Application for Health

PRACTICE MEMBER INFORMATION

_____ _____ _____
LAST NAME FIRST NAME M.I.

_____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

_____ _____
BEST PHONE NUMBER TO REACH YOU E-MAIL (FOR COMMUNICATING IMPORTANT HEALTH INFORMATION)

_____ _____
YOUR EMPLOYER YOUR OCCUPATION

_____ _____ _____ _M_F_ _____
DATE OF BIRTH AGE SOCIAL SECURITY # (FOR INSURANCE) SEX MARITAL STATUS

_____
NAMES AND AGES OF CHILDREN

Scoliosis can be prevented or minimized if detected early enough. Would you like to receive complimentary scoliosis examinations for your children? □ Yes □ No

Will you be using health insurance to supplement payment to our office? □ Yes □ No
If yes, please provide us with your insurance card and we'll make a copy. We will also verify your coverage.
Are you covered under someone else's insurance? □ Yes □ No □ Spouse □ Parent
Enter their information below:

_____ _____ _____
LAST NAME FIRST NAME M.I.

_____ _____
SOCIAL SECURITY # (FOR INSURANCE) DATE OF BIRTH (FOR INSURANCE)

Are you filing a worker's compensation claim? □ No □ Yes Date reported to employer: _____

Are you filing a personal injury claim? □ No □ Yes Attorney name: _____

We provide the following healthcare services. Check ALL the types of care that you are interested in receiving.

□ **Wellness Care:** I currently have no symptoms. My goal is to maintain the health of my spine and nervous system while preventing degenerative disease.

□ **Corrective Care:** My goal is to achieve natural symptom relief and to maximally improve my posture, spinal alignment, mobility, strength, nerve function and health.

□ **Rehabilitation Care:** My goal is to achieve natural symptoms relief and maximum healing of my injuries/tissue damage.

□ **Relief Care:** My goal is to achieve natural symptom relief without the dangerous side-effects of medications.

How did you find out about Family Chiropractic? _____
Who may I thank for referring you to Family Chiropractic? _____

When was your last chiropractic visit? □ First time □ ___weeks □ ___months □ ___years
What type of care? □ Corrective/Rehabilitative □ Symptom relief □ Wellness/Maintenance

Name: _____ Date: _____

√ Check each of your health problems.

HEAD PROBLEMS
□ 1. Headaches or Migraines
□ 2. TMJ (jaw) Pain/Clicking

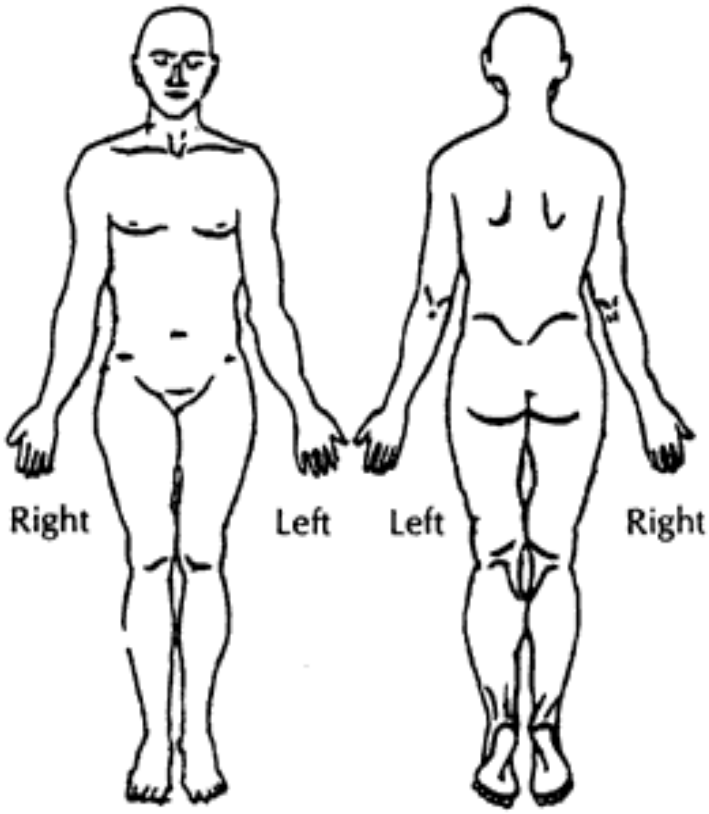
SPINAL PROBLEMS
□ 3. Neck □ Pain □ Stiffness
□ 4. Upper Shoulder (trapezius) Pain
□ 5. Upper Back (Shoulder blades) Pain
□ 6. Middle Back □ Pain □ Stiffness
□ 7. Low Back □ Pain □ Stiffness
□ 8. Pelvis/Buttock Pain

