ABOUT YOU

Today's date: _____ File #: _____

Patient Name: _____
Last First MI

Name Prefer To Be Called: _____

Date of birth: _____ Age: _____ SS#: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-Mail Address: _____

Employer: _____ How Long? _____

Occupation: _____

Spouse's Name: _____

INSURANCE INFO

Co. Name: _____ Insured Employer: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Insured's ID#: _____

Relation: _____ Date of Birth: _____

Please inform front desk of second insurance source.

REASON FOR VISIT

The reason for this visit is a result of (Please circle): work, sports, auto, trauma, or chronic.

(Explain what happened): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? _____

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ work ☐ sleep ☐ daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where? _____

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical doctor? _____ Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

☐ Nerve pill ☐ Pain killer (including aspirin) ☐ Muscle relaxers ☐ Stimulants

☐ Blood Thinners ☐ Insulin ☐ Other (s) _____

Do you have or ever had any of the following diseases or conditions?

Y N	Heart Attack/Stroke	**Y N**	Heart Surg./Pacemaker	**Y N**	Heart Murmur
Y N	Congenital Heart Defect	**Y N**	Mitral Valve Prolapsed	**Y N**	Arterial Valve
Y N	HIV+/Aids	**Y N**	Shingles	**Y N**	Cancer
Y N	Frequent Neck Pain	**Y N**	Emphysema/ Glaucoma	**Y N**	Anemia
Y N	High/Low Blood Pressure	**Y N**	Psychiatric Problems	**Y N**	Rheumatic Fever
Y N	Severe/Frequent Headaches	**Y N**	Kidney Problems	**Y N**	Ulcers/Colitis
Y N	Fainting/Seizures/Epilepsy	**YN**	Sinus Problems	**YN**	Asthma
Y N	Diabetes/Tuberculosis	**Y N**	Difficulty Breathing	**Y N**	Chemotherapy
Y N	Lower Back Problems	**Y N**	Artificial Bones/Joints	**Y N**	Arthritis

Please list any other serious medical condition(s) you have or ever had: _____

_____

List any **past** serious accidents with dates: _____

List previous surgeries/treatments with dates: _____

_____

Family Health History: _____

_____

Are you wearing: ☐ Heel Lifts ☐ Sole lifts ☐ Inner soles ☐ Arch Supports

What is the age of your mattress? _____ Is it comfortable? ☐ Yes ☐ No

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

Are you Pregnant? ☐ No ☐ Yes/How long? _____Nursing ☐ Yes ☐ NO

ACCOUNT INFO

Person ultimately responsible for account

Name: _____ Relation: _____

Billing Address: _____

City: _____State: _____Zip: _____

SSN#: _____ DL#: _____

Work Phone#: _____

Payment method: ☐ Cash ☐ Check ☐Credit Card, Circle: AMEX/MC/VISA

Card #: _____Exp. Date: _____ Security Code:_____

_____
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 this office).

- 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. If account is not paid within 30 days of the date of service and no financial arrangements have been made, I authorize you to charge the credit card listed above for any and all portions of my balance/fees. These fees can include: legal fees, collection agency fee, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information requited to process insurance claims.
- 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.

Signature: _____Date: _____
Adult Patient /Parent or Guardian Spouse

PAIN CHART

Name: _____ File #: _____

What is your current weight: _____ lbs. and height _____ Ft. _____ In.

Please describe your condition:

