

INTEGRITY CHIROPRACTIC

11582 Cumming Highway
Canton, GA 30115
(678) 400-0202
www.IntegrityChiropractor.net

CONFIDENTIAL PATIENT INFORMATION

Name _____ Date _____

Home Phone _____ Cell Phone _____

Address _____ City _____ Zip _____

Social Security Number _____ Age _____ Birth Date _____

Marital Status Married Single Widowed Divorced How many children? _____

Occupation _____ Employer _____ Office Ph. _____

Work Address _____ Email Address _____

At Integrity Chiropractic, we believe in educating our patients on a variety of subjects relating to a health and wellness lifestyle. To help achieve this goal, periodically we send out electronic newsletters to our patients via e-mail. These e-newsletters are intended strictly as informational and are not meant to intrude upon your privacy or to create e-mail spam. Please be assured that your e-mail address will be kept strictly confidential. If you would like to receive these e-newsletters, please indicate so below.

- Yes, I would like to receive the Integrity Chiropractic newsletters via e-mail.
- No, please do not send these e-newsletters.

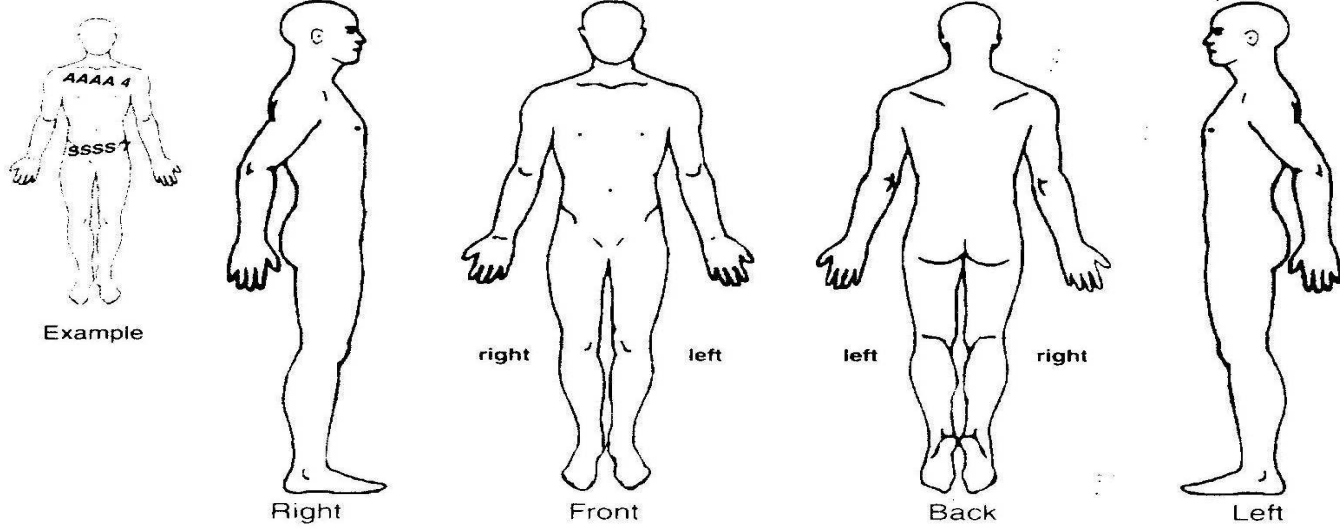
Name of Spouse _____ Occupation _____ Employer _____

Who may we thank for referring you to our office? _____

Have you had chiropractic care before? Yes No

If so, when and who was the doctor/clinic? _____

PRIMARY CONDITION (the condition for which you would most like to have relief)



Please indicate the area(s) of injury or discomfort *as shown in the example above and left*. Please use the appropriate symbols (listed below) to describe the nature of the pain.

