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

Doctor Initials: ____

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: _____

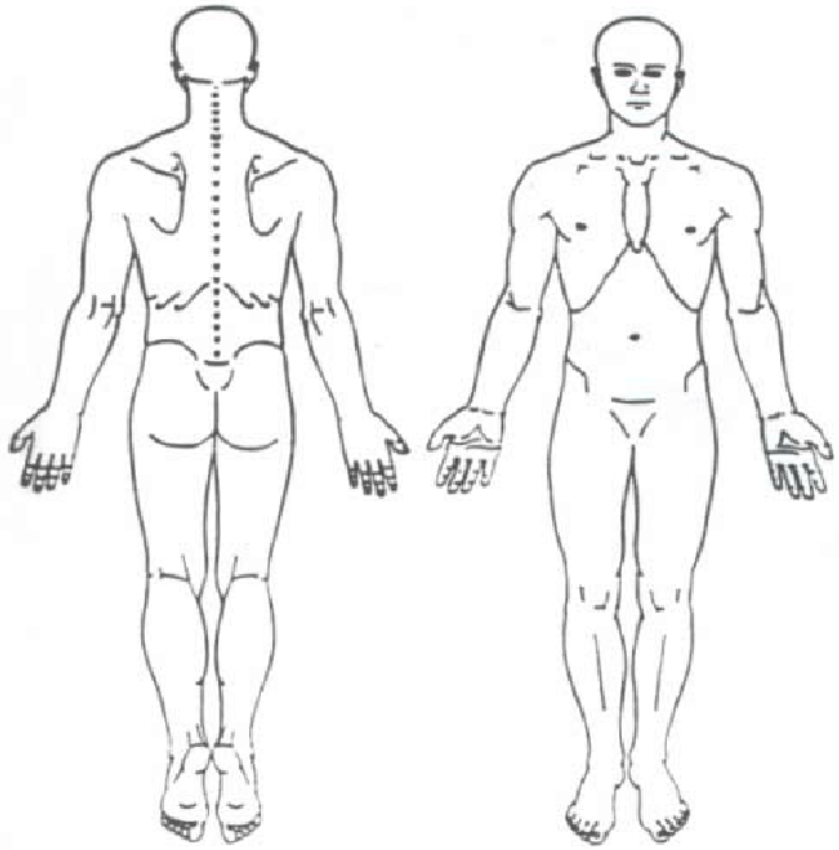
_____

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

Doctor Initials: ____

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.			

Doctor Initials: ____

INSURANCE FORM
THIS FORM MUST BE COMPLETED.

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: _____

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 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: _____

Doctor Initials: ____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, Class III or Class IV lasers, Non-surgical spinal decompression, Extracorporeal shock wave therapy, cervical and lumbar traction, and ultrasound; including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million visits.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date:_____

Witness Name: _____ Signature:_____ Date: _____

Doctor Initials: ____

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 can be subject to fees 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 cancellation 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: _____

Doctor Initials: ____

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.