_____

_____

_____

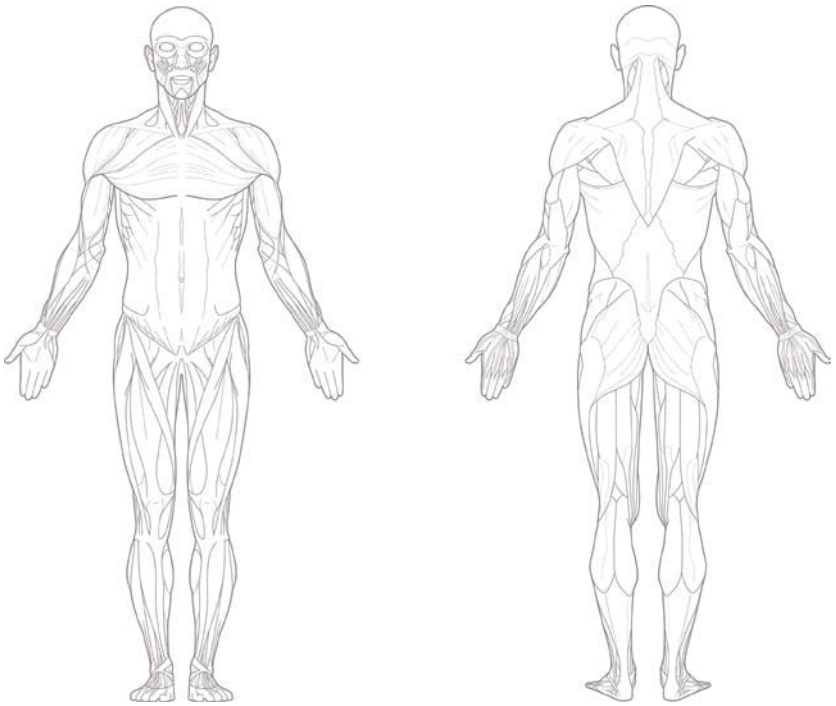
_____

_____

Signature: _____ Date: _____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).



INFORMED CONSENT TO CHIROPRACTIC TREATMENT

TO THE PATIENT: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to procedure.*

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic names below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with or serving as back-up for the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor named below and/or with office personal the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, ligamentous sprains, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, separations and some stiffness or soreness following the first few days of treatment. Ancillary procedures (Graston Technique, Heat, Ice, etc.) could produce skin irritation, burns, bruising, or other minor complications however, the probability of adverse reaction due to ancillary procedures is considered "rare." Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The risk of vascular injury or stroke has been estimated at one in every three million can be even further reduced by screening procedures. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made concerning the results intended from the treatment. Other treatment options that could be considered may include: Over the counter analgesics: the risk of these medications include irritation to the stomach, liver, and kidneys and other side effects on a significant number of cases. Medical care: typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence on a significant number of cases. Hospitalization: in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. Surgery: in conjunction with medical care adds to the risk of adverse reaction to anesthesia as well as an extended convalescent period in a significant number of cases.

Chiropractic treatment, including spinal adjustment/manipulation, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall health. The risk of injuries or treatments, medications, and procedures give the same symptoms.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have also had an opportunity to ask questions about its content, and by signing below I state that I have weighed the risks involved in undergoing treatment and I have myself decided that is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, benefits, and alternatives, I hereby give my consent to the treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

_____

Patient Name (Print)

_____

Patient Signature Date

AUTHORIZATION AND ASSIGNMENT

To: Jason M. Bongi, D.C. Atlanta Spine and Sport, Inc., 3719 Old Alabama Road, Suite 400A, Alpharetta, GA 30022
In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Authorization to Pay Directly to Doctor

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct the insurance company to make out the payment to me and mail it to me in care of Jason M. Bongi, D.C., Atlanta Spine and Sport, Inc., Alpharetta, GA 30022.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby sassing and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settlement or otherwise resolve said claim in my name or your name as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and effectors to collect the amounts owed directly from me. I understand that whatever amount you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in current manner.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services from Jason M. Bongi, D.C. at Atlanta Sport and Spine, Inc. and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be reasonably chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I hereby give permission for the provider of these services to collect this interest from the settlement on my case. Further, because of the continuing changes in the health care industry and the variety of reimbursement procedures and policy restrictions or limitations it is my understanding that the doctor at Atlanta Sport and Spine, Inc. will be basing this treatment decisions upon his clinical experience and education and not upon any third party, insurance companies reimbursed policies.

I understand that if it is determined either:

- *a) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the interest of the doctor(s): or*
- *b) If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of any attorney; or*
- *c) If I refuse an offer of settlement, then payment for services rendered by Jason Bongi, D.C. at Atlanta Spine and Sport, Inc.*

Then payment for services rendered by the doctor(s) Jason M. Bongi, D.C. at Atlanta Spine and Sport, Inc. will be made on a current basis and my bill paid in full within 30 days from my last treatment or as soon as my liability claim is settled, whichever occurs first.

A photocopy of this Authorization Assignment shall be considered as effective and valid as the original.

_____

Patient's Name Print Patient's Signature Date