

PATIENT ENTRANCE INFORMATION

Name: _____ Sex: M F Date: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

E-Mail: _____ Date of Birth: _____ Age: _____

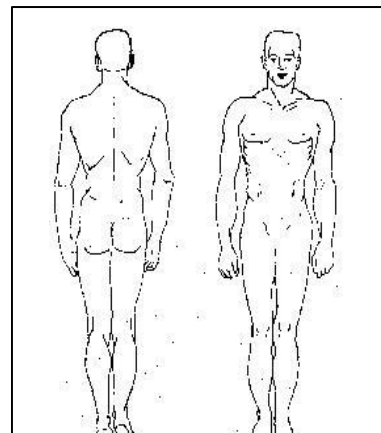
Height: _____ Weight: _____ Social Security #: _____ Occupation: _____

Employer: _____ Marital Status: S M D Number of Children: _____

Who Referred You to Our Office: _____

Emergency Contact Name and #: _____

Is today's visit related to an auto or work related accident: Y N
If yes, when: _____



Circle the Area(s) that Bother You

CASE HISTORY

Have you received Chiropractic care before: Y N
If yes, for what and when was your last visit: _____

Chief Complaint: 1. _____

Other Complaints: 2. _____

3. _____

4. _____

Complaint started on: _____ How did your problem begin: _____

What makes your condition worse: _____

What makes your condition better: _____

Quality of symptoms: Dull Ache Sharp Shooting Burning Throbbing Deep Stinging Numb/Tingle/Pins & Needles

Does your condition radiate/travel to another part of your body: Y N Where: _____

Severity of your symptoms:

	<i>No Symptoms</i>				<i>Moderate</i>				<i>Excruciating Symptoms</i>			
On average:	0	1	2	3	4	5	6	7	8	9	10	
At Best:	0	1	2	3	4	5	6	7	8	9	10	
At Worst:	0	1	2	3	4	5	6	7	8	9	10	

Symptoms are: Occasional Intermittent Frequent Constant How long do they last: _____

What time of day are your symptoms worse?: Morning Midday Late Afternoon Evening All Day

Other treatments for this condition: _____

Have you had any past injuries, fractures, surgeries or illnesses that may have contributed to your condition: Y N

If yes, describe: _____

Are you left or right dominant: L R Are you pregnant: Y N

Other conditions that you commonly experience or have had in the last 6 months:

Headaches Sleeping Problems Back Pain Neck Pain Leg Pain Balance Issues
 Cholesterol Asthma Fatigue Depression Diarrhea Stomach Upset
 Loss of Memory High Blood Pressure Chest Pain Asthma Ears Ring Frequent Colds
 Numbness Cold Hands/Feet Joint Pain Arthritis Allergies Arm/hand Pain
 Eating Disorder Menstrual Cramps Heart Issues Weight Loss Dizziness Painful Urination
 Sinus Trouble Irritable Colon Osteoporosis Fainting Constipation Thyroid Disorder

What does your condition prevent you from doing: _____

Medications and reasons for taking: _____

Vitamins/supplements taking regularly: _____

Rate your diet: Poor Fair Good Excellent

Exercise frequency: None/Rare 1-2X/week 3-4X/week 4-5X/week 6-7X/week

Describe regular exercise/activities you do: _____

Surgeries and dates: _____

Allergies: _____ Smoking habits: Y N If yes, how much _____

Past Health History/Family History ("P" for patient and "F" for family member that is a blood relative):

Abdominal pain Bulemia Fainting Kidney Stones Rapid Heart Rate Ulcer
 Allergies Cancer Heart Attack Liver Disease Tuberculosis Fractures
 Anorexia Convulsions High Cholesterol Low Blood Pressure Scoliosis Gallstones
 Arthritis Dislocations Lung disease Multiple Sclerosis Sickle Cell Anemia Diabetes
 Asthma Dizziness High Blood Pressure Osteoporosis Disc Conditions
 Blood Disorders Emphysema Irritable Bowel Frequent Urination Stroke
 Breast Condition Epilepsy Kidney Disease Prostate Disease Thyroid Disorder

I have read the above information and certify it to be true and accurate to the best of my knowledge. I hereby authorize the Doctor to provide me with evaluation and treatment of my condition in accordance with Georgia's statutes.

