CHIROPRACTIC REGISTRATION AND HISTORY

(1) PATIENT INFORMATION

DATE _____

Legal Name _____
First M. Int. Last

Address _____

City _____

State _____ Zip _____

Home Phone _____

Cell/Work _____

Email _____

Sex: ☐ Male ☐ Female

Marital Status
☐ Married ☐ Widowed ☐ Single

☐ Separtated ☐ Divorced ☐ Unknown

Birthdate _____

SS# _____

Work Status ☐ Employed ☐ Full Time Student ☐ Other

Apt Reminder ☐ Email ☐ Text

Whom may we thank for referring you? _____

(3) INSURANCE INFORMATION

(PLEASE PRESENT CARD)

Insurance Co. _____

Members# _____ Group # _____

Subscribers Name _____

Birth date _____ SS# _____

Relationship to Patient _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent (s), have insurance coverage and assign directly to Johnson Ferry Chiropractic Center. All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

JFCC doctors may use health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent,

(2) Emergency Contact

Name: _____

Phone: _____

Email: _____

(4) ACCIDENT INFORMATION

Is condition due to accident? ☐ Yes ☐ No

Date of accident _____

Type of accident ☐ Auto ☐ Work ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

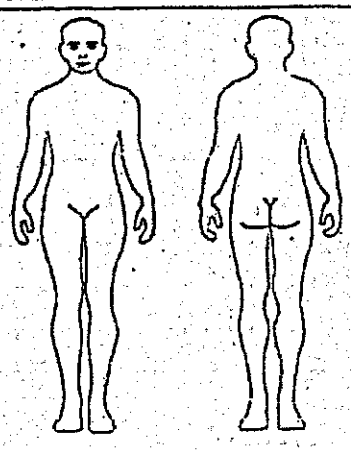
Attorney Name (if applicable) _____

(5) PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Mark and X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of Pain : ☐ Sharp ☐ Dull ☐ Throbbing
☐ Numbness ☐ Aching ☐ Shooting ☐ Burning
☐ Tingling ☐ Cramping ☐ Stiffness ☐ Swelling

☐ Constant Pain ☐ Pain comes and goes

Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chemical			High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other _____		
Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	_____		

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

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**

INSURANCE FILING POLICY
JOHNSON FERRY CHIROPRACTIC CENTER

This office has endeavored to participate in a majority of managed care programs. It is our policy to file your insurance if you are a subscriber to one of those plans. We will PREVERIFY your coverage prior to your visit, assist in determining your ESTIMATED FINANCIAL RESPONSIBILITY and answer any related questions. It is YOUR responsibility to notify this office PRIOR to your appointment of any new insurance coverage or changes in benefits.

We can not file retroactive claims due to extreme filing limit dates.

We would like you to understand, however, that there are no guarantees to the accuracy of the verification of coverage or any payment amounts received from your insurance company. Many insurance companies say one thing and do another, and the final indicator of your coverage is the check or the explanation that they send. Therefore, it is your responsibility to closely monitor every communication you receive from your insurance company for its accuracy of payment to this office.

If this office does not receive correspondence or payment from your insurance company within 60 days of your visit, the amount of charges incurred will be your responsibility.

Many Out of network plans may not cover Chiropractic, or if they do only at a minimum. You may decide to take advantage of the cash discount that is available to all patients and we will provide you with the proper receipt and documentation to submit to your insurance carrier. We can file to your out of Network Company but your total charges will be your responsibility unless otherwise indicated by your insurance company.

As always, we will continue to provide quality care to serve you with the utmost of our ability. If you ever have any financial questions, please contact our INSURANCE ADMINISTRATION OFFICE at 770-977-4483 or make an appointment to speak with our Accounts Manager.

_____ _____

PATIENT SIGNATURE DATE

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