

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

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

Email: _____@_____

Home Phone: _____ Work Phone: _____ Cell : _____

Social Security #: _____ Age: _____ Male Female

Marital Status: Married Single Divorced Separated Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation _____ Your Employer: _____

Referred to this Office by: Friend/Family Member - Name? _____

Yellow Pages Mail Clinic Location Other _____

Payment for Services will be by: Cash Check Credit Card Health Insurance

Automobile Insurance Worker's Compensation

Name of Insurance Co.: _____ Insured's Employer: _____

Insured's Social Security #: _____ Insured's Date of Birth: _____

Are you covered by more than one insurance company? Yes No Name _____

MEDICAL/FAMILY HISTORY

S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

Have you been treated by a physician for any health condition in the last year? Yes No

Have you been treated by a chiropractor before? _____yes _____no

If so, has it been in the last 6 months? _____yes _____no

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY:

1. _____
2. _____
3. _____

Date: _____
Date: _____
Date: _____

Have you ever had a metal implant? Yes No

Ever been gunshot? Yes No

ACCIDENT HISTORY Job Auto Other 1. _____ Date: _____

Job Auto Other 2. _____ Date: _____

(over please)

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms(1-10, with 1 being least serious)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER
ACCIDENT ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # _____ HOUR(S) _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

- BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
- LIFTING SNEEZING WALKING LYING DOWN STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

- blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss/confusion
- constipation depression/weeping spells diarrhea dizziness face flushed fainting fatigue fever
- head seems too heavy headaches insomnia light bothers eyes loss of balance loss of smell loss of taste
- low resistance to colds muscle jerking numbness in fingers numbness in toes pins and needles in arms
- pins and needles in legs ringing in ears shortness of breath stiff neck stomach upset

Patient's Signature

Date

DATE OF VISIT ___/___/20___ Patient _____ DOB _____

Check ONE: ___ INITIAL EXAMINATION ___ RE-EVALUATION ___ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

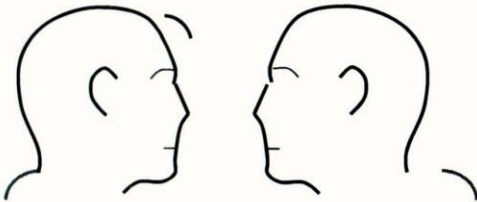
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint?

SUBJECTIVE PAIN ASSESSMENT

RATE YOUR PAIN

Right

Left

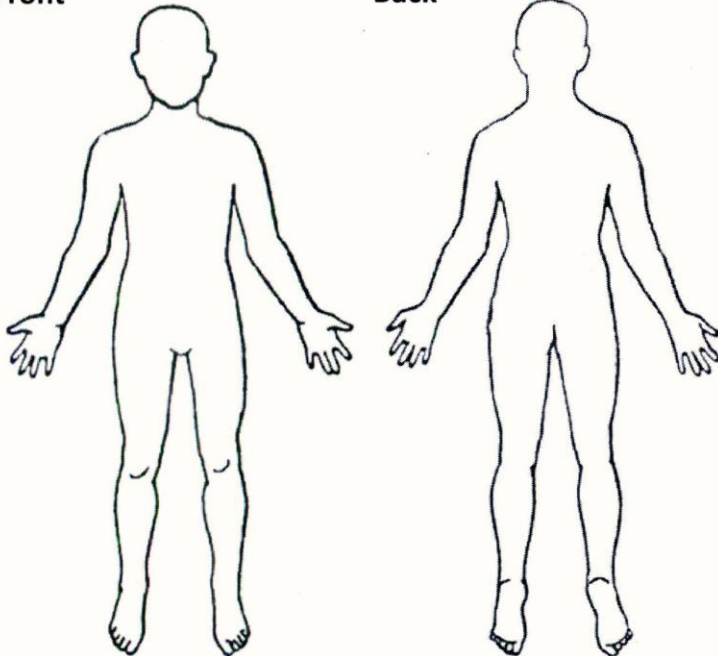


Place an "X" on the drawings where you have pain and indicate the type of pain you are experiencing:

- A=ACHE B=BURNING ST=STABBING
- SP=SPASM N=NUMBNESS P=PINS AND NEEDLES
- T= THROBBING

Front

Back



Additional Notes:

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE

LITTLE

MEDIUM

SEVERE

EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

DATE

Advanced Chiropractic Center

Financial Policy

The following is a statement of our financial policy. We require you to sign and read this document prior to treatment by this facility.

