Wilson Family Chiropractic

It is our pleasure to welcome you to our office. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better please complete the following information.

Patient Information

Patient Name: _____

Address: _____ City _____ State_____ Zip _____

Cell Phone: _____ Home Phone: _____

Email: _____

Date of Birth: _____/_____/_____ Age: _____ Sex M / F

Marital Status (circle): Married Partnership Widowed Divorced Single # of Children _____

How did you hear about our office? _____

Who may we thank for referring you? _____

Favorite hobbies or interests: _____

EMPLOYMENT

Employer Name: _____ Occupation: _____

Spouse/Partner Name: _____ Occupation: _____

HEALTH CONCERNS Health reasons for consulting our office, ***with number one being of greatest importance:***

1. _____ 3. _____
2. _____ 4. _____

Have you seen other doctors for this condition (circle) Yes / No

If yes, doctor's names and prior treatments: _____

Is the reason for your visit the result of an auto or work injury? Y / N If yes, when? _____

Other health concerns: _____

Have you had same or similar problem(s) before? Y / N How long? _____

Please explain: _____

CHIROPRACTIC HISTORY

Last time you went to a Doctor of Chiropractic:_____

Were you satisfied with the care you received there? Yes / No

Reason for Care _____

Chiropractic techniques you've had success with: _____

What daily rituals for spinal health/hygiene do you currently practice? _____

HEALTH HISTORY

Primary Care Provider
Name: _____ Phone: _____

Specialist you are currently receiving care from:

Name: _____ Phone: _____

Name: _____ Phone: _____

Have you ever been diagnosed with cancer? Y / N If yes, are you currently undergoing treatment? Y / N

Please list any surgeries you've had (including C-Section):
_____

Medication(s) you currently take: _____
_____

Vitamin(s) you currently take: _____
_____

Have you ever experienced (check all that apply)

- ☐ Chronic ear aches/infections
- ☐ Neck problems
- ☐ Joint problems
- ☐ Backaches
- ☐ Walking problems
- ☐ Arm problems
- ☐ Leg problems
- ☐ Muscle jerking
- ☐ Tremors
- ☐ Orthopedic problems
- ☐ Stroke
- ☐ Arthritis
- ☐ Neuritis
- ☐ Paralysis
- ☐ Headaches
- ☐ Hyperactivity
- ☐ Behavioral problems
- ☐ Learning disabilities
- ☐ Autism
- ☐ Ruptures/hernias
- ☐ Seasonal allergies
- ☐ Food allergies
- ☐ Frequent colds/flu
- ☐ Diabetes
- ☐ Digestive trouble
- ☐ Asthma
- ☐ Sinus trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colic
- ☐ Anemia
- ☐ Poor appetite
- ☐ Stomach aches
- ☐ Bed wetting
- ☐ Tuberculosis
- ☐ Rheumatic fever
- ☐ Convulsions
- ☐ Blood disorders
- ☐ Heart disease
- ☐ Hypertension
- ☐ Broken Bones
- ☐ Dizziness
- ☐ Fainting
- ☐ Other: _____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and potential for improvement.

Patient Signature: _____ Date: _____

Wilson Family Chiropractic

Family Health History

Patient Name: _____ Date: _____/_____/_____

Please review the below listed symptoms and conditions and indicate those are current health problems of a family member by the designated **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

Condition	Father Age_____	Mother Age_____	Spouse Age _____	Brother (s) Age(s) _____	Sister(s) Age(s) _____	Children Age(s) _____
Allergies						
Anxiety/Depression						
Arthritis						
Auto Accidents						
Back Pain						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Epilepsy						
Frequent Colds						
Gassy/Bloating						
Headaches						
Heartburn						
Heart Trouble						
High Blood Pressure						
Migraines						
Neck Pain						
Scoliosis						
Sinus Trouble						
Sleeping Problems						
Other:						

Wilson Family Chiropractic

Emergency Contacts

Patient Name: _____ Date: _____/_____/_____

1st Contact

Name: _____

Relationship: _____

Phone: _____

2nd Contact

Name: _____

Relationship: _____

Phone: _____

I hereby give Wilson Family Chiropractic LLC permission to contact the individuals listed above if there is an emergency while I am at the business location.

Signature: _____ Date: _____

Wilson Family Chiropractic

Health Information Privacy Notice

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

During your case as a patient at Wilson Family Chiropractic, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it necessary to refer you for further diagnosis, assessment, and treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, your attorney (for personal injury or auto accident), or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, email address, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- If you are not at home to receive an appointment reminder, a message may be left on your answering machine or via email. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.
- Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:
    - If we are providing health care services to you based on the orders of another health care provider
    - If we provide health care services to you in an emergency
    - If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so
    - If there are substantial barriers to communicating with you, but in our professional judgment, we believe that you intend for us to provide care
    - If we are ordered by the courts or another appropriate agency
- Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization
- We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preference.
- You have the right to inspect and/or copy your health insurance information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health-related information should be provided in writing.
- We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of your privacy practices with respect to your health information.
- We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.
- Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provided the information and may no longer be protected by the federal privacy rules.

