WELCOME

1 ABOUT YOU

Today's Date: _____ /_____ /_____

Patient Name: _____
LAST FIRST MI

What you prefer to be called: _____ • Male • Female

Birthdate: _____ /_____ /_____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: • Minor • Single • Married • Divorced • Separated • Widowed

Spouse's Name: _____

Do you have children? • Yes • No How many? _____

2 INSURANCE INFO

Primary Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone: (_____) _____

Insured's ID# _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____

Relation: _____ Date of Birth: _____ /_____ /_____

Insured's Employer: _____

Secondary Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: _____ /_____ /_____

Insured's Employer: _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS # _____

Drivers License # _____

Work Phone: (_____) _____

Payment Method: • Cash • Check

_____ _____ / _____

• Credit Card – Enter card # above (if accepted)

____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at his office).

4 IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone: (_____) _____

Signature _____ Date _____

Duluth MultiCare, Inc.
3170 Peachtree Industrial Blvd. • Suite 170 • Duluth, GA 30097
Phone: 770-497-9700 • Fax: 770-497-0795

Patient Health Questionnaire - PHQ

Patient Name: _____ Date _____

1. Describe your symptoms: _____

_____

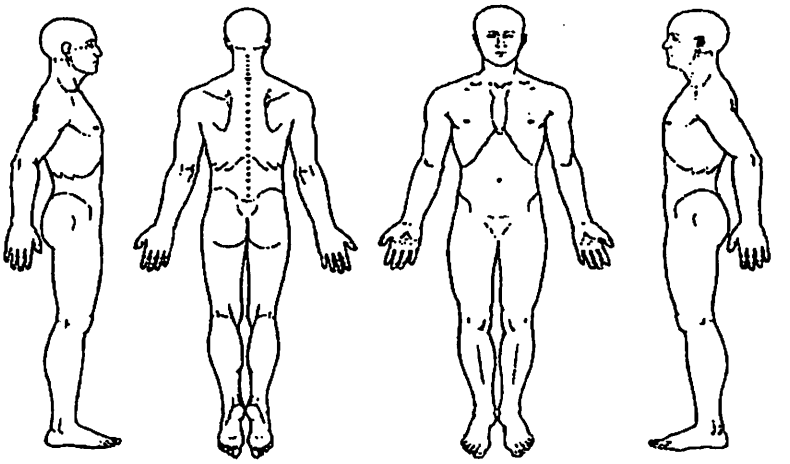
_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull Ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks</u>:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ***Unbearable***

b. How much has pain interfered with your normal work *(including both work outside and inside the home, and housework)*

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc.)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms

① Xrays *date:*_____ ③ CT Scan *date:*_____
② MRI *date:*_____ ④ Other *date:*_____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker,or a student, what is your current work status?

① Full-time ② Self-employed ⑤ Off work
② Part-time ③ Unemployed ⑥ Other

Patient Signature _____ **Date** _____

HEALTH HISTORY

Are you taking any of the following medications? ☐ Nerve pills ☐ Pain killers (including aspirin)
☐ Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s)

Do you have or have you had any of the following disease, medical conditions or procedures?

☐ Heart Attack/Stroke	☐ Heart Surg./Pacemaker	☐ Frequent Neck Pain	☐ Congenital Heart Defect	☐ HIV+ / AIDS / ARC
☐ High/Low Blood Pressure	☐ Alcohol / Drug Abuse	☐ Rheumatic Fever	☐ Severe/Frequent Headaches	☐ Anemia / Diabetes
☐ Ulcers/Colitis	☐ Cancer	☐ Sinus Problems	☐ Emphysema / Asthma	☐ Kidney Problems
☐ Difficulty Breathing	☐ Psychiatric Problems	☐ Lower Back Problems	☐ Artificial Bones/Joints/Implants	☐ Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

_____

Please list anything that you may be allergic to: _____

Family Health History: ☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Obesity

Do you take Supplements or Vitamins ☐ Yes ☐ No Do you exercise? ☐ No ☐ Yes _____ hours per week

Do you smoke? ☐ Yes ☐ No How much? _____ How long? _____

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch supports Are you dieting: ☐ No ☐ Yes Since _____/_____/_____

For women: Are you taking Birth Control? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes If so, how many weeks? _____

Describe your energy level:

☐ Energetic all day ☐ Energetic am; tired pm ☐ Tired am; energetic pm ☐ Periodic dips in energy throughout day ☐ Low energy all day

Describe your daily non-exercise activity level:

☐ very sedentary ☐ light activity ☐ moderately active ☐ very active

How many fruits and vegetables do you eat daily? _____ Fruits _____ Vegetables

Do you exercise at least 3 times per week for 30 minutes or more? ☐ Yes ☐ No

How many 8-ounce glasses of water do you drink daily? _____

Are you currently taking any vitamin supplements? Please list below.