S = Sharp A = Aching D = Dull T = Tingling Th = Throbbing B = Burning N = Numbness R = Radiating

Please describe your primary complaint: _____

When did it start? _____ Have you had it in the past? Y N When: _____

Please check the appropriate box: The pain is constant it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain: 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

Sharp/Stabbing Aching Dull Tingling Throbbing Burning Numbness Radiating Other _____

If Radiating, where does your pain travel from the point of pain? _____

Does this condition interfere with your: Work Sleep Daily Routine Recreation Other

Have you seen any other doctors for this condition: Y N Name/Specialty: _____

What other treatment have you had for this condition? Medications Surgery Chiropractic

Physical Therapy Other _____

Do any of the following make your condition better? Sitting Rest Sleep Medications Therapy

Chiropractic Adjustments Other _____

Do any of the following makes your condition worse? Walking Sitting (for long periods) Standing

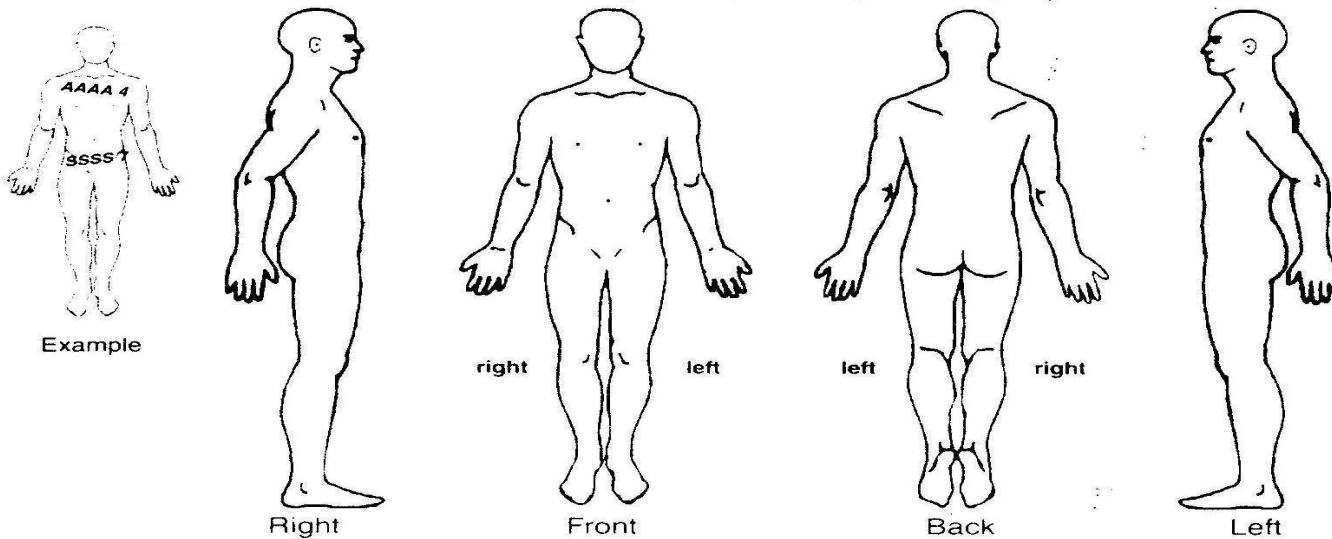
Bending/Lifting Coughing Sneezing Breathing Bowel Movements Other _____

Is this the result of either: an automobile accident? Y N Work related injury? Y N

If yes, to either question above, please explain: _____

**DOCTOR USE ONLY: _____

SECONDARY CONDITION (any other condition/symptoms, if applicable, for which you are seeking treatment)



Please indicate the area(s) of injury or discomfort as shown in the example above and left. Please use the appropriate symbols (listed below) to describe the nature of the pain.

S = Sharp A = Aching D = Dull T = Tingling Th = Throbbing B = Burning N = Numbness R = Radiating

Please describe your secondary complaint: _____

When did it start? _____ Have you had it in the past? Y N When: _____

Please check the appropriate box: The pain is constant it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain: 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

Sharp/Stabbing Aching Dull Tingling Throbbing Burning Numbness Radiating Other _____

If Radiating, where does your pain travel from the point of pain? _____

Does this condition interfere with your: Work Sleep Daily Routine Recreation Other

Have you seen any other doctors for this condition: Y N Name/Specialty: _____

What other treatment have you had for this condition? Medications Surgery Chiropractic

Physical Therapy Other _____

Do any of the following make your condition better? Sitting Rest Sleep Medications Therapy

Chiropractic Adjustments Other _____

Do any of the following makes your condition worse? Walking Sitting (for long periods) Standing

Bending/Lifting Coughing Sneezing Breathing Bowel Movements Other _____

Is this the result of either: an automobile accident? Y N Work related injury? Y N

