NEW PATIENT APPLICATION

Welcome to Corrective Chiropractic! Please answer all questions to the best of your ability. Thank you.

Name:_____ Today's Date:_____

Address:_____

City/State/Zip:_____ E-Mail:_____

Phone: Cell:_____ (H):_____ (W):_____ Fax:_____

Birth date:_____/_____/_____ Age:_____

Marital status: ☐ Married ☐ Partnership ☐ Widowed ☐ Divorced ☐ Single

Number of Children: _____ Children's names & ages:_____

Employer Name: _____ Occupation:_____

Employer Address:_____

Spouse/Partner Name:_____ Age:_____

Spouse/Partner Employer:_____

Who may we thank for referring you? _____

Favorite hobbies or interests:_____

Last time you went to a Doctor of Chiropractic:_____

Name of your prior Doctor of Chiropractic:_____ City/State:_____

Chiropractic techniques you've had success with:_____

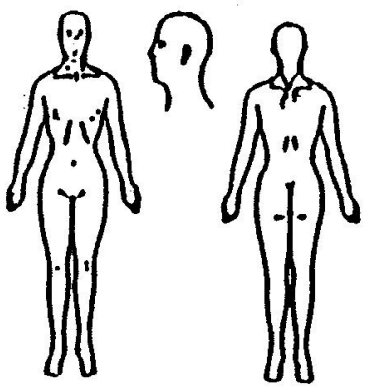
Preferred Method of Payment: ☐ Cash ☐ Check ☐ Credit Card ☐ FSA/HSA

Do you have health insurance? ☐ Yes ☐ No

Primary Insured: ☐ Self ☐ Spouse/Partner

General Practitioner Name:_____

Phone:_____



MARK THE AREA(S) OF HEALTH CONCERNS

CORRECTIVE CHIROPRACTIC
The Ultimate in Structural Correction

Corrective Chiropractic
2233 Peachtree Rd NE, Suite 204
Atlanta, GA 30309
404-355-5499
www.CohenChiropracticCentre.com

Health reasons for consulting our office, ***with number one being of greatest importance***:

1._____ 3._____

2._____ 4._____

Please list any specialists you are currently receiving care from:

Name: _____Phone: _____

Name: _____ Phone: _____

Have you had same or similar problem(s) before? ☐ Yes ☐ No

How long?_____ Please explain:_____

Do any of the following immediate family members have the same condition?
☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Children

Are you interested in our nutrition program and a healthier diet plan? ☐ Yes ☐ No

What is your primary nutritional goal? Weight loss ☐ Muscle Gain ☐ Detox ☐ Disease Prevention ☐ Increased Energy ☐

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If so, what type?_____

If Yes, are you presently undergoing treatment? ☐ Yes ☐ No If so, what type?_____

Do you still have your:	Appendix	☐ Yes	☐ No	Gall Bladder	☐ Yes	☐ No
	Tonsils	☐ Yes	☐ No	Reproductive Organs	☐ Yes	☐ No

Please list any surgeries you have had: _____

Is the reason for your visit the result of an auto or work injury? ☐ Yes ☐ No If yes, when?_____

Other doctors who have treated this problem:_____

Medication(s) you currently take:_____

What have you heard about chiropractic care?_____

Do you know what a subluxation is? ☐ Yes ☐ No If yes, please describe_____

What daily rituals for spinal health do you presently practice?_____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.
Patient or Guardian Signature:_____ Date:_____

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THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

In the course of your care as a patient at Cohen Chiropractic Centre we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as you billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, email address and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- If you are not at home to receive an appointment reminder, a message may be left on your answering machine or via email. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care
- Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:
    - If we are providing health care services to you based on the orders of another health care provider.
    - If we provide health care services to you in an emergency.
    - If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
    - If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
    - If we are ordered by the courts or another appropriate agency.
- Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.
- We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form please advise us in writing as to your preference.
- You have the right to inspect and/or copy your health insurance information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided in writing.
- We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.
- We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.
- Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provided the information and may no longer be protected by the federal privacy rules.
- If you have a complaint, or would like further information regarding our privacy notice, policies and practices you should direct your inquiry or complaint to:
  Dr. Austin Cohen, Privacy Officer for Cohen Chiropractic Centre

CHIROPRACTIC AND MEDICAL INFORMATION DISCLOSURE FORM (PAGE 2)

- This office utilizes an "semi-open-adjusting" environment for ongoing patient care. "Semi-open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an semi-open-adjusting environment other arrangements will be made for you.
- Since this office utilizes an "semi--+open-adjusting" environment, established patients occasionally request family members or friends, be present during their visits. It is the policy of this office to allow for this.
- This office utilizes the use of patient names in some of its interior/exterior designs of the office. For example, referral boards (acknowledging patients that have referred other patients), welcome boards which display patient names, testimonial books and website testimonials where patients have written personal health information as well as the benefits of their care in this office. It is our view that these kinds of material are what is known as "incidental disclosures". If however, you do not choose for your name to be displayed or disclosed on any of the above-mentioned materials please inform us in writing. While this entire authorization is valid for seven (7) years. It is the policy of this office to not disclose any information about you without your prior consent. This office will notify you via phone, email or personal communication prior to utilizing your name for any reason.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (please print)	Signature	Date

If you are a minor, or if you are being represented by another party

_____	_____	_____
Personal Representative Printed	Personal Representative Signature	Date

_____

Description of the authority to act on behalf of the patient

Corrective Chiropractic
2233 PEACHTREE RD, STE 204
ATLANTA, GA 30309
404-355-5499

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PHYSICIAN

Private, Group, Accident and Health Insurance

I hereby authorize and direct _____ Insurance Carrier to pay by check made out and mailed directly to:

Corrective Chiropractic
2233 Peachtree Rd, Ste 204
Atlanta, GA 30309
404-355-5499

If my policy prohibits direct payment to my doctor then I hereby instruct and direct the check to be made to me and mailed as follows:

Corrective Chiropractic
2233 Peachtree Rd, Ste 204
Atlanta, GA 30309
404-355-5499

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward 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 have I agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

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

I also authorize the release of information pertinent to my case to any insurance carrier, adjuster, or attorney involved in this case.

_____ _____
Signature of Policyholder **Witness**

_____ _____
Signature of Claimant if other than Policyholder **Date**

_____
Date