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: _____

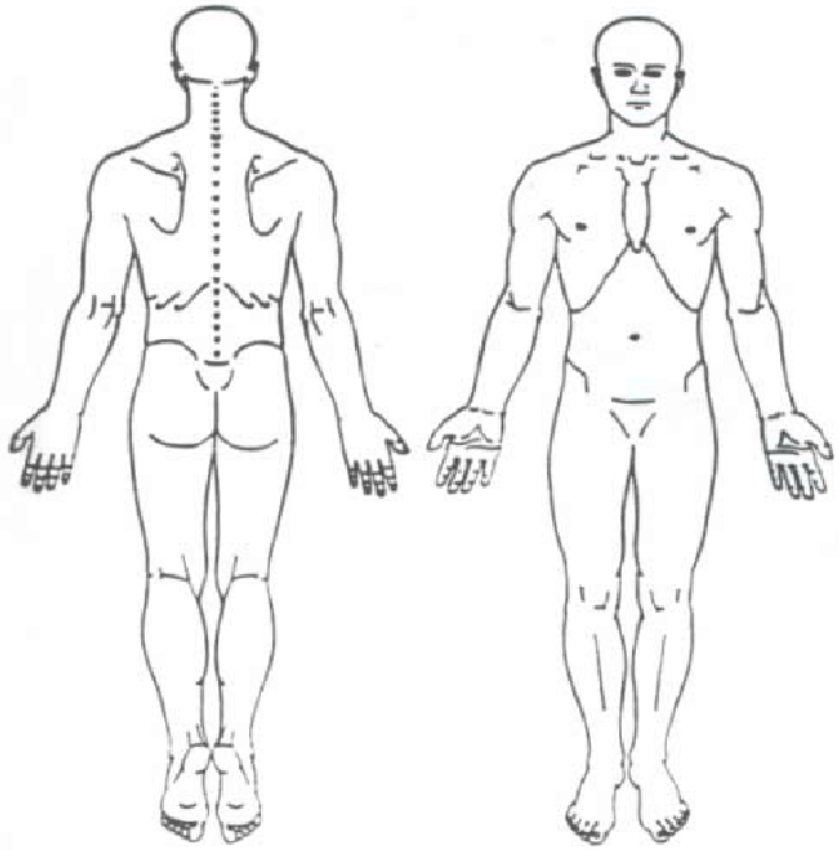
_____

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: ____

MOTOR VEHICLE/ WORKERS COMP INSURANCE FORM

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/ WORKERS COMP CASE. INITIALS: ____

(Guardian) Patient's 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.

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: ____

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any Insurance company, attorney, or adjuster To process any claim for reimbursement of charges incurred by me at your treatment facility.
2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider authority to affix my necessary signature as noted below to obtain medical information from any hospital, medical provider, etc., as It relates to the care being provided by my chiropractic doctor.
3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any Insurance company which may become obligated to pay me any sums. The Patient(s) grant(s) to the Provider a Limited Power of Attorney to receive funds, negotiate any drafts or checks and execute any documents related to payment for services rendered to me.
4. ASSIGNMENT OF RIGHT TO SUE: In the event, any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve the said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
5. RIGHT TO LIEN: I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my Injury, Including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you. I also irrevocably instruct my attorney to pay this office in full for services rendered to me for my accident-related injuries from any proceeds or settlements, claims, or judgment regarding said injuries. My legal counsel [**NAME]** or successor or any representative is to pay the doctor/clinic before distributing any proceeds to me. I instruct said legal counsel or representative not to attempt to reduce by means of negotiation my Doctor's bill for services that have been provided to me for the accident/injury/illness, which I have agreed to pay in full.
6. RIGHT FOR INFORMATION: I irrevocably authorize my attorney, [**NAME]** or successor or legal representative, insurer, or any other party regarding my care or case to release financial information about the proposed settlement, settlement/verdict payments, or amounts owed included, but not limited to other providers or legal representatives, liens, billing amounts, and balances. I also instruct all representatives to include all financial information from all facets of my case, including, but not limited to, third-party, uninsured motorists and underinsured motorists.
7. I irrevocably waive the Statute of Limitations regarding my Doctor's right to recover from me directly.
8. I hereby acknowledge that I am receiving (or about to receive) health care services, and I am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there Is no insurance company obligated to pay for the services, or if the insurance company Involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or If I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid In full

(continued)

Doctor Initials: ____

Immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim Is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

9. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all court costs, attorney's fees, service of process fees, and any reasonable additional costs incurred in order to collect or that are associated with collecting monies due on the patient's· account.
10. No Surprise Act: Our fees are derived from the Medical Fees in the United States by the Physicians Medical Information corporation 2022. They have been geographically modified and are billed at the **75th** percentile. A good faith estimated cost for the items and services that would be furnished by this provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services will be provided after my first visit. I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible, out-of-pocket limit, or be covered. I'm giving up some consumer billing protections under federal law. I may get a bill for the full charge for these services or have to pay out-of-network cost-sharing under my health plan. I irrevocably consent in accident cases to have balances applied towards liens or letters of protection with my attorney. With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured.
11. I understand that this document is irrevocable, may not be rescinded, and that my attorney shall not honor any such recession. I hereby instruct that in the event another attorney is substituted in my case, the new attorney honor this lien as inherit to the settlement, judgment, verdict, or any other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on-demand, to provide the status of such litigation to the provider or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact the provider before disbursement of any funds to ascertain any outstanding balances due and owing.

Dated Signature ___ day of _____ 20 __

Patient Signature_____

Witness Signature _____

Lawyer's Receipt Verification

___ Sent via Certified US Mail

___ Sent via Fax with Receipt Confirmation

Staff Name [print] _____

Date: _____

Staff Name [sign] _____

Doctor Initials: ____