Matias Health CHIROPRACTIC
AUTO INJURY CENTER

255 Norcross Street Suite B
Roswell, GA 30075
(470) 800-4041 office

PATIENT INFORMATION

Patient Name: _____
Last First Middle

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____

May we leave a voicemail? YES NO May we text you appointment reminders? YES NO

Email Address: _____

Sex: MALE FEMALE Date of Birth: _____

Race: ◯ White/Caucasian ◯ Black/African American ◯ Asian ◯ Other ◯ Declined

Ethnicity: ◯ Non-Hispanic/Non-Latino ◯ Hispanic/Latino ◯ Unknown ◯ Declined

Preferred Language: ◯ English ◯ Spanish

Employer: _____ Occupation: _____

May we call you at work? YES NO Work number: _____

Who referred you to our practice?

Marital Status: Minor Single Married Divorced Widowed Separated Other

SPOUSE'S INFORMATION

Spouse's Name: _____ Spouse's Employer: _____

May we speak with your spouse concerning your care? YES NO

EMERGENCY CONTACT

Name: _____ Relation: _____

Phone: (Home) _____ (Cell) _____

May we contact either of these in case of an emergency? YES NO

ACCIDENT INFORMATION

Are your injuries related to an accident? YES NO Date of injury/accident: _____

Has it been reported? YES

Type of accident? AUTO WORK OTHER NO

To whom was it reported?

Has an Attorney been assigned to your case? YES NO

Attorney's Information:

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Patient Name: _____
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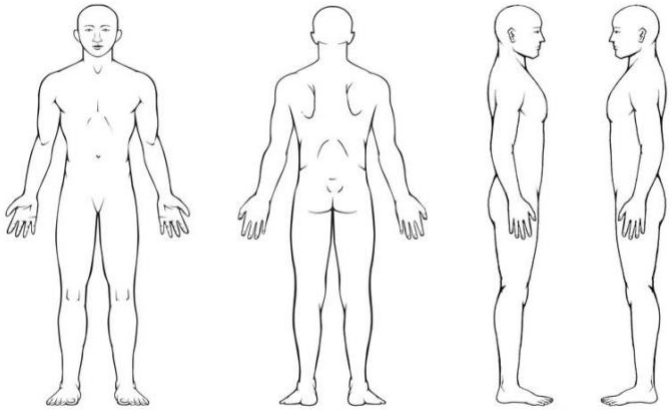
Last labs: _____ Abnormal Labs: __ YES __ NO Last physical exam: _____
Are you currently under drug and/or medical care? ___ YES ___ NO Explain: _____
Reason for visit: _____

Please circle if you have ever had any of the following:

Aids/HIV	Chicken Pox	Herniated Disc	Parkinson's Disease	Thyroid Problems
Alcoholism	Diabetes	High Cholesterol	Pinched Nerve	Tuberculosis
Allergy Shots	Eating Disorder	Kidney Disease	Pneumonia	Tumors/Growths
Anemia	Emphysema	Liver Disease	Polio	Ulcers
Appendicitis	Epilepsy	Measles	Prostate Problems	Venereal Disease
Arthritis	Eye Condition	Migraines	Prosthesis	Vertigo
Asthma	Fractures	Miscarriage	Psychiatric Care	Whooping Cough
Bleeding Disorder	Goiter	Mononucleosis	Rheumatoid Arthritis	List others:
Breast Lump	Gout	Multiple Sclerosis	Rheumatic Fever	
Bronchitis	Heart Disease	Mumps	Scarlet Fever	
Cancer	Hepatitis	Osteoporosis	Stroke	
Chemical Dependency	Hernia	Pacemaker	Suicide Attempts	



	PAIN KEY:
A	Ache
B	Burning
D	Dull
N	Numb
S	Sharp
SH	Shooting
ST	Stiff
T	Tingling
TH	Throbbing

Please circle if you are currently experiencing any of the following conditions:

Neck Pain	Mid Back Pain	Headaches	Sudden Weight Loss	Nausea
Shoulder Pain	Low Back Pain	Dizziness	Loss of Taste	Fatigue
Arm/Hand Pain	Knee Pain	Asthma	Loss of Memory	Chest Pain
Hand Swelling	Feet/Leg Pain	Sleeping Difficulties	Jaw Pain	Fever
Tingling in Arms	Cold Feet	Loss of Smell	Constipation	Fainting
Neck Stiffness	Back Stiffness	Allergies	Shortness of Breath	Depression
Hands fall asleep	Leg/feet Swelling	Blurred Vision	Bowel/Bladder Changes	Nervousness
Loss of handgrip	Tingling in Feet/leg	Light Bothers Eyes	Reduced Hearing	Tension
Cold Hands	Night Pain	Cold Sweats	Ringing in Ears	Balance Issues

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Please complete the following:
Do you sleep on your: Back Side Stomach Do you use a cervical pillow? YES NO
Which is your dominate hand? Right Left
Do your work activities involve: Sitting Standing Light Labor Heavy Labor
Primary Care Physician: _____

Family History: Indicate parent, grandparent, sibling, or child.