UPPER EXTREMITY (ARM) PROBLEMS
□ 9. Shoulder Joint Pain
□ 10. Elbow Joint Pain
□ 11. Wrist Pain
□ 12. Hand □Pain □Numbness □Tingling
□ 13. Arm □ Pain □Numbness □Tingling

LOWER EXTREMITY (LEG) PROBLEMS
□ 14. Hip Joint Pain
□ 15. Knee Joint Pain
□ 16. Ankle Joint Pain
□ 17. Foot □ Pain □Numbness □Tingling
□ 18. Leg □ Pain □Numbness □Tingling

CHEST, ABDOMINAL OR PELVIC PROBLEMS
□ 19. Chest Pain/ Symptoms
□ 20. Abdominal Pain/ Symptoms
□ 21. Pelvic Pain/ Symptoms

On the image below, circle the areas where your pain is located. Then number those areas in the order of most painful to least painful. Finally, if the pain radiates, draw an arrow to indicate the direction of the radiating pain.



Answer the following questions regarding your health problems:

Which health problem concerns you the most? _____

What do you feel caused your health problem? □ I don't know □ injury □ auto accident □ stress □ developed over time

Explain: _____

Who have you seen previously for this health problem? □ No one □ Chiropractor □ Medical □ Physical Therapist

What treatment did you receive? _____

Which of the following activities of daily life are being adversely affected by your current health problem?

□ Bending over	□ Driving Car	□ Household chores	□ Reaching overhead	□ Staying asleep
□ Caring for family	□ Exercising	□ Lifting objects	□ Rising out of chair / bed	□ Using a computer
□ Climbing stairs	□ Getting in/out of car	□ Looking over shoulder	□ Showering or bathing	□ Walking
□ Concentrating	□ Getting to sleep	□ Making love	□ Sitting	□ Participating in yardwork
□ Dressing self	□ Grocery shopping	□ Lying down	□ Standing	

Other activities not listed: _____

Name: _____ Date: _____

Below are lists of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

□ Pneumonia
□ Rheumatic Fever
□ Polio
□ Tuberculosis
□ Whooping Cough
□ Anemia
□ Measles
□ Mumps
□ Small Pox
□ Chicken Pox
□ Diabetes
□ Cancer
□ Heart Disease
□ Thyroid
□ Influenza
□ Pleurisy
□ Arthritis
□ Epilepsy
□ Mental Disorders
□ Lumbago
□ Eczema

Have you been tested HIV positive? □ Yes □ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULOSKELETAL CODE

□ Low Back Pain
□ Pain Between Shoulders
□ Neck Pain
□ Arm Pain
□ Joint Pain/ Stiffness
□ Walking Problems
□ Difficult Chewing/ Clicking Jaw
□ General Stiffness

NERVOUS SYSTEM CODE

□ Nervous
□ Numbness
□ Paralysis
□ Dizziness
□ Forgetfulness
□ Confusion/ Depression
□ Fainting
□ Convulsions
□ Cold/ Tingling Extremities
□ Stress

GENERAL CODE

□ Fatigue
□ Allergies
□ Loss of Sleep
□ Fever
□ Headaches

GASTRO-INTESTINAL CODE

□ Poor/Excessive Appetite
□ Excessive Thirst
□ Frequent Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Hemorrhoids
□ Liver Problems
□ Gall Bladder Problems
□ Weight Trouble
□ Abdominal Cramps
□ Gas/ Bloating After Meals
□ Heartburn
□ Black/ Bloody Stool
□ Colitis

GENITO-URNIARY CODE

□ Bladder Trouble
□ Painful/ Excessive Urination
□ Discolored Urine

C-V-R CODE

□ Chest Pain
□ Short Breath
□ Blood Pressure Problems
□ Irregular Heartbeat
□ Heart Problems
□ Lung Problems/ Congestion
□ Varicose Veins
□ Ankle Swelling
□ Stroke

EENT CODE

□ Vision Problems
□ Dental Problems
□ Sore Throat
□ Ear Aches
□ Hearing Difficulty
□ Stuffed Nose

MALE/FEMALE CODE

□ Menstrual Irregularity
□ Menstrual Cramps
□ Vaginal Pain/ Infection
□ Breast Pain/ Lumps
□ Prostate/ Sexual Dysfunction

OTHER PROBLEMS

□ _____
□ _____
□ _____

FEMALES ONLY:

When was your last period?

