PATIENT INTRODUCTION

Please answer the following questions completely.

Name ______________________________ SS# ______________________________

Address ______________________ Apt # ____ City ______________ State ____ Zip __________

Home Phone (   ) ______________________ Work Phone (   ) ______________________

Best Place to Reach You: ☐ Home ☐ Work ☐ Cell Phone (   ) ______________________

E-mail Address:______________________ Employer:______________ Occupation:______________

Sex: M F Marital Status: S M D W Age: _______ Date of Birth _____/______/______

How did you hear about our clinic? ____

Describe Chief Complaint: ____

Have you had Chiropractic Care before? Yes No Do you have health insurance? Yes No

Is it possible you are Pregnant? Yes No Are you on Medicare? Yes No

Are you here because of: _____ An auto accident? Date Injured:__________________

_____ An on the job injury? Do you have an attorney? Yes No

Date of last physical exam:____________ Reason:__________________________________

Please list all accidents, falls, injuries, surgeries, and major illnesses.

Type	Date	Describe/Comment

Are you presently taking any medications?

Name of Drug	Amount	Describe/Comment

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY

__Headaches
__Shooting head pain
__Sinus pain
__Loss of smell
__Hay fever
__Loss of taste
__Tightness in throat
__Inflammation in throat
__Thyroid trouble
__Face flushed
__Twitching of face
__Loss of memory
__Fatigue
__Depression

__Head feels too heavy
__Dizziness
__Fainting
__Loss of balance
__Ringing in ears
__Muscle spasms in neck
__Grating in neck
__Tight shoulder muscles
__Neuritis-arms/shoulders
__Pins & needles
__Arms/hand pain
__Cold hands
__Chest pains
__Shortness of breath

__Heart pain
__Heart palpation
__Mid-back pain
__Heart attacks
__High B.P.
__Anemia
__ Nervous stomach
__Stomach trouble
__Ulcers
__Nerves & nervousness
__Irritability
__Cold sweats
__Liver trouble
__Gallbladder trouble

__Indigestion
__Intestinal gas
__Low back pain
__Constipation
__Menstrual cramps
__Menstrual irregularity
__Diabetes
__Swelling
__Arthritis
__Slipped disc
__Pinched nerve
__Irregular sleep
__Leg/feet pain
__Neck pain

Are any of your family members experiencing any of the above difficulties?

Family Members: ______________________ Difficulties:______________________

______________________ ______________________

______________________ ______________________

Payment/Insurance Information

Please complete all applicable information

OUR OFFICE POLICY STATES THAT PAYMENT IS DUE WHEN SERVICES ARE RENDERED. AS A COURTESY TO YOU, WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU.

- ☐ **Cash/Check/Credit Card:** Payment is due in full when services are rendered. We accept Visa, Master Card, American Express, and Discover cards for payment.
- ☐ **Insurance:** We will file your medical insurance for you. We must have a copy of your health insurance card as well as your driver's license for your file. Deductible amounts and co-payment amounts are due in full as services are rendered. Any charges not covered by the insurance company will be billed directly to you for payment.
- ☐ **Automobile Insurance:** We must have verification of insurance, a copy of your insurance card, a copy of your driver's license, and the accident report. Any charges not covered by the insurance company will be billed directly to you for payment.
- ☐ **Workers Compensation:** Authorization for treatment must be in writing from your employer. If this is not possible on the first visit, we will accept verbal authorization until authorization can be obtained in writing.

Insurance Information:

Insured Full Name: ____ Insured Date of Birth ____/____/____

Relationship to the Insured: ____________________________ Insured Home Phone (   ) __________________

Insured SS#: ____

Insurance Company Name: ____

Insurance Company Phone: (   ) ______________________________ Group #:__________________________

Insured Employer: _____________________________________ Employer Phone: (   ) ___________________

*I authorize the release of any information pertinent to my case to any insurance company or adjuster for purposes of obtaining payment for my bills. **Signed:** ____

*I further authorize and direct the ___________________________ Insurance Company to pay Cooperative Chiropractic directly for services rendered to me.

Signed: ____ Date ________________________________

*Due to new government regulations, please give Cooperative Chiropractic permission to display your name in our office for our patient showcase's such as sign in sheets and our display boards, etc.

I give permission for Cooperative Chiropractic to display my name for in office use only.

Signed: ____ Date ________________________________

I have reviewed and received a copy (if requested) of the offices Notices of Privacy Practices

Signed:_______________________________________ Date:______________________________________

*I ____, have read the above and checked of one method of payment. I have agreed that the unpaid balance is my responsibility and will pay any balance that has gone unpaid over 60 days. If my account is turned over to collections, I agree to pay the balance plus collection fees of 40%.

Patient Signature: ____

Witness: ____

Date: ________________________

Cooperative Chiropractic

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Consent to receive treatment

Georgia law states anytime a free service is rendered in a professional office and is followed by any additional service for which there may be a charge that any further treatment shall be agreed upon in writing and signed by both parties.

I, ___________________________________ hereby agree and give consent to further examination and treatment and understand that I will be responsible for any charges incurred, I further understand that I may discontinue receiving further care at any time.

____ _________________

Signature Date

____ _________________

Witness Date

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change, if we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

✱ Protected health information may be disclosed or used for treatment, payment, or health care operations

✱The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice

✱The practice reserves the right to change the notice of Privacy Policies

✱The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions

✱The patient may revoke this Consent in writing at any time and all future disclosures will then cease

✱The Practice may condition treatment upon the execution of this Consent

This Consent was signed by:

____
Printed Name of Patient and/or Patient Representative

_______________________________________ Date:___________________
Signature of Patient and/or Patient Representative

Relationship to Patient:________________________________

Witness:____ Date:______________
Printed name and signature of Practice representative