Kenney Family Chiropractic
Georgia Centers for Spinal Health and Wellness
99 Weatherstone Dr, Suite 940, Woodstock, GA, 30188-7005
(678) 388-7670 (Office) (678)388-7671 (Fax)

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ___/___/_____ Birth Date: ___/___/_____ Age: ____ Gender: F M

CURRENT ADDRESS

Street: _____

City: _____ State: _____ Zip: _____

Phone: (____)_____

Email Address: _____

Your Occupation: _____ Employer: _____

Work Address: _____ Work Phone: (____)_____

Student at: _____ ☐ Full-Time ☐ Part-Time

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

Name of Spouse: _____ Spouse's Date of Birth: ___/___/_____

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

Spouse's Work Address: _____ Work Phone: (____)_____

Spouse is a student at: _____ ☐ Full-Time ☐ Part-Time

Who should we contact in the event of an emergency? _____ Phone: (____)_____

Address of contact person: _____

****

Have you had chiropractic care before? ☐ Yes ☐ No If so, who was your previous doctor?_____

Were you pleased with your care? ☐ Yes ☐ No If not, please explain:

_____

_____

_____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Approximately, when did your injury or condition occur? ___/___/____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

_____

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Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

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Date of last physical examination? _____

What surgery have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

What medications or drugs are you taking? _____

Have you ever suffered from:

Y / N	Y / N	Y / N
☐ ☐ Dizziness	☐ ☐ Arthritis	☐ ☐ Digestive Disorders
☐ ☐ Backaches	☐ ☐ Headaches	☐ ☐ Nervousness
☐ ☐ Heart Trouble	☐ ☐ Numbness	☐ ☐ Sinus Trouble
☐ ☐ Diabetes	☐ ☐ Asthma	☐ ☐ Anemia
☐ ☐ Hernia	☐ ☐ Neuritis	☐ ☐ Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____ Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO If yes, who is the employer? _____

Group #: _____ Member ID: _____

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date:

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___/___/___

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information
("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Kenney Family Chiropractic.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print):

Signature: _____

Date: ____/____/____

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X-Ray Consent and Statement of Non-Pregnancy

X-rays are one way of looking inside a person's body. Chiropractors use X-ray analysis as one of the tools that help tell if your body is properly balanced and if your vertebrae and other skeletal structures are in proper alignment. This helps us determine your structural integrity.

Long-standing spinal nerve stress (vertebral subluxations) may cause a condition of inflammation of the bone and related structures and premature aging called spinal degeneration. An X-ray can tell us if you have this condition.

If you have read the above information and give the doctor and his/her associates permission to perform an X-ray evaluation.

Patients Name: _____

Patients Signature: _____ Date: ___/___/_____

Pregnancy Release:

I, _____, in signing this form, state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

Patients Signature: _____ Date: ___/___/_____

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Authorizations and Releases

Patient Name: _____ Today's Date: ___/___/_____

Consent for Treatment

I the undersigned, hereby authorize the doctor and his staff named below and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHANGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient Name: _____ Date: ___/___/_____

Authorization to Release Medical Information

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition and treatment to any insurance company or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and herby release him/her of any consequences thereof. I also agree that all insurance information given to this clinic is correct and complete. I agree that a photo static copy of this agreement shall serve as the original.

Patient Name: _____ Date: ___/___/_____

Authorizations to Pay Doctor/Clinic-Insurance

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to this doctor/clinic named below as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given the power of attorney to endorse/sign my name on any and all drafts for payment of my bill. I agree that a photo static copy of this agreement shall serve as the original.

Patient Name: _____ Date: ___/___/_____

Authorization to Pay Doctor/Clinic-Attorney

I, the undersigned patient am directing my attorney to pay any outstanding bills out of me settlement and, in effect, protection any such balance. I hereby make and declare the instructions herein contained to irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's protections and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current status.

Patient Name: _____ Date: ___/___/_____

Consent for Treatment of a Minor

I (we) being the parent, guardian or custodians of _____ a minor. The age of ____, do hereby authorize, request and direct, the doctor and his staff named below and whomever he/she may designate as his/her assistant(s) to perform in his/her judgement any necessary examination, X-ray, and chiropractic treatment as is necessary.

Authorization to Pay
Release Authorization
Is Granted to:

Kenney Family Chiropractic, Inc.
99 Weatherstone Dr, Suite 940, Woodstock, GA, 30188-7005
(678) 388-7670 (Office)