

Alexander Spine Center

11705 Jones Bridge Road, Suite D101 Johns Creek, GA 30005

Phone: 678-297-0901

PLEASE PRINT ALL INFORMATION

Patient Information

First Name: _____ Last Name: _____ MI: ____ Preferred Name: _____

Date of Birth: ____/____/____ AGE: _____ SSN: ____-____-____ () Male () Female

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Name of Employer: _____ Occupation: _____

Phone Numbers: () _____ () _____ () _____
(Home) (Work) (Cell)

Marital Status: () Single () Married () Widowed () Divorced

Emergency Contact: _____ Relationship: _____ Contact Phone: _____

Primary Care Dr.: _____ & Phone: _____

How were you Referred: _____; if by a patient what is the patient's name: _____

Email Address: _____ May we email you reminders, events and newsletters: __Yes __No

Health Insurance Information: (Please complete if you have insurance.)

Primary Health Insurance:

Company: _____ PPO / HMO / Fed / EMO / POS	Insured Name: _____
Relationship to patient: Self / Spouse / Child / Other _____	Insured DOB: _____
Policy #: _____ Group #: _____	Insured SSN: _____
Claim #: _____ Insurance Phone: _____	Insured Employer: _____

Secondary Health Insurance:

Company: _____ PPO / HMO / Fed / EMO / POS	Insured Name: _____
Relationship to patient: Self / Spouse / Child / Other _____	Insured DOB: _____
Policy #: _____ Group #: _____	Insured SSN: _____
Claim #: _____ Insurance Phone: _____	Insured Employer: _____

Please Read Before Signing – Signature on File Statement.

I hereby give my permission to the doctor to perform such procedures and administer treatment as he may deem medically / chiropractically necessary in the diagnosis and / or treatment of my condition. I agree to participate in medical and therapy treatments by this provider and accept that no guarantee of results or outcome is expressed. I authorize use of this form on all of my insurance submissions. I authorize release of information to all of my insurance companies. I authorize payment directly to **Alexander Spine Center**. I permit a copy of this authorization to be used in place of the original. I understand that my insurance coverage is a contract between my insurance co. and myself and that **Alexander Spine Center** will submit claims on my behalf but will not be responsible for filing appeals or disputing rejections. I agree with the above requirements and request that **Alexander Spine Center** submit claims on my behalf. I understand that I am responsible for all charges incurred regardless of my insurance status. I understand that there will be a \$25.00 fee for all returned checks.

Patient Signature

Parent / Guardian Signature

Today's Date

Health Record # _____

Alexander Spine Center

11705 Jones Bridge Road, Suite D101, Johns Creek, GA 30005 * 678-297-0901

Confidential Health Questionnaire

Patient Name: _____ Date of Birth: _____ Date: _____

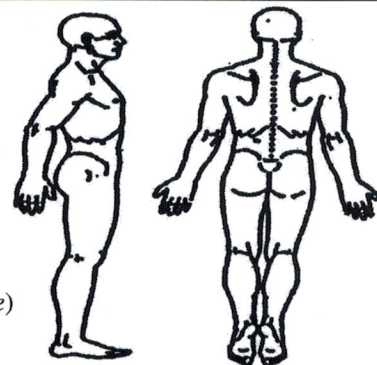
Present Complaint(s): _____

1. Have you ever been in an automobile accident? No Yes, when _____

2. Have you ever been injured at work? No Yes, when _____

3. Indicate on the drawings below where you have pain/symptoms:

4. Please select all that apply: Sharp Dull Achy Burning Stiff
 Numbness Shooting Tingly Radiating Soreness Stabbing Other
 Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)



5. Intensity of your symptoms: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable) (Please circle)

6. How do you think your problem began? _____

7. How long have you had this problem? _____ days _____ months _____ years

8. How are your symptoms changing with time? Getting Worse Staying the Same Getting Better

9. What aggravates your problem? _____

10. What alleviates your problem? _____

11. Have you had this problem before? _____

12. How much has the problem interfered with your work?
 Not at all A little bit moderately Quite a bit extremely

13. How much has the problem interfered with your sleep?
 Not at all A little bit moderately Quite a bit extremely

14. How much has the problem interfered with your social activities?
 Not at all A little bit Moderately Quite a bit Extremely

15. This problem prevents me from: _____

16. Who else have you seen for your problem?
 Chiropractor Neurologist Massage Therapist Primary Care Physician No one
 ER physician Orthopedist Physical Therapist Other: _____

17. How would you rate your overall Health? Excellent Very Good Good Fair Poor

18. What level of exercise do you do? Strenuous Moderate Light None

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Fax: 678-297-0903

Authorization To Pay Physician

I, _____, hereby authorize the _____ insurance company to pay by check/EFT made out and mailed directly to:

Alexander Spine Center
11705 Jones Bridge Road, Suite D101
Johns Creek, GA 30005

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, the balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to the doctor, I authorize you to make the check out to me and mail it as follows:

C/O Alexander Spine Center
11705 Jones Bridge Road, Suite D101
Johns Creek, GA 30005

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

I understand that ultimately I am financially responsible for all services rendered to me.

I hereby give my permission to **Alexander Spine Center** to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby give my permission to **Alexander Spine Center** to file formal grievances with the Georgia Insurance Commissioner when necessary on my behalf, should my insurance company deny payment of all or part of my medical bills.

Patient / Guardian Signature

Today's Date

Alexander Spine Center

Pregnancy Disclaimer – (FOR WOMEN ONLY)

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In so doing, I release Alexander Spine Center from responsibility for potential damage arising from this procedure.

At the present time:

_____ I am sure that I am NOT pregnant.

_____ It is possible that I could be pregnant.

_____ I am pregnant.

Date of LMP _____

Patient Signature

Today's Date

Witness Signature

Today's Date

Alexander Spine Center

11705 Jones Bridge Road, D101, Johns Creek, GA 30005

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Alexander Spine Center. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____@_____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Alexander Spine Center to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Deidra James about my concerns.

Signature of Patient/Guardian

Date

Witness (Office Staff)

Date

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ **Last Name:** _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/___ **Gender:** () Male () Female

Your Employer: _____ **Occupation:** _____

Employers Address: _____

Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

***If more than 3 medications, please continue list on back of page**

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ **Date:** _____

For office use only

Height: _____ **Weight:** _____ **Temp:** _____

Blood Pressure: _____ / _____ **Heart Rate:** _____



ALEXANDER SPINE CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

11705 Jones Bridge
Rd Suite D101
Johns Creek, GA
30005

Phone: 678-297-0901
Fax: 678-297-0903

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: _____

Organization Providing the Information: _____

Organization(s) or Person(s) Receiving the Information: Alexander Spine Center

Specific Description of Information Disclosed:

Purpose of Disclosure:

You must read and initial the following statements:

1. I understand this Authorization will expire on ____/____/____ (DD/MM/YYYY) or on the following event. Initials: _____
2. I understand that I may revoke this Authorization at any time by notifying Alexander Spine Center in writing, but if I do, it will not have any effect on any actions Alexander Spine Center took before they received the revocation. Initials: _____

Signature of Patient or Representative

Date

Relationship to Patient

Date

***You may refuse to sign this Authorization.
We cannot condition treatment on your signing this Authorization.***