthcare options. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care of for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

__**You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,**__ upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and awe may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

__Complaints__
You may complain to us or to the Secretary of Health and Human Services if your believe your privacy rights have been violated by us. You may a file complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/ or before January 1, 2012.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is acknowledgement that you have received this Notice of our Privacy Practice:

THIS IS YOUR COPY TO KEEP FOR YOUR RECORDS.

MITCHELL CHIROPRACTIC

FINANCIAL & CLINIC POLICIES

- Statements are mailed monthly. Payments are due by the 15th of the following month unless other payment arrangements have been made with the office manager.
- All co-pays, co-insurance, or deductibles are due at the time of service.
- If no payment is received by the next statement date, a late fee of $20.00 or 20% will be added, whichever is more, to the balance.
- Accounts that have not received payments for 3 months will be sent out to a collection agency. Furthermore, an additional collection fee may be placed on the balance.
- Patient medical records are property of MITCHELL CHIROPRACTIC. Any requests for records including x-rays require 24-hour advanced notice prior to pick up or being mailed out. Additionally, any patient requesting a copy of their medical record will be a charged a fee that is set by Georgia State Mandate.
- Benefits and coverage are checked as a courtesy for you the patient. All patients are ultimately responsible to know and monitor their own benefits. (Things to look for regarding your policy are deductibles, co-pays, co-insurances, referrals, number of visits, any non-covered services, and if the doctor is in network with your specific plan)
- The office will bill your insurance company for you; however, we allow the insurance company 60 days to pay the office. After this period, the balance will become the patient's responsibility, and then you can follow up with your insurance company for reimbursement.
- Any letters, documents, or forms that are requested for the doctor to write or fill out will be charged a $10.00 minimum and require at least 24 hours prior notice to needing them (the doctor may require more time depending on the schedule).
- Any insufficient fund checks will be charged a fee of $25.00.
- Appointment cancelation fee is $25.00 for all appointments canceled with less than 24-hour notice. You may leave a message on our answering machine in order to cancel an appointment.
- Any payments over $500.00 that are placed on a credit card will be subject to an additional 3% charge.
- Any and all other financial account questions should be discussed with the office manager.

I understand the above financial policies of Mitchell Chiropractic. I have been given a chance to have any questions answered. I agree to consent to financial responsibility for any charges acquired. I understand the clinic's policies regarding payment, cancellations, and additional requests. I have received a copy of the HIPAA Policies and know a copy can be requested.

Patient/ Guarantor Signature: ______________________________ Date: _____________________

Print Patient's Name: ____________________________________

Mitchell Chiropractic
2098 Teron Trace, Suite 300 Dacula, GA 30019
Office: (770)614-4060
Fax: (678)482-7788

AGREEMENT OF ASSIGNMENT OF SETTLEMENT; REDIRECTION OF PAYMENTS

Patient ___________________________

Attorney/Insurance Co _________________________

Telephone _______________________________

I, hereby authorize and direct you, my attorney, to pay directly to MITCHELL CHIROPRACTIC all sums that are due and owed to MITCHELL CHIROPRACTIC for health services rendered to me for this person injury and for any other bills due and to withhold such sums from any judgement, settlement, or verdict to satisfactorily protect MITCHELL CHIROPRACTIC. I also permit that the settlement check may be made payable to the attorney, MITCHELL CHIROPRACTIC, or the patient and no payment that is due to MITCHELL CHIROPRACTIC can be paid to me.

I, hereby further irrevocably create this assignment on my case and irrevocably assign with preference said assignment to the above-named PROVIDER against any and all proceeds of the settlement, judgment, or verdict which may be paid to you my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said PROVIDER for all health care services rendered to me and this assignment is made solely for the PROVIDERS additional protection and in consideration to said PROVIDERS awaiting payment in the event this case is assigned by me to attorney not a signatory herein. I understand and agreed that all monies due to said PROVIDER would be due and payable immediately. I further agree that the PROVIDER has only agreed to wait a period of twelve (12) months from the date of hereof for payment, and if not paid within the time, I understand that the PROVIDER may look to me for immediate payment.

I UNDERSTAND THAT THIS AN IRREVOCABLE ASSIGNMENT

(Guardian) Patient's Signature __________________________________ Date: ____________________

Print Patient’s Name: ______________________________

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IRREVOCABLE ESCROW INSTRUCTION AND AGREEMENT

The undersigned patient (herein after "Patient") in order to induce Mitchell Chiropractic to extend credit to the Patient, hereby irrevocably instruct my attorney, insurance adjuster, and escrow agent, to pay the Provider, from the proceeds of my personal injury settlement or award within ten (I 0) days of receipt by him of same, excepting time for any negotiable instrument to clear.

This escrow instruction and agreement is irrevocable by me and is being used to include the Provider to provide continued medical services to me resulting from my accident.

(Guardian) Patient's Signature ______________________________ Date: _________________

Print Patient’s Name: _____________________________