GEORGIA
SPINE & SPORTS
REHAB

Dr. Joseph A. Krzemien & Dr. Corie Terwilliger

Patient Information Forms

Name: _____ Date of Birth: _____ Age: _____ Sex: ☐M ☐F

Address: _____ City: _____ State:____ Zip:_____

Cell Phone: _____ Email Address:_____

Check One: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

Preferred Method Of Contact: ☐Cell Phone ☐Email

May We Leave A Message Regarding Your Healthcare And/or Appointment? ☐Yes ☐No

Employer: _____ Position: _____

Employer Address: _____

How Did You Hear About Our Office?

_____

Person to Contact in Case of an Emergency: _____

Emergency Contact Phone Number:_____

If A Patient Is a **Minor** Do You Authorize Georgia Spine And Sports Rehab To Treat Said Minor Without A
Parent/Guardian Present For Future Appointments? ☐Yes ☐No

Signature of guardian if applicable to above: _____

I hereby give consent for the above named doctors to treat me. This may or may not include the need for x-rays. If x rays are needed I will be informed by the doctor first. I agree to accept financial responsibility for any charges incurred. I also hereby assign to the above named doctors all benefit payments provided by my health insurance company, auto insurance company or a settlement from my attorney for services described. I give Georgia Spine and Sports Rehab permission to treat me in an open room with other patients. I am aware other people may overhear some of my health information. I authorize the release of any medical or other information necessary to process my insurance claim or pending legal case. I acknowledge that I have been informed of Georgia Spine and Sports Rehab financial and HIPAA policy.

Signature of Patient/Responsible _____

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Medical/Surgical History:

Purpose of This Appointment: _____

Have you received chiropractic care before? ☐ Yes ☐No

Doctors Seen For This Condition: _____

Type of Treatment: _____

Results: _____

When did This Condition begin? _____

Has This Condition Occurred Before? ☐ Yes ☐No

Is This Condition: ☐ Job Related ☐ Auto Accident ☐Home Injury ☐Fall ☐Other:_____

Date and Time of Accident(if applicable) _____

Have you made a report of your accident to your employer? ☐ Yes ☐No

Any major accidents or falls in the past? _____

Check (x) all symptoms you currently have or have had in the past year

General: ☐ Chills ☐ Depression / low mood ☐ Dizziness ☐ Fainting / passing out
☐ Fever ☐ Forgetfulness / memory issues ☐ Headache
☐ Loss of sleep / insomnia ☐ Unintentional weight loss
☐ Nervousness / anxiety ☐ Numbness / tingling
☐ Sweats (daytime or night)

Muscle/Joint/Bone Pain, Weakness, numbness in: ☐ Arms ☐ Back ☐ Feet ☐ Hands ☐ Hips ☐ Legs
☐ Neck ☐ Shoulders

Genito-urinary: ☐ Blood in urine ☐ Frequent urination ☐ Lack of bladder control ☐ Painful urination

Gastro-Intestinal: ☐ Poor Appetite ☐ Bloating ☐ Bowel Changes ☐ Constipation ☐ Diarrhea
☐Excessive Hunger ☐ Excessive thirst ☐ Hemorrhoids ☐ Indigestion ☐ Nausea ☐ Rectal Bleeding
☐Stomach Pain ☐ Vomiting

Skin: ☐ Bruise Easily ☐ Hives ☐ Itching ☐ Changes in moles ☐ Rash ☐ Scars ☐ Sores that don't heal

Cardio-Vascular: ☐ Chest Pain ☐ High Blood Pressure ☐ Irregular Heartbeat

☐ Low Blood pressure ☐ Poor Circulation ☐ Rapid Heartbeat ☐ Swelling of ankles

☐ Varicose Veins ☐ History of blood clotting

Men Only: ☐ Erection Difficulties ☐ Lump in testicles ☐ Penis Discharge ☐ Sore on Penis

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Women Only: ☐ Abnormal Pap Smear ☐ Bleeding between periods ☐ Breast Lump

☐ Extreme Menstrual Pain ☐ Hot Flashes ☐ Nipple Discharge ☐ Painful intercourse

Are you currently pregnant? ☐ Yes ☐ No Number of Children:_____

Conditions: ☐ AIDS ☐ Alcoholism ☐ Anemia ☐ Anorexia ☐ Appendicitis ☐ Arthritis

☐ Asthma ☐ Bleeding Disorders ☐ Breast Lump ☐ Bronchitis ☐ Bulimia ☐ Cancer

☐ Cataracts ☐ Chemical Dependency ☐ Chicken Pox ☐ Diabetes ☐ Emphysema

☐ Epilepsy ☐ Glaucoma ☐ Goiter ☐ Gonorrhea ☐ Gout ☐ Heart Disease ☐ Hepatitis

☐ Hernia ☐ Herpes ☐ High Cholesterol ☐ HIV Positive ☐ Kidney Disease ☐ Liver Disease