Cancer:	Heart Disease:	Kidney Disease:
Diabetes:	Hypertension:	Stroke:

Medications: List all medications including vitamins, supplements and over the counter

Name of Medication	Dose	Frequency	Diagnosis/Reason

Surgeries/Hospitalizations: (List all)

Year	Surgery	Overnight Stay	Name of Hospital

Allergies: _____
Caffeine use: (this includes tea, soda, coffee) NONE 1-3cups/ day 3-6cups/day 6+cups/day
Tobacco use: NEVER Former Current Smoker _____packs/day
Alcohol: NONE Casual Moderate Heavy Beer Wine
Drug use: YES NO
Exercise: NONE Daily Weekly Walks Runs Swim Other: _____

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INFORMED CONSENT TO CHIROPRACTIC AND OR MEDICAL TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor named below and/or in his clinic authorized by the doctor listed below. I have had an opportunity to discuss with the doctor listed below and/or other office or clinic personnel, the nature and purpose of the chiropractic and/or medical adjustment and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic and/or medical there are some very slight risk of treatment, including, but not limited to muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor considers at the time, based upon the facts then known, is in my best interests.

I have been informed that it is not uncommon for the patient to have some increased discomfort after and adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms, I can call the clinic where I am being seen during office hours for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room. If any test were performed outside of this office (laboratory, MRI, or any other diagnostic procedures). I understand that the Doctor will notify me of the results at my next schedules appointment.

OPEN ROOM AUTHORIZATION –

I give MATIAS HEALTH CHIROPRACTIC permission to perform my therapies in an open room, where other patients are also being treated. The doctors and staff of MATIAS HEALTH CHIROPRACTIC will do all that in their power to protect my personal health information, but due to the physical conditions, I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

_____ _____

Patient / Guardian's Name Date

_____ _____

Signature of Patient or Guardian (if applicable) Witness

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Financial Policy

We are committed to providing you with the best possible medical care. If you have a special financial need, we are willing to work with you. The following information is provided to avoid any misunderstandings or disagreements concerning payment for professional services. We will file your insurance as a courtesy to you, however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL.

1. Our office will be happy to submit to most insurance carriers. We participate with a variety of insurance plans, including Medicare. It is your responsibility to:
    - Provide the office with any updated insurance information.
    - Pay your co-pay and/or any deductibles at each visit. Payment can be made by cash, check, or credit card. We accept Visa, Master Card, Discover, and Care Credit.
    - Pay in full for any services that are not covered by your insurance plan.
    - Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.
2. If you have insurance that we do not participate in, our office is happy to file the claim upon request, however, payment in full is expected at the time of service.
3. Financially you will be responsible for all charges whether or not paid by your insurance provider.
4. If the patient is a minor (18 years and not emancipated), the parent or guardian must sign below. The parent or guardian who presents with the minor is responsible for any payment due at the time of service or any remaining balance after insurance pays.
5. If you have any questions about your insurance, we are happy to help you. However, specific coverage issues should be directed to your insurance company member services department. The phone number should be located on your insurance card.
6. Returned checks must be paid by cash, money order, cashier's check, or credit card. The fee for a returned check is $25.00 per check and payment with a check will no longer be accepted.
7. Financially you will be responsible for all charges for services rendered.

By hereby signing this financial policy, I state that I fully understand all statements made herein and that any questions I have about the financial policy of Matias Health Chiropractic have been answered in full.

_____
Patient Name

_____ _____
Patient or Parent/Guardian Signature Date

Consent to Treat

I, the undersigned, hereby authorize the Providers at Matias Health Chiropractic and whomever they may designate as their assistant to provide care to include but not limited to appropriate testing, diagnosis, analysis, therapy, and adjustments. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. It is the responsibility of the patient to make it known to the doctor of any specific health problems prior to treatment.

_____
Patient Name

_____ _____
Patient or Parent/Guardian Signature Date

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Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Matias Health Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Right to Restrict

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to see someone who involved in your care or payment of your care. *We are not required to agree to your request*. If we do agree, we will comply with your request unless the information is needed to provide you EMERGENCY treatment. To request restriction, you must make your request in writing to the Privacy Officer.

Please **list the people you give permission to** disclose and speak with about your care, treatment, medical information, and all other information we deem necessary to your well-being.

1. _____ 2. _____

3. _____ 4. _____

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

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RECORDS RELEASE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION PUSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

1.My name is _____,

My address is _____,

My date of birth is _____,I hereby authorize the use or disclosure of my health information as described below for the purpose of protecting my legal rights.

2.The following individual(s) or organization(s) (or any other individual or organization to whom this document is provided along with a written requests) is/are authorized to make the disclosure:

*Doctor's Office/Hospital: _____

Request of Records are from date of service of _____ to the present.

3.The type and amount of information to be used or disclosed is my entire medical chart and itemized billing statement.

