APPLICATION FOR TREATMENT Date_____

LEGAL NAME_____ Nickname _____

Address_____

PHONE_____ EMAIL_____

(check one _____male ____female _____married _____ single _____divorced _____widowed

Birthdate_____ Referred to our office by_____

Work Status ___ employed ___full time student ___retired ____ other

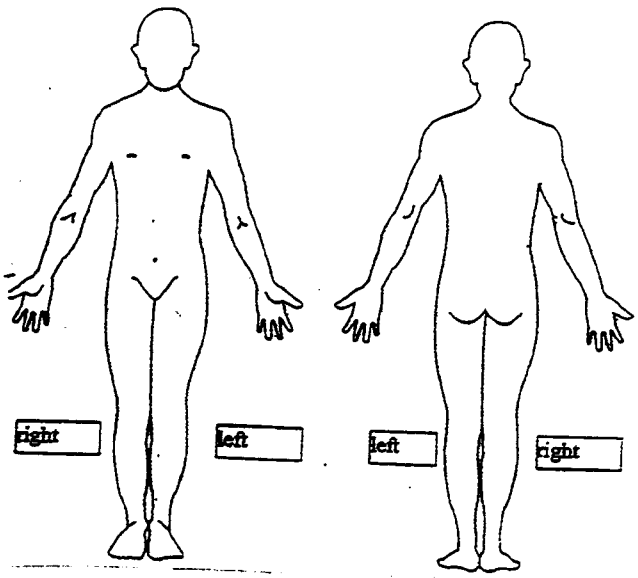
NOTE: IF THIS IS AN ACCIDENT OR INJURY YOU MUST HAVE THE CLAIM# AND TELEPHONE NUMBER FOR THIS OFFICE TO PREVERIFY COVERAGE. PLEASE COMPLETE THE ACCIDENT INFORMATION IN DETAIL ON THE REVERSE SIDE OF THIS FORM

Your Auto Carrier for Medical Payments_____

Agent_____ Phone_____Claim #_____

If you are in pain, please mark the exact location of your pain on the MAJOR COMPLAINT diagram below. Also describe the type and frequency of your pain, as well as, any activity which aggravates the pain.

COMPLETE THESE DIAGRAMS- PAIN CHART



(Please describe only your major problem)

How did the condition develop? What caused it?

_____

_____

_____

_____

_____

_____

_____

When was the very first time you were aware of this problem? _____

Have you ever had this problem before? If yes explain _____

Do any of these make your condition worse ____ standing _____ sitting _____working ___lifting

PLEASE COMPLETE THE REVERSE SIDE

Have you ever been in an automobile accident? (Check one) _____past year _____past 5 years _____over 5 years ____never

List and describe any surgery you may have had:

_____

CURRENT MEDICATIONS (CHECK) ___Antidepressants ___Pain medication ___Muscle Relaxants ___Diet Pills
____Insulin ___Birth Control Please list all others)

_____

X-rays remain the property of this clinic, however, a 24hr. advance notice is required to prepare any medical documents or X-rays to be released.

I understand and agree to authorize the doctors and employees of this clinic to administer exam procedures and treatments as deemed necessary for the undersigned or minor child.

_____ _____
Signature of Patient or Authorized Representative **Date**

ACCIDENT/INJURY

Accident/Injury date _____**State** _____
(Check one) _____**Auto Accident** _____**Work Related Injury** _____**Other**___

(CHECK ONE) Did you report the injury to your employer? ____yes _____no _____not applicable

If Workers Comp injury did they recommend care at this office? _____yes _____no ___not applicable
Have you lost any days of work ____yes ____no Dates_____
Briefly describe the accident **and extent of your injuries**_____
_____

If an Auto Accident, were you _____driver _____passenger _____pedestrian?
If an Auto Accident were you struck from __behind ___right side ___left side ___front __auto was parked
Did your car strike the other(s) involved? _____yes ____no
Did the other car strike yours? _____yes ____no ____undetermined
As a result of the accident, were traffic citations issued to you? ____yes _____ no
Were you taken to the hospital after the accident? _____yes _____no