☐ Measles ☐ Migraines ☐ Miscarriage ☐ Mononucleosis ☐ Multiple Sclerosis

☐ Mumps ☐ Pace Maker ☐ Pneumonia ☐ Polio ☐ Prostate Problems

Hospitalizations (Women-Include Pregnancy History) Please include year, which hospital, and the reason or outcome:

_____

_____

Known Allergies:_____

List any medications you are currently taking:_____

_____

_____

FINANCIAL POLICY

1. STATEMENTS ARE MAILED OUT EACH MONTH. PAYMENTS ARE DUE 28 DAYS AFTER THE STATEMENT DATE UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE.
2. ACCOUNTS THAT HAVE NOT RECEIVED ANY PAYMENTS FOR 3 MONTHS WILL BE REFERRED TO A COLLECTION AGENCY. ADDITIONALLY, A COLLECTION FEE MAY BE ASSESSED ON THE BALANCE.
3. PATIENT'S MEDICAL RECORDS ARE THE PROPERTY OF GEORGIA SPINE AND SPORTS REHAB. ANY PATIENT REQUESTING A COPY OF THEIR MEDICAL RECORD WILL BE CHARGED A FEE THAT FOLLOWS THE GUIDELINES SET BY GEORGIA STATE MANDATE.
4. ALL INSUFFICIENT FUND CHECKS WILL BE CHARGED A $25.00 FEE.
5. APPOINTMENT CANCELLATION FEE IS **$55.00 FOR ALL APPOINTMENTS CANCELED WITH LESS THAN 24 HOURS NOTICE OR MISSED APPOINTMENTS.** _____**Initials**
6. APPOINTMENT CANCELATION FEE IS **$65.00 FOR DECOMPRESSION APPOINTMENTS CANCELED WITH LESS THAN 24 HOURS NOTICE OR MISSED APPOINTMENTS.** _____**Initials**
7. IF A PATIENT IS GOING TO BE MORE THAN 15 MINUTES LATE TO AN APPOINTMENT, THEY MUST CALL TO LET THE OFFICE KNOW IN ORDER TO KEEP THEIR APPOINTMENT FOR THE DAY. _____**Initials**

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I understand the above stated financial policy and Specific Authorizations of Georgia Spine and Sports Rehab. I have been given an opportunity to have all my questions answered regarding these policies. I agree to accept financial responsibility for any charges incurred.
Patient Signature_____
Office Staff_____

Options for discount plans for all self pay patients

☐ **Chirohealth USA (Discount Plan)**

Chirohealth provides a 50% discount for chiropractic services rendered in this office. Your membership fee of $49 needs to be purchased before the discount can be extended. **Payment is due at the time services are rendered.**

This plan is good for 1 year and does not automatically renew. You will be notified by Chirohealth when your membership is about to expire. You can renew your plan at Georgia Spine and Sports Rehab. We will provide you with a receipt of your office visit that you may use to submit to your insurance company.
Patient Signature_____ Date____/_____/_____
Office Staff_____ Date _____/_____/_____

☐ **Patient Options Plan**

The Patient Options Discount Plan, which provides patients with a 50% discount on chiropractic services. Enrollment in this plan is **free of charge**, making it an affordable option for those who prefer not to use insurance. Please note that **services received under this plan cannot be submitted to insurance for reimbursement.** Patients must choose whether to enroll in this plan at their first visit, and once selected, all visits will remain under the chosen option.

Patient Signature_____ Date____/_____/_____
Office Staff_____ Date _____/_____/_____

Patient Messaging Consent: By supplying my cell phone number, email address and other personal contact information, I authorize my health care provider to use my personal information, my name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balance due or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary. TEXT MESSAGES ARE A COURTESY. YOU WILL RECEIVE A TEXT MESSAGE 2 DAYS BEFORE YOUR SCHEDULED VISIT. THERE WILL BE A $55 MISSED APPOINTMENT FEE FOR MISSING YOUR APPOINTMENT IF YOU DO NOT CONTACT US 24 HOURS BEFORE YOUR APPOINTMENT. IT IS YOUR RESPONSIBILITY TO KEEP TRACK OF YOUR APPOINTMENT(S). WE RECOMMEND PUTTING THE APPOINTMENT IN YOUR PHONE'S CALENDAR OR ASKING FOR AN APPOINTMENT CARD.

Patient Signature _____

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Medical Information Release Form

(HIPAA Release Form)

HIPAA Compliance Patient Consent Form Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that: Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐Yes ☐No

May we leave a message on your answering machine at home or on your cell phone? ☐Yes ☐No

May we discuss your medical condition with any member of your family? ☐Yes ☐No If Yes, please name the members allowed with their relation to you:

_____

_____

This consent was signed by: _____ (PRINT NAME)

Signature: _____

Date: _____/_____/_____

Witness: _____

Date: _____/_____/_____