



Today's Date: _____

Confidential Patient Data

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

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 _____



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

Phone 912-748-0350

Fax 912-450-0350

Email: AdvancedChiro912@gmail.com

MEDICAL/FAMILY HISTORY

S = Self M = Mother F = Father

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

Grid of checkboxes for medical conditions: AIDS, anemia, arthritis, asthma, back pain, bladder trouble, bone fracture, cancer, chest pain, concussion, convulsions, diabetes, indigestion, dislocated joints, epilepsy, German measles, headaches, heart trouble, reproductive disorders, high blood pressure, HIV/ARC, kidney disorder, bowel control loss, menstrual cramps, multiple sclerosis, muscular dystrophy, neck pain, nervousness, numbness, polio, poor circulation, hepatitis, rheumatic fever, rheumatism, scarlet fever, serious injury, sinus trouble, tuberculosis, 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. Date:

2. Date:

3. Date:

Have you ever had a metal implant: Yes No Have you ever had a gunshot: Yes No

ACCIDENT HISTORY

Job Auto Other 1. Date:

Job Auto Other 2. Date:

(If more, please turn over)

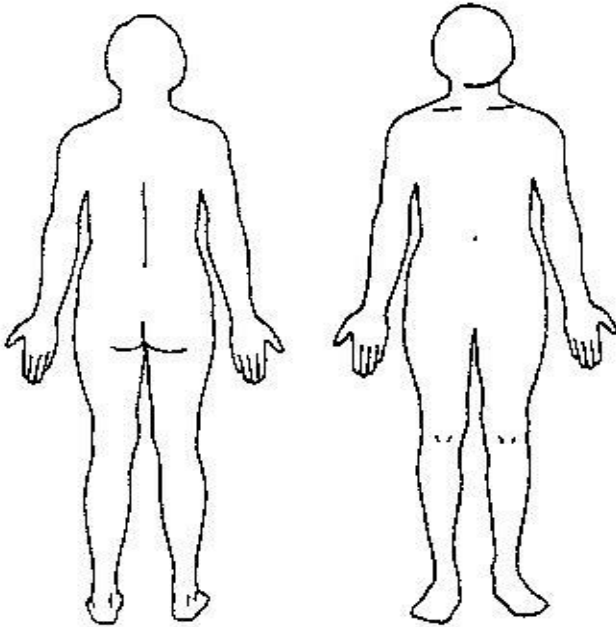
PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

- | | |
|-----------------------------|-------|
| 1. _____
Major Complaint | _____ |
| 2. _____
Major Complaint | _____ |
| 3. _____
Major Complaint | _____ |
| 4. _____
Major Complaint | _____ |

RATE YOUR PAIN

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

- | | |
|-------------|--------------------|
| A=Ache | B=Burning |
| N=Numbness | P=Pins and Needles |
| ST=Stabbing | SP=Spasm |
| T=Throbbing | |



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 | | Moderate | | | Severe | | Excruciating | |

Major Complaints Continued...

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:

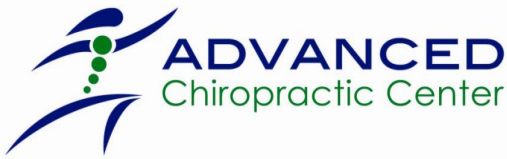
BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD
REACHING WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

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

Patient's Signature

Date



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408 SW HWY 80

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Email: AdvancedChiro912@gmail.com

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



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**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 (Please Print)

Signature

Date



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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 known 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 90 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 5 days after your first visit.

If the bill has not been paid by your insurance company within 3 months, we will contact you to discuss the issue. If the issue cannot be resolved with your insurance company, the liability will then fall to you and we will make 3 attempts to collect the payment with you. If no payment can be collected, we will then charge your credit card.

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: (circle one) VISA MC DISCOVER

CARDHOLDER NAME: _____

CARD # _____ EXP. DATE: _____

CSC # (3 digits on back of card): _____

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 90 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

A.Preston L.Peacock DC 408 US HWY 80SW Pooler, GA 31322

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Non coverage (ABN)

NOTE: If Medicare doesn't pay for the service below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the service below.

D. Services	E. Reason Medicare May Not Pay:	F. Estimated Cost
Initial Exam or re-exam	Non-Covered Medicare Service	65-85
X-rays		50-90
Therapies		10
Manipulation of an extremity		35
Manipulation of spine	Maintenance Care is not covered by Medicare	35

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.

Ask us any questions that you may have after you finish reading.

Choose an option below about whether to receive the services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the **service** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the **service** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the **service** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.