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

___Headache	___Irritability	___Numbness in Toes	___Face Flushed	___Feet Cold
___Neck Pain	___Chest Pain	___Shortness of Breath	___Buzzing in Ears	___Hands Cold
___Neck Stiff	___Dizziness	___Fatigue	___Loss of Balance	___Stomach Upset
___Sleeping Problems	___Head seems too heavy	___Depression	___Fainting spells	___Constipation
___Back Pain	___Pins and Needles in Arms	___Light bothers Eyes	___Loss of Smell	___Cold Sweats
___Nervousness	___Pins and Needles in Legs	___Loss of Memory	___Loss of Taste	___Fever
___Tension	___Numbness in Fingers	___Ears Ring	___Diarrhea	

Symptoms not listed above_____
Have you lost any days of work _____yes ____no Dates_____

Attorney Info: (if applicable)
_____ _____
ATTORNEY NAME CONTACT PERSON

_____
ATTORNEY ADDRESS

_____ _____
CLAIM # TELEPHONE NUMBER

Have you ever been in an automobile accident? (Check one) _____past year _____past 5 years _____over 5 years ____never

List and describe any surgery you may have had:

_____

CURRENT MEDICATIONS (CHECK) ___Antidepressants ___Pain medication ___Muscle Relaxants ___Diet Pills ____Insulin ___Birth Control Please list all others)

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_____ _____

Signature of Patient or Authorized Representative **Date**

ACCIDENT/INJURY

Accident/Injury date _____**State** _____
(Check one) _____**Auto Accident** _____**Work Related Injury** _____**Other**___

(CHECK ONE) Did you report the injury to your employer? ____yes _____no _____not applicable

If Workers Comp injury did they recommend care at this office? _____yes _____no ___not applicable
Have you lost any days of work ____yes ____no Dates_____
Briefly describe the accident **and extent of your injuries**_____
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___Tension	___Numbness in Fingers	___Ears Ring	___Diarrhea	

Symptoms not listed above_____
Have you lost any days of work _____yes ____no Dates_____

Attorney Info: _____ _____
(if applicable) ATTORNEY NAME CONTACT PERSON

_____
ATTORNEY ADDRESS

_____ _____
CLAIM # TELEPHONE NUMBER

PATIENT CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialists of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physician's procedures often depends on the environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from the Chiropractic health care services and its whole food approach to health.

ANALYSIS

A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. The Doctor may also recommend whole food supplementation as an adjunct to treatment. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body and your willingness to follow the doctor treatment protocol.

DIAGNOSIS

Although Chiropractic Physicians are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his total condition. Your Chiropractic Physician may express an opinion as to whether or not you should take this step, and will refer you to another healthcare specialist if needed, but you are responsible for the final decision, as well as disclosing all medical allergies and conditions.

INFORMED CONSENT FOR CHIROPRACTIC CARE and WHOLE FOOD SUPPLEMENTS

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or any care, if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or learn through healthcare procedures whatever he is suffering from; latent pathological defects, illness or deformities which would otherwise not come to the attention of the Chiropractic Physician. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Chiropractic- Physician provides a specialized non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC since there are so many variables; it is difficult to predict the time schedule of efficacy of the Chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less then expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond chiropractically may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease. I understand the Standard Process whole food supplements and MediHerb products recommended by this Chiropractor can be processed and/or packaged in a facility that manufactures other products containing soy, milk, egg, wheat, peanut, tree nuts, fish and shellfish. All nutritional supplements and herbal programs are not intended as a primary therapy for any disease, but rather to provide nutritional and herbal support for normal body physiology and repair. All patients must disclose any known allergies to the provider.

_____ _____

(DATE) (SIGNATURE)

I REFUSE _____ AS PART OF MY CARE _____

(PRINT NAME HERE)

HIPPA COMPLIANCE: Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it._____

initial

FINANCIAL POLICY/ ADMINISTRATIVE FEES

Our goal at this office is to make sure your health care experience is delivered with thoroughness and superior quality. We want to keep your insurance and other health requests as simple as possible.
In order to accomplish this in a cost-effective manner, we ask that you adhere to some simple guidelines.

