



Application for Health PI



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	
DATE OF BIRTH	AGE	SOCIAL SECURITY # (FOR INSURANCE)
	SEX	MARITAL STATUS
	M F	
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.

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.

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

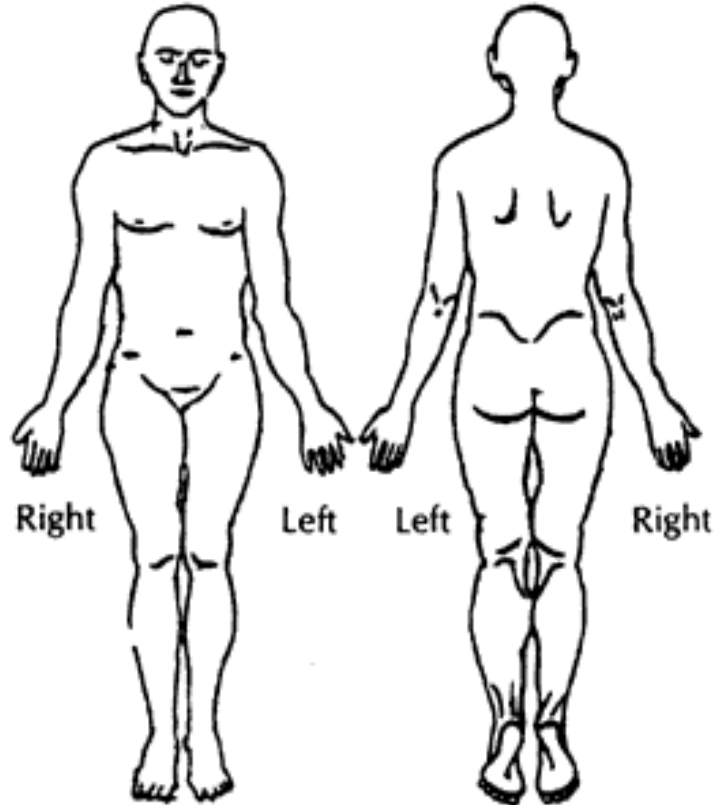
- 9. Shoulder Joint Pain
- 10. Elbow Joint Pain
- 11. Wrist Pain
- 12. Hand Pain Numbness Tingling
- 13. Arm Pain Numbness Tingling

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



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?

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

- Gas/ Bloating After Meals
- Heartburn
- Black/ Bloody Stool
- Colitis

GENITO-URNIARY CODE

- Bladder Trouble
- Painful/ Excessive Urination
- Discolored Urine

NERVOUS SYSTEM CODE

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

C-V-R CODE

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

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

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

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

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: _____

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
6703 SHANNON PKWY. STE. 14 UNION CITY, GA 30291

LOUIS OKUN, D.C.
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 _____

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 _____

5136 Central Ave., St. Petersburg, FL 33707

Phone: 727-579-2500

Toll Free: 877-579-8800

Fax 727-579-1060

Family Chiropractic • 6703 Shannon Parkway, Suite 14 • Union City, GA 30291 • (770) 964-3334

Page 6 of 9

File #: _____

Personal Injury Intake Information

Personal injury cases are usually more involved than other cases; therefore your cooperation is greatly needed. In some cases we are able to wait for the carrier to pay the bill. This sometimes means that our office must wait six (6) months to a year for payment.

Even though you may not be responsible for the accident, we need to bill all insurance carriers. Billing all insurance carriers may cover your medical bills either in part or whole before your case settles. Remember, regardless of what insurance agents tell you about opening a Medical Payments claim, if you have Medical Payments on your car insurance policy, it is primary coverage and must be used first.

You must remember that if for any reason the case is not settled, you are responsible for your bill in full.

To expedite your case, the following **MUST** be brought into our office (we can make copies of any documents necessary):

- Accident report
- Copies of driver's license and social security card
- Copy of group insurance policy/ policies including major medical insurance
- Copy of automobile insurance policy on each and every vehicle in the household on the day of the collision. (You may contact your insurance agent to get this faxed to the office. Our **fax number is (770) 306-2680**)
- Insurance information on the third party (person who was liable for accident)
- Pictures of vehicles – can be emailed to ins@okunchiropractic.com if digital. Please notate patient name and date of accident in email.
- Pictures of injuries – can be emailed to ins@okunchiropractic.com if digital. Please notate patient name and date of accident in email.
- Copies of ambulance trip report and emergency room notes (a release can be signed in the office so we can obtain them.)
- Physical and mailing addresses of patient (must have physical address – no P.O. Boxes.)
- If an attorney is involved, we **MUST** have a signed Doctor's Lien on file for your case to proceed. We can refer you to an attorney if you need one. (The lien must be signed by the patient and the attorney.)

Remember, we are here to help you. Please keep the lines of communication open in the office so we can stay aware of what is going on with your case at all times. Thank you.

I have received this information on this date. For the items that are applicable to my case, I will bring them to Family Chiropractic within one week of starting care.

Patient Signature

Date

**Any information can be faxed at any time to Family Chiropractic at (770) 306-2680
Information can also be emailed to ins@OkunChiropractic.com**

**LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY**

Claim or File#: _____ Insured's Name: _____
Date of Loss: _____ Address: _____
Patient: _____
Policy #: _____

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, liability insurance adjustor, and/or my attorney, to pay directly to: **Family Chiropractic** such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No Fault benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits name herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this Office, including reasonable attorneys' fees. This agreement is solely for said provider's additional protection and in consideration of the Medical Service Provider awaiting payment in this matter.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Lien and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I hereby instruct that in the event another attorney is substituted in this manner, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him. A photocopy of this Agreement shall be considered as effective and valid as the original.

Date: _____ Signed: _____
Witness: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named.

Date: _____ Signed: _____
Printed name of attorney: _____

Note to attorney: If you prefer, please send your acknowledgement of this lien on your letterhead.

Family Chiropractic

6703 Shannon Parkway, Suite 14 • Union City, GA 30291
(770) 964-3334

AUTHORIZATION TO SIGN MEDICAL LIEN

I, _____, the undersigned, do hereby authorize and direct my attorneys to enter into an agreement with my health care provider, Family Chiropractic, to ensure the payment of my medical bill to said health care provider from my portion of any settlement or verdict proceeds.

I further certify that I understand this authorization give my attorney express authority to deduct medical expenses from my portion of any recovery in my case. I instruct my attorneys to deduct sufficient monies to pay the outstanding medical bills due Family Chiropractic and pay the sum of the medical lien to Family Chiropractic without further written authority from me.

My attorneys are also authorized to release an accurate settlement statement with offers from any insurance company, on insurance company letterhead or email header, to Family Chiropractic.

My attorneys have explained to me that signing a lien to the extent necessary to cover the medical expenses is irrevocable; that is, I may not cancel or withdraw such consent to pay Family Chiropractic without Family Chiropractic's written notarized authorization for me to cancel the lien.

I also understand that my health care provider has conditioned further treatment of me upon receiving the written assignment and lien on the proceeds of my claim.

Date

Patient Signature

Witness Signature