Atlanta Natural Health Clinic
NRT PATIENT INFORMATION FORM

Name_____ Date_____
Address _____
City _____ State_____ Zip_____ Date of Birth _____ Age _____
Home Phone (_____) _____-_____ Work Phone (_____) _____-_____
Cell Phone (_____) _____-_____ Social Security number: _____
e-mail address: _____
Occupation _____ Employer_____
Referred by: _____
Sex: M / F Height _____Weight _____ Overall health (circle one): Excellent Good Fair Poor

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____
_____
_____

Previous treatments for this complaint

_____
_____
_____

Current medications/drugs being taken: (use separate sheet if needed)

_____
_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name, date of last visit and indicate the specialty)

_____

Nutritional supplements you are taking:

_____
_____
_____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)
Cigarettes _____ Coffee _____ Alcohol_____

HISTORY:
List any major illnesses with approx. dates:

_____
_____
_____
_____

List any surgery or operations with approx. date:

_____
_____

Past Accidents or injuries:

_____
_____
_____
_____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply):
Cancer
Diabetes
Heart
Other _____

Any household pets or other animals you or family members are in close contact with:
_____
_____

What can we do to make you happier?
_____
_____
_____

I specifically authorize the natural health practitioners at the Atlanta Natural Health Clinic to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease. I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems. I understand that Nutrition Response Testing is not a method for "diagnosing' or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing. This permission applies to subsequent visits and consultations.

Print Name: _____ Signed: _____

Witness: _____ Date: _____

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Office Use Only:

FINANCIAL AGREEMENT

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you to get the best results in the shortest amount of time. The following are the most common services we provide:

PROCEDURE	PURPOSE	WHEN PERFORMED	FEE
CONSULTATION	Meet with the doctor, discuss your reasons for being here, and review your case history	First visit, new injuries, or new condition	No charge
EVALUATION / EXAM	Ascertain the nature and severity of your health problem. Assess and evaluate your new or current health status and determine and appropriate course of action	First visits, new conditions, exacerbations, and progress examinations	$90.—$220
DIAGNOSTIC IMAGING (X-RAYS and scans)	Visualize the location of spinal problems and confirm other exam findings.	As necessary for 1st visit, re-injuries and progress examinations	$25. -.$150.
CHIROPRACTIC ADJUSTMENTS	Reduce and remove the Vertebral Subluxation	As indicated by examination	$39. - $65.
NUTRITIONAL RESPONSE TESTING	Access any nutritional imbalances or toxins that may be contributing to or compromising your body's ability to heal and function at its optimal state	As indicated by examination and evaluation and interest of patient	$140. Initial $39 Follow Up
BEMER	Improvement of micro vascular function	Interest of patient	$15 - $20 (packages available)
NSRT / BAX	Stress reduction using Low Level Light Laser Therapy and homeopathic support.	Interest of patient	$120 (packages available)
DETOX FOOTBATH	Stimulate detoxification processes and pull toxins from the body	Interest of patient	$35 (1st only $30) (packages available)
HEALTH COACHING	Create a vision and plan for attaining the ideal expression of your authentic expression of potential.	Interest of patient	$120 (packages available)

Forms of Payment

We accept cash, personal checks, Visa, Mastercard, Discover, Tradebank, and Equitrade. Payment is expected at time of service unless other arrangements have been made**. <u>Billing is taken care of at the front desk</u> unless other arrangements need to be made.**
For the convenience of our patients, services may be paid for in advance.

Special Arrangements

We have never denied anyone the benefit of care due to their inability to pay our published fees. Individual contracts can be designed to help specific financial needs. **The most important thing to us is that people are given what they need.**

Preferred Chiropractic Doctor (PCD)

ANHC is a participating provider with a national organization that legally allows us to reduce our fees for participating members. PCD membership is available to all patients. **Reduced PCD rates are only applicable when insurance reimbursement is not going to be used**. Annual membership fee is $37.00. You can join here or online at www.bewell2.com. Under the "PCD umbrella", d**iscounted prepayment plans are available to PCD members,** details available at the front desk.

Product Returns

Unopened supplements may be returned for a full refund within 90 days of purchase. There is no refund on opened products.

I certify that all information provided is true and complete. I agree to pay the amount invoiced in full. I further agree to pay all costs of collection, including costs of a collection agency if the account is turned over to a collection agency, and including 15% attorney's fees and court costs in the event this balance is turned over to an attorney. It is agreed that this agreement will be governed under the law of the State of Georgia. The Atlanta Natural Health Clinic has the option of pursuing an action under this agreement in any court of competent jurisdiction in the State of Georgia and I consent to jurisdiction in the State of Georgia.

Signature of patient: _____ **Date:** _____