# Per Day	Vitamin/Supplement and Brand (List all that you are currently taking)

☐ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

☐ Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager.

☐ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or other medical/legal services engaged on my behalf.

☐ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

☐ Parent or Guardian: I authorize the staff to administer treatment as deemed necessary for my _____
Indicate Relationship

Signature _____ Date _____/_____/_____

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

I, _____ , understand that as part of my health care, Duluth MultiCare 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 health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a ***Notice of Information Practices*** 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 health care operations.

I understand that Duluth MultiCare 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 taken 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 Duluth MultiCare 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_____ _____ 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:_____

_____

_____

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 (authorized representative signing for the patient) Date

FOR OFFICE USE ONLY

☐ Consent received by _____ on _____

☐ Consent refused by patient, and treatment refused as permitted.

☐ Consent added to the patient's medical record on _____

TPO CONSENT

Auto Accident

Today's Date: _____ **Name:** _____

1. **What was the date of the accident?** _____
2. **What time did the accident occur?** _____
3. **How many vehicles were involved in the accident?** _____
4. **What was the estimated damage to the vehicle you were in?** _____
5. **What state did the accident occur in?** _____
6. **What city did the accident occur in?** _____
7. **What street or intersection were you on when the accident occurred?** _____
   _____
8. **What direction were you traveling in?** _____
9. **What type of impact was the auto accident?** _____
10. **Did your vehicle hit anything after the accident? If yes, please describe.** _____
    _____
11. **Where were you sitting in the vehicle during the accident?** _____
12. **Did you know the accident was coming?** _____
13. **What type of vehicle were you in?** _____
14. **What type of vehicle impacted yours?** _____
15. **At the time of the impact, how fast was your vehicle moving?** _____
16. **At the time of the impact, how fast was the other vehicle moving?** _____
17. **During and after the crash, what happened to your vehicle? Circle all that apply.**
    - -- Kept going straight
    - -- Kept going straight, hitting a car in front
    - -- Was hit by another vehicle
    - -- Spun around
    - -- Spun around and hit a stationary object
    - -- Hit a stationary object
18. **Did you lose consciousness during the accident?** ____ Yes ____ No
19. **How was your head positioned during the accident?** _____
20. **How was your torso positioned during the accident?** _____
21. **How were your hands positioned during the accident?** _____
22. **Did your head hit anything during the accident?** ____ No ____ Yes, please describe.
    _____

Auto Accident

23. **Did your face hit anything during the accident?** ____ No ____ Yes, please describe.

_____

24. **Did your shoulders hit anything during the accident?** ____ No ____ Yes, please describe.

_____

25. **Did your neck hit anything during the accident?** ____ No ____ Yes, please describe.

_____

26. **Did your chest hit anything during the accident?** ____ No ____ Yes, please describe.

_____

27. **Did your hips hit anything during the accident?** ____ No ____ Yes, please describe.

_____

28. **Did your knees hit anything during the accident?** ____ No ____ Yes, please describe.

_____

29. **Did your feet hit anything during the accident?** ____ No ____ Yes, please describe.

_____

30. **What kind of headrest was in your vehicle?**
-- Movable fixed headrest -- Non-movable fixed headrest -- No headrest

31. **Where was the headrest positioned on your head?** _____

32. **Did you have your seatbelt on during the accident?** ____ Yes ____ No

33. **Did you slide out of your seatbelt during the accident?** _____

34. **What was damaged in your vehicle? Circle all that apply.**

-- Windshield	-- Rear bumper	-- Mirror	-- Side window
-- Steering wheel	-- Front bumper	-- Knee bolster	-- Front right door
-- Dashboard	-- Trunk	-- Back right door	-- Rear window
-- Seat frame	-- Front left door	-- Completely totaled	-- Back left door