1. You are ultimately responsible for payment of services rendered from our office, regardless of insurance coverage. This office will file your insurance but it is your responsibility to see that all claims are paid within 60 days or you will be liable.

2. **IT IS YOUR RESPONSIBILITY PRIOR TO YOUR VISIT TO:**
   (a) provide all updates on current address, telephone numbers and insurance information.
   (b) contact your Insurance carrier to confirm that this doctor is participating in your plan.
   (c) pay all co-pays and fees at time of service
   (d) contact this office 24-hr. prior to canceling or rescheduling your appointment. ($35.00 missed apt. fee will be assessed)

3. An **Optional $15.00** Administrative Service Fee will be charged- one time per calendar year. This admin fee is intended to cover the cost of certain administrative services we provide that are not covered by your insurance. If you choose not to pay, you will be charged per item during the year, eg; statements, clinical records , letters, disability forms, school forms, sports trainers, massage etc.

CHECK ONE
( ) CASH- All fees paid at the time of service- cash, debit, all credit cards and checks accepted.
( ) MEDICARE/ CASH PT- This office files- patient is reimbursed by Medicare.

( ) Health Insurance- we will verify your coverage prior to your visit and file your claims as contracted- you will be totally responsible for your co-pays, deductibles, or any balance not covered by your insurance.
"I authorize and direct that payment be made directly to Johnson Ferry Chiropractic Ctr. for any and all insurance benefits or reimbursement for services rendered by the doctor which amounts would otherwise be payable to me under any insurance or prepaid health care plan. I also authorize the release of any information concerning my health and healthcare services to my insurance companies or prepaid health plan."

( ) Workers Compensation- You have notified your employer, you have a claim number and it has been pre-verified by this office to bill the insurance carrier. There should be no charge to you.

( ) Automobile Insurance- You have reported the accident to your carrier, received a claim number, this office has pre-verified your Med-Pay coverage and it will pay us direct. (as required by the state of Ga.)- If you do not have Med-Pay coverage a letter stating such must accompany the filing of your Health Insurance claims.

( ) Attorney Lien, You have signed and chosen to obtain an attorney who will guarantee payment out of your settlement from the responsible insurance carrier.

ACCEPTANCE

( ) I accept this policy that includes payment of the Administrative Service Fee $15.00

( ) I accept this policy **BUT CHOOSE NOT TO PAY** the Administrative Service Fee. I understand that if I elect not to pay the Administrative Service Fee, I will pay for the services as I need them.

_____ _____

SIGNATURE **DATE**

ADMINISTRATIVE SERVICE FEES

1. **Completion of all forms (to include but not limited to) $30.00/request**

   a. **DISABILITY LETTERS/ FORMS**
   b. **LIFE INSURANCE FORMS**
   c. **MASSAGE LETTERS**
   d. **SCHOOL FORMS/LETTERS FOR BOOKS ETC.**
   e. **SPORTS/PERSONAL TRAINOR LETTERS**
   f. **OTHER MISCELLANEOUS ADMINISTRATIVE FORMS REQUIRED BY THIRD PARTIES OTHER THAN YOUR INSURANCE COMPANY THAT WE ARE ALREADY FILING.**

2. **Patient requested computer generated reports (additional claims, receipts, statements, payment Histories, etc. $10.00/request**

3. **Copying of Medical Records $35.00/request**

4. **Transferring X-rays to other Facilities $10.00/request**

5. **Other administrative services that are not a covered service/benefit under your certificate of Insurance. Fee to be determined at the time of request.**

NOTE:

All of these activities add to our cost of caring for patients. Still, we are committed to providing you with the best care. We look forward to a lasting a healthy relationship and thank- you for your understanding and cooperation. Always feel free to ask any questions if there is any doubt about our office policies and fees.