

Patient Information Update

Title: Mrs. Ms. Miss

Patient Name: _____ **Date of Birth:** _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ **Social Security #:** _____

E-Mail Address: _____

Employment Status: Employed Full-Time Student Part-Time Student Retired Unemployed

Insured's Employer: _____

Employer's Address: _____ **City:** _____ **Zip** _____

Insured's Social Security #: _____ **Insured's Date of Birth:** _____

Spouse's Cell Phone: _____ Spouse's Work Phone: _____

Marital Status: _____ Number of Children: _____

Name of Spouse: _____ Spouse's Date of Birth: _____

Is your spouse a patient of the clinic: Yes No

Who is responsible for payment? Self Spouse Parent Other

Emergency Contact Name: _____ Phone: _____

Are you taking any medication? Yes No If yes, please list: _____

Have you had any surgery? Yes No If yes, please explain: _____

What is the purpose of this appointment? _____

Have you had any new falls or accidents Yes No Date of Injury: _____

Details of fall or accident: _____

Who referred you to us: _____

Who is your family doctor?: _____

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:

Date:

****All bolded information is required**

ATLAS CHIROPRACTIC
Michael J. Schmitt, DC, P.A.
John M. Bovard, DC
7928 Council Place, Ste. 116
Matthews, NC 28105

Informed Consent To Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. This includes various modes of physical therapy and diagnostic radiographs performed on me or on the patient named below, for whom I am legally responsible. I further understand that this may be performed by the Physician of Chiropractic named here (Dr. Michael J. Schmitt or Dr. John M. Bovard) and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. This will include those employed by, working for, or associated with Atlas Chiropractic.

I have had an opportunity to discuss with Dr. Michael J. Schmitt/Dr. John M. Bovard and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in my best interests, at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

To be completed by the patient's representative, if necessary. (e.g. if the patient is a minor or is physically or mentally incapacitated)

Print Patient's Name

Print Name of Patient

Print Name of Representative

Signature of Patient

Signature of Representative

Date

Date

ATLAS CHIROPRACTIC HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patient's SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES ATLAS CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give **Atlas Chiropractic** permission to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, and information about treatment alternatives or other health related information.
- If **Atlas Chiropractic** contacts me by phone, I give them permission to leave a phone message with a member of my household, on my answering machine or voice mail.
- I give **Atlas Chiropractic** permission to treat me in an area where other patients are also being treated. 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 room for these conversations.
- By signing this form I am giving **Atlas Chiropractic** permission to use and disclose my protected health information in accordance with the directives listed above.

EXPIRATION

This notice is effective as of _____. This Authorization shall expire seven years after the date on which you last received services from **Atlas Chiropractic**.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke the AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **Atlas Chiropractic**. The written notice must contain the following information:

- Your name, social security number and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature

The revocation is not effective until it has been received by our Compliance/Privacy Officer.

This AUTHORIZATION is requested by **Atlas Chiropractic** for its own use/disclosure of Private Health Information. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **Atlas Chiropractic** will not refuse to provide treatment.

You have the right to inspect or copy the Private Health Information to be used/disclosed.

**** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU ****

Signature of Patient: _____ Date: _____

Signature of Personal Representative: _____

ATLAS CHIROPRACTIC
Michael J. Schmitt, DC
John M. Bovard, DC
7928 Council Place, Ste. 116
Matthews, NC 28105

Dr. Schmitt/Dr. Bovard utilizes a treatment technique that requires taking "post x-rays" of the cervical spine. Many of the referrals we receive are because of this procedure. Because these x-rays (rarely more than 2, usually just 1) are not for *initial* diagnosis purposes, insurance companies do not and will not pay for them. To *objectively* evaluate your progress, these films are necessary (if your condition warrants the taking of cervical x-rays). These x-rays range from \$35-\$75 each.

I understand that I am responsible for the post x-ray charges and I intend to comply with the above policy.

Signature

Date