If yes, to either question above, please explain: _____

**DOCTOR USE ONLY: _____

Place a check mark if any of the following apply to you presently or have ever applied to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Gout | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Allergies/Sinus Conditions | <input type="checkbox"/> Head Trauma/Injury | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches - Severe/Frequent | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Artificial Bones/Joints/Prosthesis | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heel Spurs | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Broken Bones/Dislocations | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Hernia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Herniated/Bulging Disc | <input type="checkbox"/> Ringing In Ears |
| <input type="checkbox"/> Chest Pain/Tightness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Colic (Infant) | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Infertility | <input type="checkbox"/> Sensitivity to Light |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Coughing -Frequent/Persistent | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Knee Pain/Leg Pain/Ankle Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Digestive Difficulties | <input type="checkbox"/> Menopause | <input type="checkbox"/> Stroke/TIA's |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Menstrual Difficulty/Irregularity | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Double Vision/Blurry Vision | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Miscarriage of pregnancy | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Muscle Spasms/Tightness | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Fainting Episodes | <input type="checkbox"/> Muscle Weakness/Atrophy | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Fallen Arches | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Walking Difficulties |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Weight Loss (Unexplained) |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Numbness/Pins and Needles | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other |

Family History: Insert age and check any box that applies

	Age (if living)	Heart Disease	Diabetes	Cancer	Neck Pain	Low Back Pain	Carpal Tunnel	Headaches
Mom								
Dad								
Brother								
Sister								
Other								

Medication: Please list all medications you are currently taking:

1. _____ 3. _____ 5. _____ 7. _____
 2. _____ 4. _____ 6. _____ 8. _____

Nutritional Supplements: Please list all nutritional supplements you are currently taking:

1. _____ 3. _____ 5. _____ 7. _____
 2. _____ 4. _____ 6. _____ 8. _____

For Females Only:

The 10-day period from the start of a female's last menstrual cycle is considered to be the safest time to X-ray a female without fear of her being pregnant. Please read the following questions and answer "Yes" or "No" appropriately.

- Are you currently having menstrual cycles? Yes No If yes, when was the first day of your last cycle? _____
 Is there any chance you are pregnant? Yes No Are you currently late with your menstrual cycle? Yes No
 Do you have irregular menstrual cycles? Yes No Are you past menopause? Yes No
 Are you taking oral contraceptives? Yes No Have you had a hysterectomy or tubal ligation? Yes No

This is to certify that to the best of my knowledge, I am not pregnant and hereby give permission to Integrity Chiropractic to perform an X-Ray evaluation.

Signature _____ Date _____

FINANCIAL ARRANGEMENT

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our patients are able to receive the needed care in an affordable manner. If you have insurance coverage, our office will provide the courtesy of billing your insurance company. Although we provide the service of billing the insurance, any payments that are not received from your insurance company within 60 days **will ultimately become your responsibility**. The amount of your insurance coverage and out-of-pocket expense will be discussed in detail. If you choose to enter into care at our office several different payment options will be available. Any arrangements for credit will be agreed upon in writing before care begins.

ATTENTION MEDICARE INSURED: Medicare will **ONLY pay for one service** through any chiropractic office: the chiropractic adjustment (billing codes 98940 AT, 98941 AT and 98942 AT). Medicare will only pay for these services if they feel that this service is **MEDICALLY NECESSARY**. **Necessity for care is ultimately determined by Medicare.** Medicare and any Supplemental insurance you may have will not pay for any other services that might be needed to establish medical necessity and to provide you with the care that is needed as determined by the doctor. These services include, but are not limited to: exams, X-rays, Low Level Laser Therapy (cold laser), Spinal Decompression Therapy, Asyra, ionic detoxifying footbath, Body Composition Analysis, ultrasound, rehabilitative procedures and ice/heat therapy.

Medicare requires all Medicare insured patients to sign an additional form called an ABN form before any of these services are performed to ensure that you understand this arrangement.

Please note: A quote of coverage benefits by the insurance company is **NOT A GUARANTEE OF PAYMENT**.

