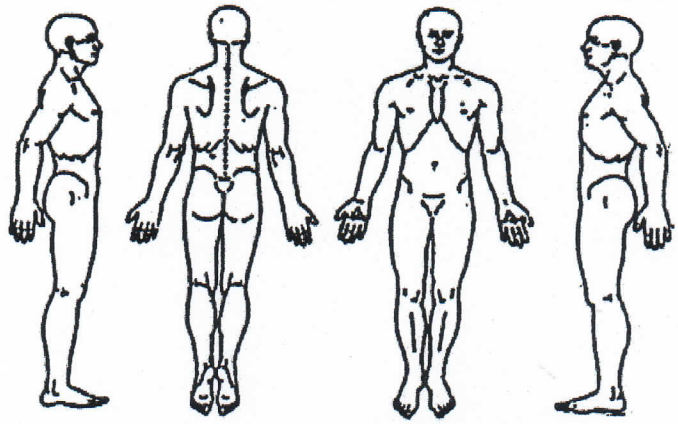
Garber Chiropractic Center

PATIENT INTAKE FORM

Patient Name: _____ Phone: _____ Date: _____

1. Is your problem: □ Auto Related □ Work Related □ Neither

2. Indicate on the drawings below where you have pain/symptoms



Office Use Only

Onset: _____/_____/_____

_____

_____

_____

_____

_____

_____

_____

_____

PCP:

3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

Office Use Only

_____

_____

_____

_____

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem/s?

1 2 3 4 5 6 7 8 9 10 Neck = _____ Mid Back = _____ Low Back = _____ Head = _____

mild ⇨ *moderate* ⇨ *severe* Other_____ = _____ Other_____ = _____

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____ **Date Problem Began:** _____/_____/_____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13A. What aggravates your problem?

_____

13B. What makes it better?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Date of Birth** _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. List all prescription medications you are currently taking:

_____

21. List all of the over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

LIST VITAMINS YOU TAKE:

_____
_____
_____
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma or a bad injury? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

GARBER CHIROPRACTIC CENTER

PATIENT & INSURANCE INFORMATION FORM

Patient Name: _____ Age: _____

Address: _____

_____

City State Zip

Date of Birth: _____ Sex: ☐Female ☐Male

Phone Numbers: Home ( ) _____ -- _____

Cell ( ) _____ -- _____

Work ( ) _____ -- _____

Social Security Number: _____ Drivers Lic. # _____

Employer: _____

Employed: ☐Fulltime ☐Part Time

Marital Status: M S D W Student: ☐No ☐Yes - Part Time / Full Time

Email: _____

Family Doctor: _____

Referred By: _____

Emergency Contact Person: _____ ☐Spouse ☐Mother ☐Father ☐Other_____

Emergency Contact Phone Number: _____

****

INSURANCE INFORMATION

Health Plan: ☐BC/BS ☐AETNA ☐CIGNA ☐UHC ☐MEDICARE Other:_____

Insurance Plan: ☐PPO ☐HMO ☐POS Other: _____

Policy Holder: _____ Date of Birth:_____

Policy Holder SS# _____

Relation of Policy Holder to Patient: ☐Self ☐Spouse ☐Child Other:_____

Policy Holders Employer: _____

Policy Holders ID#: _____ Group # _____

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive health care services from Garber Chiropractic Center, I understand that I am liable for all charges for services rendered and I agree to notify Garber Chiropractic Center immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that Garber Chiropractic Center may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to Garber Chiropractic Center to contact my physician if necessary.

Patient Signature: _____ Date: _____

Steven J Garber, D.C., P.C. (DBA Garber Chiropractic Center)
207 E Felton Rd. Suite 111
Cartersville, GA 30121
PH: 770-386-7707

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Steven J Garber, D.C., P.C. (DBA Garber Chiropractic Center) or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

GARBER CHIROPRACTIC CENTER FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Insurance companies define benefits to include diagnosis and related services and are limited to one visit and treatment per day. Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other Physician for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to **maintain** a level of functioning or to prevent a medical problem from occurring or reoccurring.

PATIENTS WITHOUT INSURANCE (ASK ABOUT OUR TIME OF SERVICE PLAN)

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made per visit or at the end of the week if you sign a credit guarantee form. We are happy to accept your cash, check, debit or credit cards.

FLEX PLANS OR MEDICAL SAVINGS ACCOUNTS: Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement. Additional copies are available for a fee of **$10 each**.

INSURANCE AND MANAGED CARE PLANS

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We have verified your benefits and while **your insurance company did not guarantee payment,** they stated that you have a $_____deductible $_____of which has been met. Additionally, your insurance company stated that they will pay _____% of covered charges, leaving _____% of each visit due by you. Visit Limit_____.

- ☐ A referral from your primary care physician will be necessary. Out of network benefits are available if a referral is not obtained.
- ☐ Benefits are available for up to _____visits per year. A $_____co-pay is due at the time of service.

"ON THE JOB" INJURY AND AUTOMOBILE ACCIDENTS

Worker's Compensation pays in full for Chiropractic care. Upon being released from care, a 3 month time period is allowed for settlement of your claim. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

Auto Accident: Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient: A credit guarantee is required to be on file.

- ☐ Pay cash for your care and we will provide billing statements and submit reports whenever necessary.
- ☐ We will bill (accept assignment) from the Med Pay portion of your auto insurance and receive payment directly from them. However if this is a Georgia 3rd part liability case the other person's insurance does not accept assignment from the doctor and payment is due at time of service.
- ☐ We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient. You will be on a payment plan of _____ per visit, week, other_____ until settled.
- ☐ We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to **(six)** months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

My signature below states that I have read and understand the above policies and agree to abide by these terms

_____

PATIENTS/SPOUSE/GUARDIAN SIGNATURE: DATE

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Garber all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges wither or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Should I default, I agree to pay all cost of collection, including collection agency fees, court cost, and reasonable attorney's fees.

Responsible Party Signature:_____ Relationship:_____

GARBER CHIROPRACTIC INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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 the patient named below, for who I am legally responsible by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by working or associated with servicing us as back up for the doctor of chiropractic named above.

I understand that I will have an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the 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, including but not limited to, fractures, disc injures, strokes, dislocations, and sprains. I do not expect the doctor to be able anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on facts the known, as in my best interests.

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

TO BE COMPLETED BY PATIENT OR PATIENTS REPRESENTATIVE, IF NECESSARY, E.G., IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACTIATED:

_____

PRINT PATIENTS NAME SIGNATURE DATE

_____

REPRESENTATIVE RELATIONSHIP DATE

_____

WITNESS TO PATIENTS SIGNATURE DATE