Patients without Insurance:

We request that 100% of the first visit be paid at the time of service. We do offer a time of service discount for follow-up visits. We are happy to accept your cash/check, MasterCard, Visa or Discover Credit Card.

Initial _____

Group or Individual Insurance:

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are **not a guarantee of payment**. As a courtesy to you, our office will file your claim with your insurance carrier. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, co pays or deductibles. It is the patient's responsibility to understand their insurance coverage.

Initial _____

Patient Responsibility

When you receive a statement from our office you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, please contact our office. Do not ignore the bill as it may result in turning the balance over to an outside collection agency.

I understand that I am financially responsible to Advanced Chiropractic Center for any balance not covered by the insurance carrier.

Initial _____

Assignment of Benefits

I authorize this office to release any medical information relating to my treatment to any insurance companies, which may be responsible for paying benefits to me. I hereby assign and authorize my insurance benefits to be paid directly to Advanced Chiropractic Center.

Patient name (please print)

Patient or Responsible Party's Signature

Date



Preston Peacock DC

408 HWY 80 SW

Pooler GA, 31322

Phone 912-748-0350

Fax 912-450-0350

Email:AdvancedChiro@hargray.com

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

Advanced Chiropractic Center has the right to use and/or disclose information about me (or someone else for whom I have the authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations. I understand they will not release any record without written authorization by me or persons elected.

The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient.

The Practice may communicate confidential information to me, including invoices for services, e-mail, and call for appointment times or missed appointments, birthday cards and Holiday cards.

I also realize that I may be overheard or may hear other patients talking while in the therapy bay.

Authorizing Patient Name and Signature

Date



Preston Peacock DC DABCO

408 SW Highway 80
Pooler GA, 31322

Phone 912-748-0350

Fax 912-450-0350

Email: AdvancedChiro@hargray.com

Informed Consent

Patient Name: _____

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. The procedure is referred to as “spinal manipulation” or “spinal adjustment” . As the joints in your spine are moved, you may experience a “pop” as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains , and dislocations., Bernard-Horner's Syndrome (also know as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-rays equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

Date

Printed Name

Signature or Signature of Guardian or Parent



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CREDIT GUARANTEE INSURANCE ASSIGNMENT

INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 30 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

FILING PROCEDURE

Claims for initial services are submitted within 48 hours after your first visit.

On Day 30, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. You will be sent a payment voucher. Any payments made on these claims thereafter will be immediately refunded to you.

PERSONAL BALANCES

Estimated personal portions are paid at the time of service unless you prefer to pay weekly. Weekly payments also require this credit card guarantee, and any personal balance not paid by Friday will also be automatically charged to your designated card below.

CREDIT CARD: VISA MC DISCOVER

CARDHOLDER NAME _____

CARD # _____ EXP. DATE _____

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 60 days after submission of my claim, or should I terminate care before being dismissed by your physician, I will be charged the amount due.

SIGNATURE

DATE



Preston Peacock DC DABCO
408 SW Highway 80
Pooler GA, 31322

Phone 912-748-0350

Fax 912-450-0350

Email: AdvancedChiro@hargray.com

Broken Appointment Policy

Advanced Chiropractic Center would like you to understand that your appointments are reserved exclusively for you. We wish to provide all our patients with the highest quality of care and for this reason we ask to be notified 12 hours prior to your appointment of any changes or cancellation. By not cancelling in a timely manner, our practice is unable to fill those appointment times with other patients, therefore resulting in a loss of revenue for the practice and, more importantly, we are unable to treat someone else that is need of care.

If appropriate notification is not received within 12 hours prior to your appointment, **a broken appointment fee of \$25 will be charged to your account.**

However, Advanced Chiropractic Center understands that emergency situations may arise; therefore the office may make exceptions when deemed necessary. Exceptions are determined on an individual basis and according to the circumstances only.

***For personal injury case patients, this fee will be charged directly to the patient.**

Signed: _____

Date: _____

AMERICAN RADIOLOGICAL SERVICES

(419) 269-2140

(800) 442-1202

PATIENT _____ CLINIC _____ FILM DATE _____
AGE _____ SEX M F SOCIAL SECURITY # _____ / _____ / _____ DATE OF BIRTH _____
PATIENT ADDRESS _____ CITY _____ STATE _____ ZIP _____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to American Radiological Services (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE: _____ DATE: _____
WITNESS: _____

PATIENT HISTORY

PATIENT PRESENTATION _____

TRAUMA? YES NO EXPLAIN _____

PAST MEDICAL HISTORY _____

MALIGNANCY? YES NO DETAILS _____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE] _____

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE