

# WELCOME

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ 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.

The above-named doctor 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 or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
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 (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

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

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

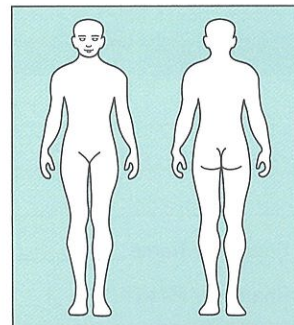
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

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 or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

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:

- |                     |  |                     |  |                      |  |                              |  |
|---------------------|--|---------------------|--|----------------------|--|------------------------------|--|
| AIDS/HIV            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts           | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____                  |  |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Chicken Pox         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease      | <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 |                              |  |

### 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 \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### MEDICATIONS

### ALLERGIES

### VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

# TOMPKINS FAMILY CHIROPRACTIC

1485 Peachtree Parkway  
Suite D-7  
Cumming, Georgia 30041  
Phone (770) 888-9027  
Fax (770) 888-9028

671 Lumpkin Campground Rd.  
Suite 20  
Dawsonville, Georgia 30534  
Phone (706) 265-7017  
Fax (706) 265-8276

## HEALTH CARE AUTHORIZATION FORM

Patient's Name: \_\_\_\_\_

Patient's SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **TOMPKINS FAMILY CHIROPRACTIC** TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

### SPECIFIC AUTHORIZATIONS

- I give permission to **Tompkins Family Chiropractic** to use my address, phone number, email, 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 **Tompkins Family Chiropractic** contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give **Tompkins Family Chiropractic** permission to disclose protected health information in the presence of anyone accompanying me into a treatment room or consultation room by my request.
- I give **Tompkins Family Chiropractic** permission to treat me in an open room 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 you are giving **Tompkins Family Chiropractic** permission to use and disclose your protected health information in accordance with the directives listed above.

**EXPIRATION: The authorization shall expire upon your request.**

### RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this 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 **Tompkins Family Chiropractic**. *The written notice must contain the following information: Your name, SS# 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 the Privacy Official receives it.

This AUTHORIZATION is requested by **Tompkins Family Chiropractic** for its own use/disclosure of PHI (minimum necessary standards apply).

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

You have a right to inspect or copy the PHI to be used / disclosed.

**\*A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON YOUR REQUEST\***

Print Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_

### **FOR OFFICE USE ONLY:**

Signature of Personal Representative: \_\_\_\_\_

Description of Representative's Authority to Act for Patient: \_\_\_\_\_

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## New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, \_\_\_\_\_, understand that as part of my healthcare, **Tompkins Family Chiropractic** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices For Protected Health Information* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that **Tompkins Family Chiropractic** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **Tompkins Family Chiropractic** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **Tompkins Family Chiropractic** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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### ASSIGNMENT OF BENEFITS

I hereby direct and authorize, without equivocation, my insurance company, or attorney, to make payment directly to Tompkins Family Chiropractic for any and all benefits due as a result of my treatment. It is my responsibility to contact my insurance carrier to confirm that Dr. Tompkins participates on my plan, and I understand my insurance benefit requirements.

By signing this document, I hereby release to Tompkins Family Chiropractic the rights and privileges and those causes of action not in violation of O.C.G.A. 44-12-24 against any insurance carrier or other proper party that may be responsible for payment toward any claims incurred. This assignment of benefits shall expressly exclude any assignment of the patient's personal injury claim.

This authorization will supersede and have precedence over any foregoing agreement. I also understand that I am personally responsible for charges and/or any amount not recovered by Tompkins Family Chiropractic through any insurance payment or settlement distribution. Tompkins Family Chiropractic may use a 3<sup>rd</sup> party collections agency that may contact me by any means in the event of any unpaid balance within a timely manner.

I understand if I have an unpaid balance to Tompkins Family Chiropractic and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

In order for Tompkins Family Chiropractic or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Tompkins Family Chiropractic and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. Furthermore, I consent the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, e-mail, and mail notification.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

# Tompkins Family Chiropractic

## Cancellation and no-show policy

Our goal is to provide quality chiropractic care to all our patients in a timely manner. Any time you are unable to keep your appointment, please contact our office as soon as possible so we may cancel your appointment and use the appointment time for another patient.

### Chiropractic

Any established patient who no-shows or does not cancel/reschedule their appointment in a 24-hour period will be charged a **\$25 fee**. These fees are charged to the patient, not the insurance company.

### Massage

Massage appointments require a deposit to book

- \$25 for 30 minutes
- \$40 for 1 hour
- \$60 for 1 hour and 30 minutes

Any patient who no-shows or does not cancel/reschedule their appointment in a 24-hour period, their deposit will be non-refundable.

We understand there may be times when an unforeseen emergency happens.

You may call our office at 770-888-9027

*By signing below, you acknowledge that you have read this notice and understand Tompkins Family Chiropractic's cancellation and no-show policy.*

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Print name of patient

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Date

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Signature of patient or legal guardian

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Relationship to patient