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

INSURANCE INFORMATION

Primary Insurance Company: _____

Insurance Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____

Policy/ID #: _____ Group #: _____

Relationship of Insured to the patient (Circle one): Self / Spouse / Child / Other

Name of Insured: _____ Insured date of birth: _____

I understand that insurance is being filed as a courtesy for me. I understand and agree that, 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, co-insurance, deductibles, or any dates of service denied by my insurance company are ultimately my responsibility and due at the time of service. I also understand that if I suspend or terminate my care and treatment, and 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 the office of any changes in my status of the above information.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

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.

Patient/ Guarantor Signature: _____ Date: _____

Print Patient's Name: _____