IN THE EVENT THE INSURANCE COMPANY REJECTS OR DENIES YOUR CLAIM YOU WILL BE RESPONSIBLE FOR FULL PAYMENT OF ALL SERVICES RENDERED. IF OUR OFFICE IS BILLING YOUR INSURANCE AND YOUR INSURANCE CARRIER HAS NOT PAID A CLAIM WITHIN 90 DAYS, YOU WILL BE RESPONSIBLE FOR TAKING AN ACTIVE PART IN THE RECOVERY OF THE CLAIM. AFTER 120 DAYS, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL FOR ANY OUTSTANDING BALANCE.

In the event of discontinuation of care you will be billed for any outstanding balance and payment is expected within 60 days.

If your bill remains unpaid after 120 days and no satisfactory payment arrangements have been made towards reconciling it, then the debt on your account may be assigned to a collection agency.

I have read and understand the statements above and give the doctor permission to evaluate me. I further agree to the fee schedule set forth by Integrity Chiropractic, LLC and will ultimately be the party that is financially responsible for this account.

Name: _____ Signature: _____ Date: _____

PRIVACY STATEMENT

We recognize and respect the privacy expectations of today's consumers and the requirements of applicable federal and state privacy laws. We believe that making you aware of how we use your non-public Personal Information, and to whom it is disclosed, will form the basis for a relationship of trust between us and the public that we serve. This Privacy Statement provides that explanation. We reserve the right to change this Privacy Statement from time to time consistent with applicable privacy laws.

In the course of our business, we may collect Personal Information about you from the following sources:

- From applications or other forms we receive from you or your authorized representative;
- From your transactions with or from the services being performed by us, our affiliates or others;
- From our internet websites;
- From the public records maintained by governmental entities that we either obtain directly from those entities or from our affiliates or others; and
- From consumer or other reporting agencies

OUR POLICIES REGARDING THE PROTECTION OF THE CONFIDENTIALITY AND SECURITY OF YOUR PERSONAL INFORMATION:

We maintain physical, electronic and procedural safeguards to protect your Personal Information from unauthorized intrusion. We limit access to the Personal Information only to those employees who need such access in connection with providing products or services to you or for other legitimate business purposes.

OUR POLICIES AND PRACTICES REGARDING THE SHARING OF YOUR PERSONAL INFORMATION:

We may share your Personal Information with our affiliates, such as medical doctors, radiologists and/or other chiropractors for the purpose of rendering patient care. We may also disclose your Personal Information as applicable to:

- Your insurance company for the purpose of reimbursement
- Your employer as related to Workers' Compensation injuries, and
- Attorneys as related to personal injury/automobile accident/workers compensation cases.

In addition, we will disclose your Personal Information when you direct or give us permission, when we are required by law to do so, or when we suspect fraudulent or criminal activities. We also may disclose your Personal Information when otherwise permitted by applicable privacy laws, for example, when disclosure is needed to enforce our rights arising out of any agreement, transaction or relationship with you.

RIGHT TO ACCESS YOUR PERSONAL INFORMATION AND ABILITY TO CORRECT ERRORS OR REQUEST CHANGES OR DELETION:

You are afforded the right to access your Personal Information and, under certain circumstances, to find out to whom your Personal Information has been disclosed. Also, you are afforded the right to request correction, amendment or deletion of your Personal Information. We reserve the right, where permitted by law, to charge a reasonable fee to cover the costs incurred in responding to such requests. Anyone wishing to obtain a copy of their records must sign a release form. All requests must be made in writing via mail, fax or in person.

Print Name _____

Patient Signature _____

Date _____

PATIENT CONSENT FORM

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

I, _____ hereby state that by signing this consent, I acknowledge and agree as follows:

____ 1. Integrity Chiropractic's Privacy Notice has been provided to me and I have carefully read it prior to my signing this consent.

____ 2. Integrity Chiropractic reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I consent to the following appointment reminders that may be used by Integrity Chiropractic:

- Postcards mailed to the addresses I have provided.
- Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.
- E-mail

____ 4. Integrity Chiropractic may use and/or disclose my Personal Health Information (PHI) (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that Integrity Chiropractic, LLC restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the clinic is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, Integrity Chiropractic has the right to refuse to treat me.

____ 7. I give Integrity Chiropractic permission to treat me in a private room while at times leaving the door ajar. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a private room for these conversations.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Date: _____

Patient's Name (Printed) _____

Patient Name (Signed) _____

Patient DOB: _____