

Back In Motion Chiropractic
Kenneth C. Morris, D.C., DABSP
10515 Bells Ferry Road, Suite 100
Canton, GA 30114

Auto Related Accident

Name: _____

Today's Date: _____

Date & Time of accident: _____ am/pm

Were you the:

Driver Front Passenger Rear Passenger

If a traffic violation was issued, to whom was it issued?

Number of people in your vehicle? _____

Did the police come to the accident site? Yes No

Was a police report filed? Yes No

Were there any witnesses? Yes No

Were you wearing your seatbelt? Yes No

Was the vehicle equipped with air bags? Yes No

If yes, did they inflate? Yes No

In relation to the base of your skull, where was the headrest? Above Below At base of skull

What did your vehicle impact?

Another vehicle Other: _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, please describe: _____

Make & Model of the vehicle you were occupying: _____

Name & location / street on which you were traveling: _____

In which direction were you headed?

N S E W

What was the approx. speed of your vehicle? _____

Did the impact come from the:

Front Rear Right Left

Other: _____

During the impact, were you facing

Forward Right Left

Were you: Aware of Surprised by the impact

If accident vehicle made impact with another vehicle:

Make & Model of the other vehicle: _____

Direction the other vehicle was heading

N S E W

Approx. speed of the other vehicle: _____

In your words, please describe the accident: _____

After Injury

Did the accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

Have you gone to a Hospital or seen any other Doctor?

Yes No

When did you go? Immediately Next day 2+ days

How did you get there? Ambulance

Private Transport

Name of Hospital and/or Attending Doctor: _____

Was he/she a: D.C. M.D. D.O. D.D.S

Describe any treatment you received: _____

Were X-Rays taken? Yes No

Was medication prescribed? Yes No

Have you been able to work since this injury?

Yes No

Are your work activities restricted as a result of this injury? Yes No

Indicate the symptoms that are a result of this accident:

Dizziness Difficulty Sleeping Jaw Problems

Nausea Arm/Shoulder Pain Memory Loss

Irritability Back Pain Headache(s)

Fatigue Numb Hands/Fingers Stomach Upset

Chest Pain Blurred Vision Back Stiffness

Leg Pain Shortness of Breath Neck Pain

Buzzing in Ear Ear Ringing Neck Stiffness

Low Back Pain Numb Feet/Toes Tension

Other: _____

Is your condition getting worse?

Yes No Constant Comes and Goes

Please Continue on the Back

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Indicate the degree of comfort while performing the following activities

	Comfortable	Uncomfortable	Painful
	(even if only sometimes)		
Lying on Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Recovery

To evaluate the effect that continuing work will have on your recovery phase, please complete the following:

How many hours are in your normal work day? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform:

- | | | |
|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Driving | <input type="checkbox"/> Operating Equipment |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Twisting | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Crawling | <input type="checkbox"/> Bending |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Stooping | <input type="checkbox"/> Work w/arms over head |

Other: _____

What positions can you work in with minimum physical effort and for how long?

Prior to the injury were you capable of working on an equal basis with others your age? Yes No

Do you work with others who can help you with any heavy lifting? Yes No

While in recovery, is there any light duty work you could request? Yes No

Attorney

Have you retained an attorney? Yes No

If so, whom? _____

His/ Her phone number: _____

Additional Insurance

Type of Insurance: _____

Company Name: _____

Address: _____

Phone #: _____

Insured's name: _____

Insured's SS#: _____

D.O.B. _____

Policy #: _____

Claim #: _____

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember that you are ultimately responsible for your account.

Signature

Date

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 _____
 Language: English Spanish Other: _____
 Race: Afr. Amer. Asian Caucasian Other: _____
 Ethnicity: Hispanic/Latino Other: _____
 Spouse's Name _____
 Birth Date ____/____/____
 SS# _____
 Spouse's Employer _____
 How did you hear about our office? _____

PHONE NUMBERS

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

IN CASE OF EMERGENCY, CONTACT

Name _____
 Relationship _____
 Home Phone (____) _____
 Cell Phone (____) _____

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 COMPLETE THE BACK SIDE OF THIS FORM

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

ACCIDENT INFORMATION

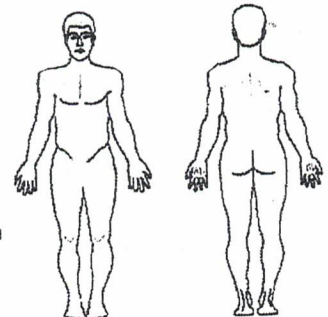
Is condition related to an accident Yes No

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.

Please mark on the picture
where your symptoms are located



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 <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bladder Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No Gout <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No Herniated Disc <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Infection <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Measles <input type="checkbox"/> Yes <input type="checkbox"/> No Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No Polio <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Tumors/ Growths <input type="checkbox"/> Yes <input type="checkbox"/> No Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medical History _____ _____
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EXERCISE <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	WORK ACTIVITY <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	HABITS <input type="checkbox"/> Smoking: <input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current: Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
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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 _____ _____ _____
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PLEASE REVIEW AND SIGN ALL ATTACHED POLICY FORMS

Back In Motion Chiropractic Electronic Health Records Intake Form

In compliance with requirements for the government EHR program

First Name: _____ Last Name: _____

DOB: ___/___/___ Gender (Circle one): Male / Female Preferred Language: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____

Date: _____

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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 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.

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 _____

Back In Motion Chiropractic

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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 affect 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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10515 Bells Ferry Rd Suite 100
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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

I hereby authorize the release of personal medical information on my 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

Back in Motion Chiropractic
Kenneth C. Morris, D.C., DACBSP
10515 Bells Ferry Rd, Ste 100
Canton, GA 30114
770-704-0114

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, mechanical traction, therapeutic ultrasound, therapeutic exercises or hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures, fractures to the rib cage, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. Some patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, falls or other minor complications.

Other Treatment Options Which May be Considered may include the following:

- *Medical care*
- *Orthopedic care*
- *Physical therapy*

The risks and types of other treatment options will need to be discussed and reviewed with the healthcare provider providing those treatments.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, decrease function in the nervous system and induce chronic pain cycles. It is quite probable that delay of treatment may complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, with the above stated risks and hereby give my full consent to treatment.

Patient's Printed Name

Patient's Signature

Date

Witness' Printed Name

Witness' Signature

Date

Back in Motion Chiropractic

Kenneth C. Morris, D.C., DACBSP

10515 Bells Ferry Rd, Ste 100

Canton, GA 30114

(770)704-0114

I hereby request and authorize Back In Motion Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatments to my son/daughter _____.

This authorization extends to all doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Guardian Signature

Printed Name

Relationship to patient

Date

Witness

Date