

## Patient Information

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year  
 Marital Status  Single  Married  Partnered  Separated  Divorced  Widowed  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Patient SS# (optional) \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Emergency Contact Phone \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_ Email me monthly exclusive spa specials  Yes  No

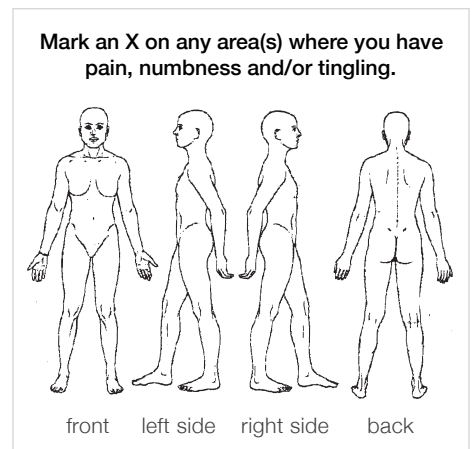
<p><b>Height</b> ____ Ft. ____ In. <b>Weight</b> _____ Lbs.  <b>Dominant Hand</b> (Check all that apply)  <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ambidextrous</p>	<p><b>Sleeping Position</b>        (Check all that apply)  <input type="checkbox"/> Back <input type="checkbox"/> Stomach  <input type="checkbox"/> Right Side <input type="checkbox"/> Left Side</p>	<p><b>Exercise</b>        (Check all that apply)  <input type="checkbox"/> None <input type="checkbox"/> Moderate  <input type="checkbox"/> Daily <input type="checkbox"/> Heavy</p>	<p><b>Work Activity</b>        (Check all that apply)  <input type="checkbox"/> Sitting <input type="checkbox"/> Standing  <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor</p>
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## Patient Condition

Reason for Visit \_\_\_\_\_  
 Has this condition been diagnosed by a physician or other healthcare provider?  Yes  No  
 If yes, diagnoses \_\_\_\_\_  
 Have you had any previous treatment for this condition?  Yes  No If yes, describe \_\_\_\_\_  
 Did these treatments help?  Yes  Somewhat  Not Much  Not At All  
 Are you currently being treated for this condition by anyone else?  Yes  No If yes, describe \_\_\_\_\_  
 Are these treatments helping?  Yes  Somewhat  Not Much  Not At All  
 How does this condition affect you? \_\_\_\_\_  
 Is this condition due to an accident?  Yes  No If Yes, type:  Auto  Work  Other \_\_\_\_\_ Date: \_\_\_\_\_  
 When did this condition and/or your symptoms first appear? \_\_\_\_\_

**Please answer the following questions if you have pain:**

Is this condition getting progressively worse?  Yes  No  Unknown  
 Rate the severity of your pain (0=no pain to 10=severe pain) \_\_\_\_\_  
 Type of pain:  Sharp  Burning  Throbbing  Numbness  Aching  Swelling  Dull  
 Tingling  Stabbing  Shooting  Stiffness  Other \_\_\_\_\_  
 How often do you have this pain? \_\_\_\_\_  
 Describe your pain:  Constant  Comes and Goes  Other \_\_\_\_\_  
 Activities/Movements painful to perform:  Sitting  Standing  Lying Down  
 Walking  Bending  Other \_\_\_\_\_



## Health History

Indicate if you **currently have or have ever had** any of the following:

ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies/Sinus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurring Fevers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Growing/Back Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head/Neck Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rubeola	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated/Bulging Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bed Wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Dislocation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sprain/Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temper Tantrums	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Torticollis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Colds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor/Growth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Digestive Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Uneven Leg Length	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dyslexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Pain/Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss/Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other \_\_\_\_\_

Describe/explain any treatment(s) you have had or are currently receiving for any of the conditions checked 'Yes' above. \_\_\_\_\_

List all past/present injuries, dislocations, broken bones and/or surgeries with date.