4.I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5.This information may be disclosed to and used by the following individual or organization for the purposes of protection my legal rights: MATIAS HEALTH CHIROPRACTIC 255 NORCROSS STREET SUITE B ROSWELL, GA 30075. STONE MOUNTAIN HWY SUITE 320 SNELLVILLE, GA 30039

6.I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to MATIAS HEALTH CHIROPRACTIC.I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one (1) year from the dated signature below.

7.I understand that the information which may be released to MATIAS HEALTH CHIROPRACTIC includes, but is not limited to, my entire medical, psychiatric, or psychological record and all records of any type, including records of drug/alcohol treatment and/or evaluation, HIV testing and results, and/or AIDS related information and any and all records otherwise created, received, or maintained by the above-listed facility pertaining to me.

8.I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. If I have any questions about the disclosure of my health information, I can contact MATIAS HEALTH CHIROPRACTIC at 470-800-4041.

9.This authorization and/or request to release Protected Health Information is full understood and is made freely and voluntarily on my part and includes the authority to transmit any of the above-mentioned information by facsimile.

10.Any duplicate copy of this authorization presented to you by MATIAS HEALTH CHIROPRACTIC shall have the same force and effect as the original.

All prior authorizations are canceled. This authorization shall continue in force and effect until revoked by me in writing. Photocopies of the authorization including my signature need not to be updated and may be used and should have the same weight and effect as the original.

_____ Date: _____

Patient/Guardian Signature

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LETTER OF PROTECTION

1. I, as the Patient acknowledge: MATIAS HEALTH CHIROPRACTIC have rendered and may continue to render chiropractic services for me, as the Patient named above. I, as the Patient, and as the Attorney's client, herby authorize and direct by my signature below that you as the Attorney handling my matters (i) to protect to the fullest extent possible, the out- standing bill(s) for service rendered MATIAS HEALTH CHIROPRACTIC, to me as the Patient, related to the accident/injury noted above, including without limitation, all fees for chiropractic services, office based pain procedures, administrative charges, and other costs (the "bills") , (ii) to withhold the sums reflected on the Bills from any insurance, settlement, judgment, verdict or other sources that may become available to you as my Attorney related to the Accident/Injury, and (iii) to make direct payment of the Bills to MATIAS HEALTH CHIROPRACTIC immediately upon receipt of funds by you as my Attorney from any such insurance, settlement, judgment, verdict, or other sources.

2. I, as the Patient, understand and agree that no distribution of monies will be made to me until such time as all of the Providers have been paid in full.

3. I, as the Patient, direct my Attorney to contact MATIAS HEALTH CHIROPRACTIC at the time of my Attorney's receipt of funds on my behalf from any insurance, settlement, judgment, verdict , or other sources related to the Accident/Injury and to give MATIAS HEALTH CHIROPRACTIC a copy of any settlement check, release, settlement agreement or other evidence of the resolution of the matter related to the Accident/Injury.

4. I, as the Patient, agree that the above listed instructions are irrevocable and that a copy of this authorization shall have the same force and effect as the original.

5. I, as the patient, agree that if there is dispute concerning any of the Bills that my Attorney shall hold the disputed amount of money in an escrow account until a resolution has been made between me, as the Patient, and MATIAS HEALTH CHIROPRACTIC.

6. I, as the Patient, acknowledge the chiropractic treatment being provided is the result of any injury for which a legal claim is being pursued. I, as the Patient, agree to provide to the chiropractors the name, address, telephone number and email address for the attorney pursuing redress for injury.

7. I, as the Patient, further acknowledge the payment for the treatment is the responsibility of the patient and is ultimately the patient's sole responsibility irrespective of insurance or payment in the legal matter. I, as the Patient, agree to allow MATIAS HEALTH CHIROPRACTIC to lien for any outstanding chiropractic bills due as a result of treatment, whether or not payment by insurance has been pursued. To that end I as the Patient, agree to advise my attorney, or require or my attorney, to collect and pay MATIAS HEALTH CHIROPRACTIC for all my outstanding chiropractic bills.

8. I, as the Patient, further agree: To provide all relevant and necessary information relating to the legal efforts to the Chiropractic Providers so the may be able to file appropriate liens for all outstanding bills.

9. To keep the Chiropractic Providers reasonable informed as to the status of my legal efforts and to update any change of address or change in Counsel (attorney). In the event that I, as the Patient, terminate or change legal Counsel upon whom a lien has been filed by MATIAS HEALTH CHIROPRACTIC, I will notify them of my new Counsel within ten (10) days of engaging new Counsel. Likewise, I, as the Patient, am obligated to place my new counsel on notice of the lien(s) with MATIAS HEALTH CHIROPRACTIC.

10. To acknowledge, honor, and insure payment of the lien, either by the current attorney at the time settlement funds shall be distributed, or otherwise by me, with regard to any funds that will be or may be recovered in the legal efforts undertaken on my behalf.

By signing below, all of the undersigned agree to observe and honor the terms and conditions stated above.

_____	_____	_____
Patient / Guardian's Name	Patient Signature	Date
_____		_____
Witness /Title		Date