**Peachtree Center Rehab**
***241 Peachtree Street, Suite B***
**Atlanta, GA 30303**
**Tel: (404) 522-9991 Fax: (404) 522-9890**
**peachtreecenterrehab.com**

**Today's Date:____/____/_____**

Name: First_____M.I____

Last_____

DOB___/____/_____Age_____Last 4 of SS#_____

Address:_____Apt/Unit#____

City:_____State:_____

Cellular Phone#:_____

OtherPhone#:_____hm/wk

E-mail Address:_____

*Single Married Divorced Widow Minor* (**circle one**)

Patient/GuardianSignature:_____

Guardian Name :_____

## Insurance Information

Primary Insurance Co:_____

Policy#_____

Group#_____

Provider telephone:_____

Are you the Subscriber? Yes No **(choose one)**

Subscriber Name:_____ DOB_____

Secondary Insurance Co:_____

***In case of emergency please contact:***
Name:_____
**Telephone#**_____

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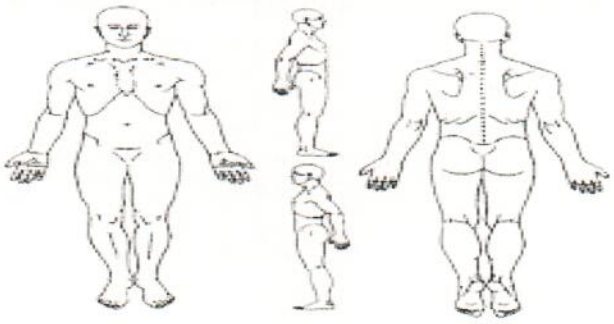
Nature of Injury: Choose one Automobile Slip&Fall Work related Other _____

Date of loss:___/___/_____ City &County of occurrence:_____/_____Were you cited? Yes / No

Were **you** a **Passenger** or **Driver**?
Do you have a copy of the accident /incident report or the report number? Yes / No Report#_____
Were you treated at a hospital, clinic or by your PCP after the accident? Yes / No Date of treatment:_____
Hospital/Clinic Name:_____

*Have you contacted the **at fault parties** insurance company? Yes No
Insurance Company_____Claim#_____
Adjusters Name_____Telephone#_____ext_____
*Have you contacted **your insurance** company? Yes No **Do you have Medpay**? Yes No Unsure claim#_____
Insurance Company_____Claim#_____
Adjusters Name_____Telephone#_____ext_____

**Please circle the area of complaint and indicate N-Numbness B-Burning A-Aching S-Stabbing P/N-Pins & Needles**



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Major Area of Complaint:_____

How often does the pain occur?_____ Constantly Frequent Occasionally

Is your pain getting better / worse / same

Have you had a previous occurrence of this complaint? Yes No Briefly explain_____

What aggravates/ relieves your complaint?_____

Do you have or have you had any of the following diseases, medical conditions or procedures? Please circle Y or N.

| | | | | |
|---|---|---|---|---|
| Y N Heart Attack | Y N Stroke | Y N Artificial Valves | Y N Pacemaker | Y N Heart Murmur |
| Y N Congenital Heart Defect | Y N Mitral Valve Pro lapse | Y N Alcohol/Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N Allergies | Y N Shingles | Y N Cancer | Y N Glaucoma | Y N Anemia |
| Y N Diabetes | Y N High Blood Pressure | Y N Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Disease |
| Y N Kidney Problems | Y N Connective Tissue Disorder | Y N Ulcers/ Colitis | Y N Seizures/Epilepsy | Y N Sinus Problems |
| Y N Asthma | Y N Emphysema | Y N Tuberculosis | Y N Chemotherapy | Y N Arthritis |
| Y N Osteoporosis | Y N Artificial Bones/Joints | Y N AIDS/HIV | Y N Headaches | Y N Multiple Sclerosis |

Please list any injuries/surgeries you have had (including falls, head injuries, broken bones, dislocations, surgeries):

_____

Please list any medications you are taking including prescription, over-the-counter, birth control, vitamins, supplements:

_____

Please list anything you may be allergic to:_____

Do you smoke? No Yes Packs/Day_____ Do you drink alcohol? No Yes Drinks/Week_____

Do you drink coffee/caffeine drinks? No Yes Cups/Day____ High stress level? No Yes (If Yes why)_____

Do you exercise? None Moderate Daily Heavy

Have you ever been treated by a chiropractic doctor before? Yes No When_____
Who_____Where_____

Date of Last: Physical Exam_____ Spinal Exam_____ Spinal X-Ray_____
Chest X-Ray_____ MRI, CT-Scan, Bone Scan_____

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## X-RAY CONSENT

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

***Please choose ONE***

_____ I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose **not to** have any x-ray at this time and release my doctor of all liabilities.

Signature: _____ Date: _____

**FEMALES ONLY:**

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus and I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exam. With those factors in mind, I am advising my doctor that:

I am pregnant _ yes _ no _ don't know
My menstrual period is late__ yes ___no
I have irregular menstrual periods __yes__no
I have had a hysterectomy __yes ___no
I have begun menopause ___yes ___no
I have had a tubal ligation ___yes ___ no
My last menstrual period began _____

**With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.**

Signature: _____ Date: _____

## Informed Consent to Chiropractic Treatment

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my conditions(s). Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. Following are the known risks:

Temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk or fracture.

Disc herniation or prolapse. Spinal disc conditions like bulges or herniation's may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence or excess risk of stroke associated with chiropractic care.

The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before their stroke.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat. I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

Signature_____ Date_____

Peachtree Center Rehab

241 Peachtree Street, Suite B

Atlanta GA 30303

(404) 522-9991 Office

(404) 393-9231 Fax

peachtreecenterrehab@gmail.com

## Authorization for Release of Medical Records

Today's Date:_____

Name of Patient:_____

DOB:_____ Last 4 digits of SSN#_____

Patient/Guardian Signature:_____

**OFFICE USE ONLY BELOW THIS LINE**

ALL records and reports for beginning date of treatment:_____

Hospital/Physician Name:_____

Telephone#_____ Fax#_____

Office Signature:_____

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## IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

I hereby authorize and direct you, my insurance carrier and/or attorney to pay directly to Peachtree Center Rehab such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident Workers Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Peachtree Center& Rehab.

I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Peachtree Center Rehab. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due to the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if Peachtree Center Rehab must take any action to collect an outstanding balance on this account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

I authorize my Attorney to sign this lien to pay the outstanding balance at settlement.

Patient Signature_____Date: _____

Please sign this Assignment & Lien of Authorization and fax to Peachtree Center Rehab.

Attorney Signature_____Date_____