_____

Are you pregnant? Yes No

FAMILY HISTORY

The following members have a same or similar problem as I do:

□ Mother
□ Father
□ Brother
□ Sister
□ Spouse
□ Child

Medication Name, Dosage, and Frequency:

Patient Signature: _____Date: _____

FAMILY CHIROPRACTIC
TERMS OF ACCEPTANCE AND CONSENT TO TREAT

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation (nerve interference). Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes disturbance of nerve function and interference to the transmission of nerve impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate intelligence. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to: fractures, disc injuries, cerebrovascular accidents and sprains. I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance that has been made by anyone regarding the chiropractic treatment that I have requested and authorized.

I, _____ have read and fully understand the above statements. All
Patient Name
questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction and alternatives to treatment have been reviewed at my request. I hereby consent to and authorize chiropractic examination, chiropractic adjustments and other treatments, diagnostic x-rays, physiotherapy and rehabilitation as deemed necessary by the doctor. I intend this consent to apply to all my present and future treatments at this office.

I also acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____ _____
Patient Signature **Witness Signature** **Date**

Consent to treat minor child

I _____ being the parent of legal guardian of _____
Patient Name(s)
_____ have read and fully understand the above terms of acceptance and hereby consent to and authorize chiropractic examination, treatment, physiotherapy and rehabilitation as deemed necessary by the doctor for my child(ren).

_____ _____
Parent or Legal Guardian Signature **Date**

Authorization to Release Protected Health Information

_____
Entity currently in possession of PHI

_____
address

_____
address

_____
phone number ● fax number

Patient Name: _____

Patient Date of Birth: _____

By signing this agreement, I authorize the above named clinic to use and/or disclose the following Protected Health Information (PHI): _____

_____
Describe the Protected Health Information you are authorizing to be used and/or disclosed.

This information may be used and/or disclosed for the purpose of _____

_____
Describe each purpose for which you are authorizing the use or disclosure.

If applicable, I authorize the above named clinic to disclose this information to:
Family Chiropractic, 6703 Shannon Parkway, Suite 14, Union City, GA 30291
OR
fax: (770) 306-2680

This authorization expires _____
Date or event upon which authorization expires.

I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.
I understand that I may revoke this authorization at any time by notifying, in writing, the above named clinic. However, a revocation will not affect any actions taken by the above named clinic prior to their receipt of the revocation.

I understand that my treatment ☐ can ☐ cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

A Copy Of This Signed Authorization Must Be Provided To The Patient.

DIAGNOSTIC IMAGING CONSULTANTS
A. Scott Thorpe, DC, DACBR, Rudy N. Heiser, DC, MS, DACBR,
Terry Sandman, DC, MPH, DACBR
FAMILY CHIROPRACTIC LOUIS OKUN, D.C.
6703 SHANNON PKWY. STE. 14 UNION CITY, GA 30291 LORI OKUN, D.C.
PH: 770-964-3334 **FAX:** 770-306-2680 EMAIL: ins@okunchiropractic.com; office@okunchiropractic.com

Films/Date Exposed ______________________________ Medical History_____________________________________

****Please print and complete form with patient's signature****

Patient Name ____ Date of Birth __________ Sex ___M___F
Address ______________________________________ City/State/Zip ______________________________
Phone ______________________________ SS# ________________ Case/Acct# __________________

BILL: ____ PIP ____ Health/Other Ins. ____DR. ____Atty. ____Patient

Primary Insurance: ____________________________ Phone ____________________________
Adjuster____ ID/Claim#__________________________
Address____ Insured ____________________________
City/State/Zip____________________________________ Date of Injury____/____/____
Attorney: __________________________________ Phone___________________________
Address_______________________________________City/State/Zip______________________________

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ASSIGNMENT, LIEN AND AUTHORIZATION/INSURANCE BENEFITS

For and in consideration of receiving services by "Assignee" and for other good and valuable consideration, I hereby agree to the following: I authorize assignee to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS:

I HEREBY ASSIGN MY insurance benefits and any and all causes of action available under my policy of automobile insurance to, DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, PA d/b/a DIAGNOSTIC IMAGING CONSULTANTS hereinafter, collectively referred to as the Assignee. Additionally, both the assignee and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances, and as such, agree the same serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignee for services, refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage, I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignee the full amount of the bill(s) submitted), to avoid exhaustion of coverage while Assignee pursues its rights under this Agreement, both parties to this agreement (the Assignee and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

IN THE EVENT MY insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I AUTHORIZE ASSIGNEE to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I UNDERSTAND THAT I remain personally responsible for the total amounts due the Assignee for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignee to await payments and they may demand payments from me immediately upon rendering services at their option, although the Assignee agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignee shall be entitled to reasonable attorney fees and costs of collection. I also understand that, if any bad check is written, I agree to pay for those added costs.

Dated this _____ day of _______________, 20 ___.

Patient Signature________________________Print Name______________________Witness___________________

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