Ackerman
Chiropractic Center
5025-H Winters Chapel Rd. Atlanta, Ga. 30360
Office: 770.399.1800

DATE:	I.D. NO:

Confidential Patient Health Record – **PERSONAL HISTORY**

Full Name: _____ SSN#: _____ - ____ - _____ Sex: M / F

Address: _____ City/State: _____ Zip: _____

Marital Status (circle one): Single - Married - Divorced - Widowed - Separated

Race/ethnicity (circle one): African American - Asian - Caucasian/white - Hispanic - Native American - Other - Decline to answer

Birthdate: ___ / ___ / _____ Home Phone: (___) ____-_____ Work Phone: (___) ____-_____

Cell Phone: (___) ____-_____ Cell Phone Carrier: _____ E-mail: _____

Emergency Contact: _____ Phone: (___) ____-_____ Relationship: _____

How were you referred to this office? _____

Occupation: _____ Employer Name: _____

Who is responsible for your bill (circle one):

Self - Spouse - Workman's Comp - Auto Insurance - Medicare - Medicaid - Personal Health Insurance

PURPOSE OF VISIT

Reason(s) for appointment:	*Date condition started:*	*Rate the condition:* (no pain) (unbearable)
1. _____	_____	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
2. _____	_____	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
3. _____	_____	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

How often are symptoms present (circle one)? (Intermittent) 0-25% - 26-50% - 51-75% - 76-100% (Constant)

Has this condition occurred before? ☐ Yes ☐ No

Is the condition…?: ☐ Job related ☐ Auto related ☐ Home injury ☐ Fall ☐ other: _____

Other doctors seen for this condition: _____

Type of treatment: _____ Results: _____

Over-the-counter or prescription medications you take now: _____

_____

Do you suffer from any condition other than that which you are now consulting us? _____

_____

PAST HEALTH HISTORY

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? _____

When? _____ Reason for visits? _____

How did you respond? _____

Did your previous chiropractor take before and after X-rays? ☐ Yes ☐ No

Did your previous chiropractor tell you that **poor posture** can negatively affect your overall health? ☐ Yes ☐ No

Are you aware of any poor posture habits in your **spouse or children**? ☐ Yes ☐ No

Explain: _____

Previous surgeries or operation: _____

_____

Major accidents or falls: _____

_____

Hospitalizations (other than above): _____

_____

SOCIAL HISTORY AND LIFESTYLE

How often do you exercise per week? ☐ None ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ other: _____

Activities? ☐ Running ☐ Jogging ☐ Weight ☐ Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming ☐_____

Do you consider yourself to be…? ☐ Underweight ☐ Normal weight ☐ Overweight ☐ Obese ☐ Severely Obese

Do you smoke? ☐ Yes How much? _____ ☐ No

Drinking habits: ☐ Water ☐ Coffee/Tea ☐ Soda/pop ☐ Fruit juices ☐ Alcohol ☐ _____

What supplements do you take? (i.e. vitamins, minerals, herbs) _____

FAMILY HEALTH HISTORY

	Present Age(s)	Age(s) at Death	Medical Problems / Cause(s) of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sister(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____

Why chiropractic? People visit Chiropractors for a variety of reasons. Some seek *symptomatic relief* of pain or discomfort (Relief Care). Others are interested in having the *cause* of the problem as well as the symptoms *corrected and relieved* (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the *highest state of health possible* with Chiropractic Care (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ *Relief Care* ☐ *Corrective Care* ☐ *Comprehensive Care*

☐ *I would like the Doctor to select the type of care most appropriate for me.*

Patient Signature: _____ Date: _____

Office Fee Schedule and Financial Policy

Prices may vary depending on what you need, everyone is different

CHIROPRACTIC SERVICES	**OFFICE FEES**
Consultation	No Charge
Initial Exam	$60 - $150
Re-Exams	$35 - $150
X-Rays (per view)	$45
Full Spine X-Rays (AP & LAT)	$150
Spinal Adjustments	$55 - $65
Medicare Adjustments	$55
Therapies/Rehab/Stretching	$15 - $35

ADDITIONAL SERVICES

Cold Laser Therapy (Class 4 LLLT)

$55 Pain / $500 Smoking Cessation / $850 Allergy Treatment

PRODUCTS

CBD PRODUCTS

Salve-Balm	$45
500mg CBD Drops	$50
1000mg CBD Drops	$70
Custom CBD Formulation up to 4000mg	Price varies

ICE THERAPIES

CryoDerm Pain Relieving Gel	$17
Gel Ice-Pack	$10

Health Insurance: If you have insurance that covers chiropractic, we will file all of the information for you. This includes your diagnosis, prognosis, and copies of your records or report. Remember your agreement with your insurance company is between you and them**. If for some reason your insurance does not pay what we expect, you will be responsible for the balance. We file your insurance only as a courtesy for you. We will discuss this option with you during your Chiropractic Report.**

I have read and I understand the above policies.

PATIENT NAME DATE

GEORGIA CHIROPRACTIC'S
PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatments, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office.. We have taken all precautions that re known by this office to assure that your records are not readily available to those who do not need them.
Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Print Name of Patient

_____

(Patient signature or Parent/Guardian) Date

This PHI Consent will be part of your medical record at this facility