35. **Choose the items that dented inward.**
-- Floorboards -- Side door -- Dashboard

36. **Choose the doors that would not open as a result of the accident.**
-- Front left -- Front right -- Rear left -- Rear right

37. **Did you go to the hospital? If no, why and do not answer 38 – 43.**

_____

38. **How did you get to the hospital?** _____
39. **What was the name of the hospital?** _____
40. **Were you hospitalized overnight?** _____
41. **Circle what you were prescribed at the hospital.**
-- Pain medication -- Muscle relaxors -- Neck brace
42. **Did you receive any stitches for any cuts at the hospital?** _____
43. **Were x-rays taken at the hospital? If yes, which area was taken?**

_____

Auto Accident

44. **If a traffic violation was issued, to whom was it issued?** _____

45. **Did the police come to the accident site?** _____

46. **Was a police report filed?** _____

47. **Was this vehicle equipped with airbags? If yes, did they inflate?** _____

48. **To evaluate the effect that continuing work will have on your recovery, please complete the following:**
    a. **How many hours are in your normal work day?** _____

    b. **Please indicate by circling below your daily job duties and any activities which you are occasionally asked to perform.**

-- Standing	-- Driving	-- Operating equipment
-- Sitting	-- Twisting	-- Work with arms above head
-- Walking	-- Crawling	-- Typing
-- Lifting	-- Bending	-- Stopping

    -- Other _____

    c. **What positions can you work in with minimum physical effort and for how long?**
    _____

    d. **Prior to the injury were you capable of working on an equal basis with others your age?** _____ Yes _____ No _____ N/A

    e. **Do you work with others who can help you with any heavy lifting?**
    _____ Yes _____ No _____ N/A

    f. **While in recovery, is there any light duty work you could request?**
    _____ Yes _____ No _____ N/A

49. **2nd Insurance Source of Auto Insurance:**
    a. Type of Insurance: _____
    b. Co. Name: _____
    c. Address: _____
    d. Phone #: _____
    e. Insured's Name: _____
    f. Policy #: _____
    g. Claim #: _____
    h. Insured's SSN: _____
    i. D.O.B.: _____ / _____ / _____
    j. Insured's Employer: _____
    k. Agent's Name: _____

50. **Have you retained an attorney?** _____ No _____ Yes
    a. If yes, whom: _____
    b. His/Her phone number: _____
    c. I direct my attorney to pay any outstanding bills out of my settlement or I will be responsible for all treatment expenses incurred by this accident.

    _____ _____
    Signature Date

AUTO ACCIDENT/PERSONAL INJURY FINANCIAL AGREEMENT

IT IS THE POLICY OF THIS OFFICE TO HAVE THE PATIENT OR THE PATIENT'S ATTORNEY PROVIDE US WITH THE NECESSARY INFORMATION.

IN THE EVENT THAT THE AUTO INSURANCE/ATTORNEY DENIES PAYMENT FOR SERVICES RENDERED TO YOU BY THIS CLINIC, THAT UNPAID PORTION WOULD BE TRANSFERRED TO YOU.

THE FOLLOWING CRITERIA MUST BE MET IN ORDER FOR A PORTION OF THE DOCTOR'S FEE TO BE DEFERRED UNTIL A SETTLEMENT HAS BEEN REACHED:

1. **ALL AUTO ACCIDENT CASES INVOLVING NO FAULT CLAIMS MUST PROVIDE A COPY OF THEIR AUTO INSURANCE CARD AND ALSO HAVE AN "APPLICATION OF BENEFITS" FORM SIGNED.**
2. **IN ALL CASES, IF AN ATTORNEY IS INVOLVED, THE PATIENT AND THE REPRESENTING ATTORNEY MUST SIGN A DOCTOR'S LIEN FORM. THIS ALLOWS THE REMAINING DOCTOR'S FEE TO BE PAID FROM THE FINAL SETTLEMENT.**
3. **THE MERITS OF YOUR CASE MUST BE ESTABLISHED BY YOUR ATTORNEY AND COMMUNICATED TO THE DOCTOR(S).**

IN CONSIDERATION OF YOUR UNDERTAKING CARE OF ME, I AGREE TO THE FOLLOWING:

IN THE EVENT ANY INSURANCE COMPANY/ATTORNEY OBLIGATED BY CONTRACTUAL AGREEMENT TO MAKE PAYMENT TO ME OR TO THE CLINIC FOR CHARGES MADE FOR YOUR SERVICES REFUSES TO MAKE SUCH PAYMENT WITHIN 60 DAYS OF YOUR BILLING, I WILL BE RESPONSIBLE FOR THAT AMOUNT. I WILL HAVE 30 DAYS TO CLEAR THAT ACCOUNT BY CALLING MY INSURANCE COMPANY/ATTORNEY AFTER BEING NOTIFIED BY YOUR OFFICE. IN ANY EVENT, IF MY BALANCE IS NOT CLEARED IN FULL WITH YOUR OFFICE AND SERVICES OF AN OUTSIDE COLLECTION AGENCY IS REQUIRED, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY AND ALL ADDITIONAL COLLECTION COSTS IN ADDITION TO MY OUTSTANDING BALANCE INCLUDING BUT NOT LIMITED TO ATTORNEY'S FEES, COURT COSTS, ETC.

I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

DATE **SIGNATURE OF RESPONSIBLE PARTY**

DATE **WITNESS**

Robert Grace Health Center
3170 Peachtree Industrial Blvd. Suite 170
Duluth, GA 30097

770-497-9700

Authorizations and Releases

NAME _____ **CASE #** _____

Consent for Treatment

I, the undersigned, hereby authorize Dr. _____ and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary.

I also certify that no guarantee or assistance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of my credit to my account. **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.**

Patient's Signature _____ **Date** ___/___/___ **Witness** _____

Authorization to Release Medical Information

I authorize Dr. _____ to release any medical information pertinent to my treatment plan to Robert Grace Health Center, Inc. or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my currently policy. I certify that all insurance information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient's Signature _____ **Date** ___/___/___ **Witness** _____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Robert Grace Health Center, 3170 Peachtree Industrial Blvd. Suite 170, Duluth, GA 30097 the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature _____ **Date** ___/___/___ **Witness** _____

Attorney Representation and Protection of Balance

I, the undersigned patient, am directing my attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current status.

Patient's Signature _____ **Date** ___/___/___ **Witness** _____

Consent for Treatment of Minor

I hereby authorize Dr. _____ and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my (indicate relationship of child) _____ (child's name) _____.

Guardian's Signature _____ **Date** ___/___/___ **Witness** _____

X-Ray / Medical Records Release

I have requested the release of records of (patient's name) _____ which are a part of the records at (facility) _____.

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward this to: (Name)_____ (Address) _____

Patient's Signature _____ **Date** ___/___/___ **Witness** _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

ACCIDENT, PRIVATE AND GROUP HEALTH INSURANCE

I HEREBY DIRECT AND INSTRUCT THE _____ INSURANCE COMPANY TO PAY BY CHECK MADE PAYABLE TO AND MAILED DIRECTLY TO:

DULUTH MULTICARE
3170 PEACHTREE INDUSTRIAL BLVD., SUITE 170
DULUTH, GA 30097

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEREBY ALSO DIRECT AND INSTRUCT YOU TO MAKE THE CHECK PAYABLE TO ME WITH DULUTH MULTICARE AS THE SECDONARY PAYEE AND MAIL IT TO:

DULUTH MULTICARE
3170 PEACHTREE INDUSTRIAL BLVD., SUITE 170
DULUTH, GA 30097

THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT POLICY AS PAYMENT TOWARDS 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 I HAVE AGREED TO PAY, IN CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT.

SHOULD I CHOOSE TO TERMINATE MY CASE WITH MY ATTORNEY OR STOP RECEIVING CARE FROM THE PROVIDERS AT DULUTH MULTICARE, I WILL IMMEDIATELY NOTIFY DULUTH MULTICARE OF SAID TERMINATIONS AND AGREE TO PAY MY BALANCE DUE IN FULL WITHIN 30 DAYS, OR PROVIDE NEW ATTORNEY INFORMATION.

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

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOVLED IN THIS CASE.

DATED AT DULUTH MULTICARE THIS _____ DAY OF _____, 20____.

_____
PATIENT SIGNATURE OR RESPONSIBLE PARTY, IF MINOR

_____
WITNESS