Welcome To Back In Motion Chiropractic

PATIENT INFORMATION

Today's Date_____
Last Name_____
First Name_____
Middle Name _____
SS#_____
Address_____
City_____
State _____ Zip_____
E-Mail _____
Sex ☐ M ☐ F Age_____
Birth Date_____/_____/_____
☐ Single ☐ Married ☐ Widowed ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ___years
Occupation_____
Employer/School _____
Employer/School Address _____
_____
Employer/School Phone (_____)_____
Spouse's Name_____
Birth Date_____/_____/_____
SS# _____
Spouse's Employer_____
How did you hear about our office? _____

INSURANCE

Who is responsible for this account? _____
Relationship to patient _____
Insurance Co. _____
Subscriber's Name_____
Birth Date _____/_____/_____ SS#_____
Subscriber ID #_____
Group #_____
Is the patient covered by additional insurance?
☐ Yes ☐ No Insurance Co. _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named insurance company and assign directly to Kenneth C. Morris, D.C., DACBSP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Kenneth C. Morris, D.C., DACBSP may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____
Signature of Patient, Parent, Guardian, or Personal Rep.

_____
Printed name

_____
Date Relationship to patient

PHONE NUMBERS

Home Phone (_____)_____
Cell Phone (_____)_____
Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____
Relationship_____
Home Phone (_____)_____
Cell Phone (_____)_____

ACCIDENT INFORMATION

Is condition related to an accident ☐ Yes ☐ No
If Yes, Please obtain additional form from receptionist

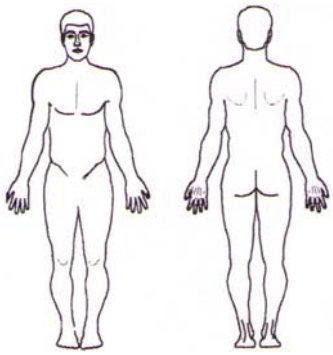
Type ☐ Auto ☐ Work ☐ Home ☐ Other
Date of accident _____

To whom have you made a report of your accident
☐ Auto Insurance ☐ Employer ☐ Worker Comp.

PATIENT CONDITION

Reason for visit_____
When did your symptoms appear?_____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Rate the severity of your pain on a scale from 0 (No Pain) to 10 (Severe Pain) _____
Type of Pain: Mark all that apply ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities that are painful ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Please mark on the picture where your symptoms are located



PLEASE COMPLETE THE BACK SIDE OF THIS FORM

HEALTH HISTORY

What treatment have you already received for this condition?

☐ Medications _____

☐ Surgery _____

☐ Physical Therapy Name of Therapist _____ Phone Number (_____)_____

☐ Chiropractic Services Name of Chiropractor _____ Phone Number (_____)_____

Name of any other doctor you have seen for this condition_____ Phone Number (_____)_____

Date of last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____ Spinal Exam_____

Chest X-Ray_____ Urine Test_____ Dental X-Ray_____ MRI, CT Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

ADD/ADHD ☐Yes ☐No	Diabetes ☐Yes ☐No	Miscarriage ☐Yes ☐No	Scarlet Fever ☐Yes ☐No
AIDS/HIV ☐Yes ☐No	Emphysema ☐Yes ☐No	Mononucleosis ☐Yes ☐No	Stroke ☐Yes ☐No
Alcoholism ☐Yes ☐No	Epilepsy ☐Yes ☐No	Multiple Sclerosis ☐Yes ☐No	Suicide Attempt ☐Yes ☐No
Allergy Shots ☐Yes ☐No	Fractures ☐Yes ☐No	Mumps ☐Yes ☐No	Thyroid Problems ☐Yes ☐No
Anemia ☐Yes ☐No	Glaucoma ☐Yes ☐No	Osteoporosis ☐Yes ☐No	Tonsillitis ☐Yes ☐No
Anorexia ☐Yes ☐No	Goiter ☐Yes ☐No	Pacemaker ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Anxiety ☐Yes ☐No	Gonorrhea ☐Yes ☐No	Parkinson's Disease ☐Yes ☐No	Tumors/ Growths ☐Yes ☐No
Appendicitis ☐Yes ☐No	Gout ☐Yes ☐No	Pinched Nerve ☐Yes ☐No	Typhoid Fever ☐Yes ☐No
Arthritis ☐Yes ☐No	Heart Disease ☐Yes ☐No	Pneumonia ☐Yes ☐No	Ulcers ☐Yes ☐No
Asthma ☐Yes ☐No	Hepatitis ☐Yes ☐No	Polio ☐Yes ☐No	Vaginal Infections ☐Yes ☐No
Bladder Problems ☐Yes ☐No	Hernia ☐Yes ☐No	Prostate Problem ☐Yes ☐No	Venereal Disease ☐Yes ☐No
Bleeding Disorder ☐Yes ☐No	Herniated Disc ☐Yes ☐No	Prosthesis ☐Yes ☐No	Whooping Cough ☐Yes ☐No
Breast Lump ☐Yes ☐No	Herpes ☐Yes ☐No	Psychiatric Care ☐Yes ☐No	
Bronchitis ☐Yes ☐No	High Cholesterol ☐Yes ☐No	Rheumatoid Arthritis ☐Yes ☐No	Other Medical History
Bulimia ☐Yes ☐No	Kidney Disease ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No	_____
Cancer ☐Yes ☐No	Kidney Infection ☐Yes ☐No		_____
Cataracts ☐Yes ☐No	Liver Disease ☐Yes ☐No		
Chemical Dependency ☐Yes ☐No	Measles ☐Yes ☐No		
Chicken Pox ☐Yes ☐No	Migraine Headaches ☐Yes ☐No		
Depression ☐Yes ☐No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day_____
☐ Alcohol Drinks/Week_____
☐ Coffee/Caffeine Drinks Cups/Day_____
☐ High Stress Level Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date_____ **Menopause?** ☐ Yes ☐ No Began on:_____

