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

3901 Mary Eliza Trace Suite 201
Marietta GA 30064
770-422-5052
Fax 770-422-8227

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

Automobile Accident Information

Today's Date: ____/____/____
Name: _____
Date & Time of Accident: ____/____/____ ____:____ ___am ___pm
Were you the: __Driver __Front Passenger __Rear Passenger
If a traffic violation was issued, to whom was it issued? _____
Please list the other people involved in the accident: _____
_____

Were other people injured? __Yes __No
Did the police come to the accident site? __Yes __No
Was a police report filed? __Yes __No
Were there any witnesses? __Yes __No
Were you wearing your seat belt? __Yes __No
Was this vehicle equipped with airbags? __Yes __No
If yes, did it/they inflate? __Yes __No
Where was the headrest in relation to the base of your skull?
__Above __Below __At the base
What did your vehicle impact? __Another vehicle __Other
If other, explain: _____
Did any part of your body strike anything in the vehicle? __Yes __No
If yes, please describe: _____
Make & model of the vehicle you were occupying: _____
_____
Name of the location/street on which you were traveling: _____
_____
In which direction were you headed? __N __S __E __W
What was the approximate speed of your vehicle? _____
Did the impact to your vehicle come from the:
__Front __Rear __Right side __Left side __Other
Were you: __aware of or __surprised by the impact?
If the accident involved another vehicle,
Make & model of the other vehicle: _____
Direction the other vehicle was headed? __N __S __E __W
Speed of the other vehicle? _____
In your words, please describe-the accident: _____
_____
_____
_____

ASSIGNMENT OF PROCEEDS, LIEN AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, agencies, governmental departments, companies, individuals, and/or other legal entities ("Payers"), which may be obligated to pay, provide, or distribute benefits to me or any medical conditions, accidents, injuries, or illnesses, past, present, or future ("Condition") to pay directly and exclusively to the name Cooperative Chiropractic ("CC") such sums as maybe owing to CC for charges incurred by me at the office relating to my condition ("Charges"), with such payments to be made exclusively in the name of Cooperative Chiropractic. I further grant a lien to CC with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of the Assignment, Lien, and Authorization (herein, "Agreement"), "Benefits" shall include but not limited to proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payment benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, disability benefits, workers-compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified with the expressed written consent of this office. I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement I further authorize and direct all payers to release to Cooperative Chiropractic any information regarding any coverage or benefits which I any have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this agreement, together with any applicable charges, with any or a, payers, regardless of whether a claim bas been established with said payers. I hereby authorize Cooperative Chiropractic to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize CC to apply any credit balances on charges incurred by me to any other outstanding charges still further authorize CC to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of these other charges being related to my condition.

I understand that I remain personally responsible for the total amounts due CC for their services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse CC for all costs of such collection efforts, including, but not limited to, all court costs, all collection agency fees, and all attorney fees.

This agreement shall not be modified or revoke without the mutual written consent of CC and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interests of CC and myself. However, should any provisions of this agreement be found to be invalid, illegal, or unenforceable, or for any reasons cease to be binding on any party hereto, all other portions and provisions of this assignment shall, nevertheless, remain in full force and effect.

Patient Name _____ (please print)

Patient Signature: _____ Date: ___/___/___

Name of custodial Parent or Legal Guardian _____ (please print)

Parent/Guardian's Signature: _____ Date: ___/___/___

ASSIGNMENT OF NET SETTLEMENT OR JUDGEMENT PROCEEDS

Attorney _____

_____

_____

_____

COOPERATIVE CHIROPRACTIC

3901 Mary Eliza Trace

Suite 201

Marietta, GA, 30064

RE: Assignment ofNet Settlement of Judgment Proceeds

I hereby grant, convey, transfer, assign and set over unto Cooperative Chiropractic (CC) all of my rights, title and interests to any proceeds from any settlement, judgment, or verdict arising from this accident, as may be necessary to fully compensate CC for any medical services rendered to me, both by reason of this accident and by reason of any other bills that are due to CC.

I hereby authorize and direct you, my attorney, to withhold from settlement, judgment, or verdict such sums as may be necessary to fully compensate CC for any medical services rendered to me, both by reasons of this accident and by reason of any other bills that are due to Cooperative Chiropractic. Such sums shall be paid directly to CC by you, my attorney, from the proceeds of any settlement, judgment, or verdict arising from this accident It is expressly acknowledged, understood, and agreed that is assignment is conditioned and subject only to the claims of you, my attorney, for fees and services arising from this accident. Presentation of a signed copy of this assignment to you, my attorney, shall constitute sufficient authority by Cooperative Chiropractic to obtain said payment.

Irrespective of the above, I fully understand that I am directly and fully responsible to CC for all medical bills submitted by CC for services rendered to me that this agreement is made solely for CC's additional protection and in consideration of CC's willingness to forgo payment fur services rendered to me for a period of 120 days. I further fully understand that such payment is not contingent on any settlement, judgment, or verdict that I may eventually recover. Accordingly, in the event payment in full is not made to CC within 120 from the date the last medical services by CC are rendered to me, I shall be responsible for making such payment in full.

Patient's Signature _____ Date _____

The undersigned attorney of record for the above patient does hereby acknowledge receipt of this assignment, agrees to all the terms of this assignment, and agrees to withhold and pay directly to CC such sums from any settlement, judgment, or verdict as may be necessary to fully compensate CC for any and all medical services rendered to said patient.

Attorney's Signature _____ Date _____