Flowery Branch Chiropractic
4875 Hog Mountain Road, Suite D, Flowery Branch, Georgia 30542
770-967-1900 / -1902 fax

Consent to Treat Minor Child/Dependent

Date: _____

I, _____, being the parent, guardian, or custodian of _____, a minor, hereby authorize the doctors of Flowery Branch Chiropractic and their associates to administer any necessary and appropriate examinations/x-rays or chiropractic treatment to my child.

I further agree to accept all financial responsibility with regard to any charges for services rendered to the aforementioned minor.

Minor's name: _____ Date of Birth: _____

Signed: _____

Relationship to Minor: parent / guardian / custodian

Witness: _____

Flowery Branch Chiropractic

Health History Form

Name: _____ Age: _____ Date of Birth: _____ Sex: _____

Patient's Chief Complaint:

_____

_____

Medications (List all medications currently prescribed):

_____

_____

Allergies (List all allergies/sensitivities):

_____

Patient's Past History: (Circle any if current or past experience)

Headaches, dizziness, fainting	Arthritis	Kidney Stones/Disease
Blurred vision	Chest Pain	Difficult/Painful Urination
Sinus trouble	High Blood Pressure	Easily Tired/Upset
Asthma	Heartburn/Indigestion	Depression
Sore Throats	Nausea/Vomiting	Convulsions
Shortness of Breath	Stroke	Back Pain/Injury
Persistent Cough	Ringing in Ears/Tinnitus	Diabetes
Night Sweats	Sudden Weight Loss/Gain	Prior Spinal Injuries

Serious Illness/Injuries/Hospitalizations	**Date**	**Outcome**

Patient's Family & Social History:

Do you use tobacco? YES / NO	Amount/How often _____
Do you use alcohol? YES / NO	Amount/How often _____
Do you exercise regularly? YES / NO	How often _____

Current Family Status:

Relation	**Age**	**State of Health**	**Serious Illness(?) / Cause of Death**
Father			
Mother			
Sibling(s)			

Patient Signature: _____ **Date:** _____

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Name: _____ Birthdate: ____/____/____ Sex: M / F

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

Home # _____ Work # _____ Cell # _____

E-mail address: _____ Preferred language: _____

Preferred method of contact/communication for office appointments (please initial): Text _____ E-mail _____

Marital Status: Married _____ Divorced _____ Widowed _____ Single _____

Occupation: _____ Employer: _____ Yrs Employed: _____

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

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

Emergency Contact & Phone: _____ & _____

Insurance Provider: _____ Subscriber/Member #: _____

Chief Complaint: _____

Cause of condition: _____

Have you had similar conditions in the past? YES / NO How did you hear about us? _____

ACCIDENT INFORMATION ***PLEASE NOTIFY THE FRONT DESK OF AUTO MEDPAY BENEFITS***

Did your accident occur on the job? YES / NO Injury reported to your employer? YES / NO

Were you involved in an automobile accident? YES / NO Date: _____ Time: _____

Do you have an attorney? YES / NO … if YES; name/number: _____

"I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable."

Patient signature: _____ Date: _____

Request for Release of Records

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip Code: _____

"I hereby request the release of my medical records (treatment or diagnostic records to include SOAP or imaging interpretations) in your facility…

_____

_____

_____

By the following facility :

Flowery Branch Chiropractic

4875 Hog Mountain Road, Suite D, Flowery Branch, Georgia 30542
FEIN 58-2559570
770-967-1900 / -1902 fax"

Patient/Parent/Guardian's Signature: _____ Date: _____

Note: ***Upon the receipt of your signed authorization, compiling of your records will begin. Depending upon the extent of the file, there may be a charge to provide the records. If there is a charge, you will be notified of the amount and once payment is received in our office, records will be forwarded.***

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Informed Consent for Examination/Treatment

I understand that neither chiropractic nor medical treatment is an exact science and that treatment involves utilization of best practices and sound judgement based on training and clinical experience. An undesirable result does not necessarily indicate judgement errors. No guarantee of result can be made or expected rather I wish to rely on the doctor to recommend and choose the best course of treatment based upon facts known in my best interest.

I understand there are certain degrees of risk associated with chiropractic and physical therapeutic modalities, which rarely includes, but is not limited to, fractures, disc injuries, strains/sprains, stroke or other musculoskeletal conditions and am willing to accept and consent to the risk associated with the care I am about to receive.

I have had the opportunity to ask questions about my case and by signing below I agree and intend this consent to cover all procedures prescribed for my condition or any future conditions for which I seek treatment/care.

By signing below, I hereby consent to the examination and treatment on myself, or my dependent, by the licensed Doctor of Chiropractic employed/engaged in this practice.

***Female patients**: To the best of my knowledge, I'm not pregnant or suspected. Date of last menstrual period _____.*

Financial Policy

It is our office policy that all services are charged directly to you, the patient, and that you are ultimately responsible for all payments regardless of insurance assignment.

Patients with Insurance: We are happy to extend the courtesy of filing your insurance claims for you. Co-pays and deductibles are expected at the time of service or end of the same week; if the balance exceeds $150 before payment, care may be suspended. We work very hard to stay on top of the maximum's allowed; ultimate responsibility is yours for services rendered.

Patients without Insurance: Payments for services are expected at the time of service, or the previously agreed to interval. Outstanding balances beyond $150 may result in suspension of service until balances are resolved; legitimate financial hardships are handled individually through consultation with our Billing Department.

ALL Patients: Returned checks or balances due over 30 days (excluding Personal Injury or Workman Compensation cases) may incur additional collection/service fees.

Signing below is acknowledgement and agreement to the above listed policy.

Privacy Practices Pursuant to HIPAA/Consent for Use of Health Information

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State and Federal Law.

A full copy of this office's HIPAA Compliance Manual is available upon request.

_____ _____

Patient's Name Signature

_____ _____

Date Relationship/Authority to Patient

_____

Witness

Flowery Branch Chiropractic