INJURIES/ SURGERIES

DESCRIPTION **DATE**

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE REVIEW AND SIGN ALL ATTACHED POLICY FORMS

Back In Motion Chiropractic
Kenneth C. Morris, D.C., DACBSP
Andrea Fjedahl-Howard, D.C.
10515 Bells Ferry Rd Suite 100
Canton, Ga 30114

Financial Policy

In order to accommodate the needs and requests of our patients, Back In Motion Chiropractic is contracted with numerous insurance companies. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending upon the type of contract your employer negotiated with that carrier on your behalf.

Providing quality chiropractic care for our patients is our primary concern.
We are happy to provide care for our patients, within their insurance contract guidelines, but we ask that our patients come prepared at the time of service to let us know what those guidelines are. In most of our contracts, Back In Motion's personnel are not permitted to interpret insurance benefits for the patient. We are expected and obligated to provide quality care to each insured person, but it is **the insured person's responsibility to understand their benefits.**

Should your insurance company require a **specialist referral** from your primary care physician before you can be seen by our physicians, it is your responsibility to obtain that referral **prior to your appointment.** You should bring the referral with you to your appointment. Our contracts with the insurance companies prohibit us from seeing you without a referral and billing them for the services. If you are seen without a referral, **you must be prepared to pay for all services in full at the time they are rendered.** *If a referral is required and you are unsure how to obtain one, please let the staff know and we will be happy to provide assistance.*

If you do not inform us of any special requirements in your insurance contract, *such as referrals or preauthorization for treatment,* and we subsequently order services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day, or if your contract contains a pre-existing clause, your insurance carrier will probably deny payment for services received and you will be responsible for paying for the denied services.
Please remember that you, the patient, are ultimately responsible for payment on your account.

Payment is expected on the day services are rendered. In the event that credit is granted, it shall be paid promptly in accordance with terms and agreements. Back in Motion Chiropractic may add one and one half percent (1 ½ %) per month to any balance owed and in the event of default to pay reasonable collection charges and/or attorney fees may also be applied.

All treatments and services rendered at Back In Motion Chiropractic will be billed according to our contracts with the insurance companies. **The act of waiving deductible, co-insurance, and co-pay amounts is strictly prohibited.** According to our insurance contracts as well as well as the insured's, if you have an insurance policy that covers chiropractic services, we are required to bill the services to the insurance policy. You may not elect to not use your insurance benefits. We are required to bill "self-pay" patients and insurance policies the same rates for all services.

With your cooperation and help, you should be able to receive all of the insurance benefits offered to you, and we will be able to concentrate on caring for your chiropractic needs.

Thank you for your cooperation,
Kenneth C. Morris, D.C., DACBSP

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO FINANCIAL RESPONSIBILITY AS DESCRIBED.

_____ _____
Patient/Guardian Signature Date

If Guardian, print name of patient _____

Back in Motion Chiropractic

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MISSED APPOINTMENT POLICY

Our appointment policy will include a charge of $30.00 for a missed appointment with **NO NOTICE GIVEN** to the office prior to any given time.

When possible, a notice of 24 hours is appreciated.

_____ _____

Patient/Guardian Signature Date

If Guardian, print name of patient _____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
- The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request had been presented.
- For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
- Patients have the right to file a formal complaint with our privacy about any possible violations of these policies and procedures.
- If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and agree to these policies and procedures.

_____ _____

Patient/Guardian Signature Date

If Guardian, print name of patient_____

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Release of Information Authorization

Patient Name:_____

I hereby authorize release of my personal medical information to the following individual(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

☐ Check here if authorizing us to leave personal medical information on your voicemail at the following numbers:

_____ _____ _____

This authorization will remain in effect until further notice and it is my responsibility to update this authorization if any contact information should change.

_____	_____
Patient/Guardian Signature	Date