Patient/Parent/Guardian Signature: _____ Date: _____

Chiropractic Office HIPAA Form

325 Hammond Drive, Suite 201
Atlanta, GA 30328
404-256-0114

*THIS NOTICE PERTAINS TO PRIVACY MEASURES TO ALL DOCTORS
OPERATING AT 325 HAMMOND DRIVE, SUITE 201, ATLANTA, GA 30328.*

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for the Doctor (the Practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the following address/phone number/fax number/e-mail address:

The Practice may communicate confidential information about me to the following individual(s):

Patient/Patient Representative

____/____/____
Date

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Bianca Kiovanni and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, mild to severe bruising or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options, which could be considered, may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. I have read, or have had read to me, the above consent. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have had the opportunity to discuss with the Doctor of Chiropractic the nature and purpose of chiropractic adjustments and other procedures.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

To be completed by patient's Parent/Legal Guardian if the patient is under legal guardianship or minor

SIGNATURE OF PARENT/GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____

Office Financial Policy

325 Hammond Drive, Suite 201
Atlanta, GA 30328
(404)-256-0114

RESPONSIBILITY OF BILL

I, _____, (referred to hereafter as “the undersigned”) agree and understand that payment for any treatment/therapy/massage is due at the time of service, unless previous arrangements have been made. The undersigned hereby accepts full financial responsibility for charges and services rendered. I also agree that this obligation shall exist regardless of private contractual agreement between the undersigned and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges for services not covered by insurance or for which payment is denied through any utilization review or pre-certification procedures. I also understand that if I suspend or terminate my care or treatment, the fees for services already rendered to me will be immediately due and payable. In the event of my payment default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required for collection. I understand that this policy applies if I am signing for a minor and/or dependent.

INSURANCE

If I have insurance all deductibles and co-payments are expected at the time of service or by an office approved, signed payment plan. (A "deductible" is a specific dollar amount that your health insurance company requires that you pay out-of-pocket each year before your health insurance plan begins to make payments to any doctor for your healthcare claims.) If I do not have health insurance, I understand payment is due at the time of service, or I have the option of creating an approved, affordable payment plan.

RETURN CHECK POLICY

Each check that is returned to the office for insufficient funds will automatically be subject to a \$25.00 return check fee. Future payments must be made in guaranteed funds (cash, money order, debit card) and checks may not be accepted for a minimum period of six months.

CANCELLED OR MISSED APPOINTMENTS

I understand that a \$20.00 fee may be assessed at the Doctor’s discretion for any prior scheduled appointment that I fail to attend without 24 hours advance notice to reschedule or cancel.

I have read or have had read to me, the above Office Financial Policy. I have also had the opportunity to ask any questions about its content, and by signing below I agree to this policy.

PATIENT NAME: _____ **DATE:** _____

To be completed by patient’s Parent/Legal Guardian if the patient is under legal guardianship or minor

SIGNATURE OF PARENT/GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____

Cancellation & Missed Appointment Policy

325 Hammond Drive, Suite 201

Atlanta, GA 30328

404-256-01114

In order to respect the time of other patients in the office as well as the time of the Doctor, the following policy will be enforced on patients who are significantly late, cancel with a minimum amount of time, or regularly fail to show for appointments.

- Patients are required to give as much notice as possible. In the case of a morning appointment this notice should be given before the close of the office on the prior day. In mid to late day appointments notice should be given a minimum of 2-3 hours before the scheduled appointment.
- Not showing up for an appointment is **never** acceptable without prior notice. Please have respect for the doctor's and/or therapist's time as much as you would like your time respected. When this happens it also effects other patients who may have wanted to schedule an appointment for that same time. **Note:** If you are late for your massage, that time will be deducted from your allotted time.
- We do understand that sometimes things happen that are outside of our control. Therefore up to 15 min after a scheduled appointment you will not be considered late. After 15 minutes the Doctor may deem you late and may proceed to the next patient, leave the office, or by consider you a "no-show" for that appointment.
- In any of the above listed situations, the Doctor reserves the right to charge you a fee of \$20 to make up for the missed appointment, and time lost. This fee is never covered by insurance, and will be billed automatically.

Thank you for your consideration.

Patient Signature _____ Date _____