- If you have a complaint, or would like further information regarding our privacy notice, policies, and practices, please direct your inquiry or complaint to:

  Drs. Jacob & Katherine Wilson, Privacy Officers for Wilson Family Chiropractic

- This office utilizes an "open-adjusting" environment for ongoing patient care. "Open-adjusting" involves several patient being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an "open-adjusting" environment, other arrangements will be made for you.
- Since this office utilizes an "open-adjusting" environment, established patient occasionally request family members or friends be present during their visits. It is the policy of this office to allow for this.
- This office utilizes the use of patient names in some of it's interior/exterior designs of the office. For example, referral boards (acknowledging patients who have referred other patients), welcome boards which display patient names, testimonial books, and website testimonials where patients have written personal health information as well as the benefits of their care in this office. It is our view that these kinds of materials are known as "incidental disclosures". If however, you do not choose for your name to be displayed or disclosed on any of the above-mentioned materials, please inform us in writing. This entire authorization is valid for (7) years. It is the policy of this office to not disclose any information about you without your prior consent. This office will notify you via phone, email, or personal communication prior to utilizing your name for any reason.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name: _____ Date: _____/_____/_____

Signature: _____

If you are a minor, or if you are being represented by another party

Representative Name: _____ Date: _____/_____/_____

Signature: _____

Description of the authority to act on behalf of the patient: _____

Wilson Family Chiropractic

Assignment and Instruction for Direct Payment to Physician

Please complete this form to authorize Wilson Family Chiropractic to bill and be reimbursed by your insurance company

Private, Group, Accident, and Health Insurance

I hereby authorize and direct _____ insurance carrier to pay by check made out and mailed directly to:
(Insurance company name)

Wilson Family Chiropractic

2494 Jett Ferry Rd, Ste 103

Dunwoody, GA 30338

678-205-1573

If my policy prohibits direct payment to my doctor, then I hereby instruct and direct the check to be made to me and mailed as follows:

Wilson Family Chiropractic

2494 Jett Ferry Rd, Ste 103

Dunwoody, GA 30338

678-205-1573

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and have I agreed to pay, in a current manner, any balance of said professional service chargers over and above this insurance payment.

A PHOTOCOPY OF THIS AGREEMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of information pertinent to my case to any insurance carrier, adjuster, or attorney involved in this case.

_____ _____

Signature of Policyholder **Witness**

_____ _____

Signature of Claimant if other than policyholder **Date**

_____

Date

Wilson Family Chiropractic Payment Policy

We strive to provide the highest quality healthcare while maintaining affordability. We understand that even with insurance, most patients experience at least some out of pocket expense. We request that your payment for services be made at the time of your visit. This policy simplifies our billing and helps keep your cost down. For your convenience, we gladly accept Cash, Checks, Visa, MasterCard, Discover, American Express, Care Credit as well as HSA /FSA cards.

As a benefit to you, we are in-network with Blue Cross Blue Shield and United Health Care. We will bill directly to these insurance companies. However, you are responsible for the difference between what your insurance pays, and the total charges for your care. Health insurance is designed to help you meet the cost of your health care, but ultimately the responsibility of payment is yours. Your insurance contract is strictly between you and your insurance company and we are not a party to that contract. If you have a plan under which we are contract providers, you will likely have a co-pay, coninsurance, and/or deductible. Please be prepared to pay those charges at the time of your visit. If your insurance is out of network, as a courtesy, and upon your express request, we will provide you with itemized statements to submit to your insurance company. You will be reimbursed directly by your insurance carrier according to the provisions of your policy.

We also offer special payment plan discounts to make care more affordable. These discounts will be discussed in detail during your Report of Findings visit (2nd day), and the discount offer will expire 30 days after your Report of Findings visit. Please let us know within that time frame if you would like to take advantage of the discounts, but if not, you will be responsible for the fees incurred during that time.

We may request that a card be kept on file for any unpaid charges that you occur in our office. We reserve the right to charge this card if there are any unpaid balances on your account. If at any time you'd like to update the card we have on file for you, please let us know and give us the information for the replacement card and we will happily update this for you.

Auto accident and worker compensation claims will be charged directly to you if the claim is denied or your benefits are exhausted. If that occurs, we can send the charges to other health coverage you may have, as long as we are contracted with them. What is not paid will be transferred to your balance. We require a claim number and insurance and/or attorney contact information for your case within the first 14 days of care.

Name: _____ Date: _____/_____/_____

Signature: _____ Date: _____/_____/_____

Wilson Family Chiropractic

Photo, Video, and/or Testimonial Release Consent

Purpose of Consent: By signing this form, you are consenting to allow *Wilson Family Chiropractic* and any associated staff members to use and distribute your photograph, video content, and/or written testimonial.

Right to Revoke: You have the right to revoke this release at any time by providing written notice of your revocation and submitting it to the contact person listed below. Please understand that revocation of this release will not affect any action *Wilson Family Chiropractic* took in reliance on this release before receiving your revocation.

I understand that I am providing the video content and/or written testimonial information to *Wilson Family Chiropractic* and that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I hereby grant permission to allow *Wilson Family Chiropractic* to use photographs and videos of me, and my written testimonial. I hereby agree and acknowledge that this content will be released to the public via public relation efforts of *Wilson Family Chiropractic.* I further acknowledge and agree that my photo, video, and/or testimonial may be used by the media.

I waive the right of prior approval and hereby release *Wilson Family Chiropractic* from any and all claims for damages of any kind based on the use of my photo, video, or information contained in my testimonial.

By signing below, I agree and acknowledge that I have read and understood the above release and agree to all terms described. I am of legal age and freely sign this release.

Name: _____ Date: _____

Signature: _____