_____	Date _____
_____	Date _____
_____	Date _____

**Medications & Vitamins/Herbs** List all medications, vitamins and/or herbs you are currently taking & reason.

\_\_\_\_\_

\_\_\_\_\_

## Pediatric Consent

I, being the parent or legal guardian of \_\_\_\_\_ **(patient name)**, hereby consent to the treatment of my child by Village Health Georgia, PC. I understand that the nature of the treatment may include diagnostic examination, chiropractic manipulation, x-ray and/or various ancillary procedures such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, traction and stretches.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been presented with a copy of the Village Health Georgia, PC 'Notice of Privacy Practices'. This notice describes how Village Health Georgia, PC may use and disclose by protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights that I have regarding my protected health information.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

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## Informed Consent & Release

**The nature of Chiropractic Treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a click or a pop such as the noise when a knuckle is cracked and you may feel movement of the joint(s). Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, traction and stretches may be utilized.

**Possible Risks:** As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints or injury to the intervertebral disks, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries in the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. The risks of complications due to chiropractic treatment have been described as rare, about as often as complications from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in ten million and can be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

*I have read the above information, have fully evaluated the risks and benefits of being treated and hereby give my full consent for examination and chiropractic treatment(s) to be performed on me by Village Health Georgia, PC (dba Village Health Wellness Spa). I further acknowledge and state that each and every visit or appointment I have with Village Health Georgia, PC, at any location, subsequent to this date, shall constitute a continuation, revival, and renewal of this release.*

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Signature of Parent or Legal Guardian

Relationship to Patient

Date

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## Patient Financial Agreement

Village Health Wellness Spa is dedicated to providing the best possible service in a cost effective manner. In order to accomplish this, we depend upon prompt payment for the services we provide and have adopted the following policies:

### Payment Due at Time of Service

I acknowledge that payment is due at the time of service. I agree that in return for the services provided to the patient by Village Health Wellness Spa, I will pay my account at the time service is rendered. I consent that I am responsible for any and all charges assigned to me by my insurance plan including, but not limited to, yearly deductibles, co-insurances, co-pays, non-plan coverage, etc. All past due balances are due and payable at the time of service.

### Patient Responsibility

I understand that filing a claim with my insurance plan does not relieve me from my responsibility for the payment of all charges. If no payment is received from my insurance plan, the full balance of my account will be my responsibility. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I accept financial responsibility for any services which are determined by my insurance plan not to be covered and/or denied. I understand and agree that if my account is delinquent, I may be turned over to a collection agency and responsible for collection expenses.

### Insurance Assignment & Release of Information

I hereby authorize Village Health Wellness Spa to release all information necessary for claim reimbursement from insurance companies to who claims may be submitted and/or to secure the payment of benefits. I assign payment of insurance benefits to Village Health Wellness Spa for services rendered.

### Blue Cross Blue Shield Payment Acknowledgement

In some cases, Blue Cross Blue Shield remits payment checks directly to the patient rather than the chiropractic office at which services were rendered. If this occurs, I understand that I am responsible for forwarding these payments to Village Health. I understand and agree that if my account is delinquent for these payments, I may be turned over to a collection agency and responsible for collection expenses.

### Self-Pay Accounts

Self-pay accounts are patients who are covered by insurance plans that the practice does not participate in, or patients without an insurance card on file or at the time of service. I agree that I am individually obligated to pay the full charges at the time of service. If a group or organization discount is received for service(s) and I am not enrolled or a member of that organization at the time of service, I will be responsible for the difference between the discounted charge and the full charge.

### Minors

Minors (patients under the age of 18) must have a signed consent for treatment by a parent or legal guardian on file. Minors must be accompanied by a parent or legal guardian in order to be treated. The parent(s) or guardian(s) accompanying a minor are responsible for payment.

### Late Fee

Past due accounts and balances not paid by the due date on the statement are subject to a late fee of \$25.00.

### Returned Check Fee

Any payment by check returned by the bank will be subject to a returned check fee of \$35.00.

*By signing below, I acknowledge that I have read, understand and agree to the above Financial Agreement.*

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Signature of Parent or Legal Guardian

Relationship to Patient

Date

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