

# C1 Spine Lab for Atlas Orthogonal Chiropractic

## NEW PATIENT REGISTRATION FORM

Date: \_\_\_\_ (DD) / \_\_\_\_ (MM) / \_\_\_\_ (YEAR)

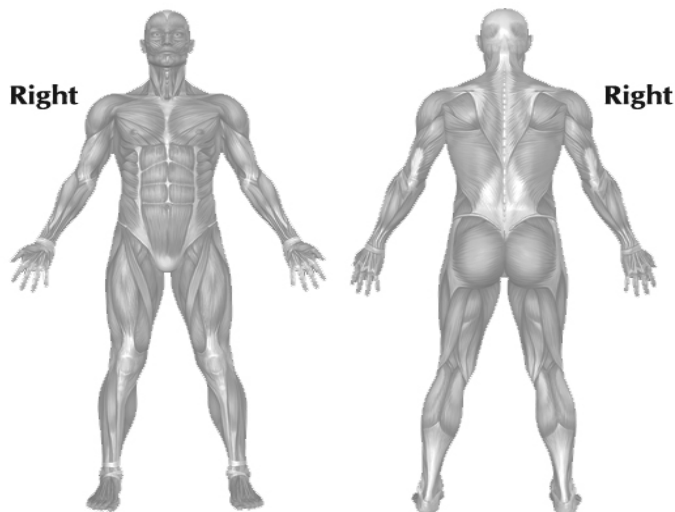
It is important that you answer all of the questions that apply to you to the best of your knowledge. If you have any questions or need assistance, please let the receptionist know. Thank you.

<input type="checkbox"/> Last Name, First Name: _____
<input type="checkbox"/> Date of Birth: _____ Sex: <input type="checkbox"/> Male / <input type="checkbox"/> Female
<input type="checkbox"/> Street Address: _____
<input type="checkbox"/> Phone Number: (    ) _____ Email: _____

<input type="checkbox"/> Is this visit due to an accident? <input type="checkbox"/> Yes / <input type="checkbox"/> No
<input type="checkbox"/> If yes, Date of Accident _____
<input type="checkbox"/> Type of Accident? <input type="checkbox"/> Auto / <input type="checkbox"/> Wok related / <input type="checkbox"/> Home / <input type="checkbox"/> Other
<input type="checkbox"/> If Accident, please describe in your own words how it happened: _____ _____ _____ _____

<input type="checkbox"/> Please describe your Major Complaint with your own words: _____ _____ _____ _____
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Mark the areas of the body where you feel the described sensations. Use the appropriate symbol. Include ALL affected areas. LEGEND: Numbness: +++ / Burning: XXX / Pins and Needles: ✓✓✓ / Sharp: ⚡ / Dull and Aching: \*\*\* / Weak: ⊙⊙⊙



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Have you been in an auto accident?  Yes /  No If you have, when? \_\_\_\_\_  
 Have you had any other personal injury or accident?  Yes /  No If you have, when? \_\_\_\_\_  
 If you have, briefly describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Been knocked unconscious?  Yes /  No  
If Yes, Why? Explain: \_\_\_\_\_  
 Use a cane, crutch, etc?  Yes /  No  
If Yes, Why? Explain: \_\_\_\_\_  
 Had a fractured bone?  Yes /  No  
If Yes, Why? Explain: \_\_\_\_\_  
 Been hospitalized for other than surgery?  Yes /  No  
If Yes, Why? Explain: \_\_\_\_\_  
 Been treated for a spine disorder?  Yes /  No  
If Yes, Why? Explain: \_\_\_\_\_  
 Are you wearing Heel lifts or similar?  Yes /  No  
If Yes, Why? Explain: \_\_\_\_\_

To your knowledge, have you any metal in your body such as surgical wire, implants, metal fragments that have not been removed?  Yes /  No  
If Yes, Why? Explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had Chiropractic Care before?  Yes /  No  
If, Yes, Please record Name of Doctor , Treated for, Results, Etc : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there any possibility that you are pregnant at this time? // Yes / // No

Person's name / Telephone number / address info for responsible for payment of the account:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* If you want to check your Insurance coverage for our services, please give card to our receptionists so they can verify



I certify that the above information is correct to the best of my knowledge.

 Patient's Signature: \_\_\_\_\_ Patient Date: \_\_\_\_\_

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## PAYMENT AGREEMENT

There are several methods of payments available. Please check the method that will apply to you.

\_\_\_\_\_ INSURANCE - I am responsible for my payment charges. I am covered by insurance and the Atlas Clinic will be happy to file my insurance for reimbursement to me. The Atlas Clinic will determine if they are in my Insurance network.

\_\_\_\_\_ AUTO ACCIDENT, WORKER'S COMPENSATION OR SLIP & FALL - (other party responsible) This usually covers your medical bills at nearly 100%. Please supply the front desk with the complete mailing address of the party responsible. For auto cases, please be aware that should your medical payment benefits become exhausted, you will be responsible for any unpaid charges. Also, as in all cases of we agree to wait for settlement, you will be responsible to make sure that this office does receive payment for services rendered at the time settlement is made. In the unlikely event that a problem arises with the settlement, you will agree to make arrangements for full payment to this office.

\_\_\_\_\_ CASH - I will be paying for each visit on a cash basis.

\_\_\_\_\_ MEDICARE - Please be aware that we are approved Medicare providers, however we do not accept Medicare assignment of benefits. We expect payment at the time of services are rendered by our Medicare patients. We will file your Medicare claim forms for you and payment will be made directly to you by Medicare as reimbursement for our services.

\_\_\_\_\_ NONE OF THE ABOVE - If none of the above applies to you, please ask for a consultation with one of our front desk assistants before seeing the doctor.

If you have insurance, we will need to make a copy of your card and have you complete and sign an insurance form for our records. We will also request your driver's license and make a copy for our records.

Returned checks will be charged \$25.00 and there may be interest of 1.5% charged to your balance should your account be over 30 days.



I UNDERSTAND THAT ALL MY CHARGES NOT COVERED BY INSURANCE, REGARDLESS OF THE REASON, ARE MY FULL RESPONSIBILITY.



Patient's Signature: \_\_\_\_\_ Patient Date: \_\_\_\_\_

## INSURANCE DISCLAIMER

Dear Patient,

Insurance companies will only pay what is covered in each individual's insurance policy. If your insurance policy does not cover services rendered from this office, you the patient are responsible for the non-covered services.

Payment is due at the time of service, unless payment arrangements have been made with the Atlas Clinic.

Unpaid balances after 90 days are to be turned over to collections and interest will be added on to the account for each month it is overdue. If the account goes into the legal phase of collections your bill is accrued to double in cost due to legal fees. This will only go into effect if you have not made a payment arrangement with the Atlas Clinic.

\* Regardless of what your insurance states, if we are not in your network, you as a patient are still responsible for the charges.

\* SOME X-RAYS AND THE G-5 MASSAGE, MAY NOT BE COVERED.



I understand that if my insurance company does not cover the services rendered, I am personally and fully responsible for the payment in full to C1 Spine Lab.



Patient's Signature: \_\_\_\_\_ Patient Date: \_\_\_\_\_

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## PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. In accordance with the applicable Health Insurance Portability and Accountability Act of 1996, the Practice reserves the right to change its privacy practices that are described in its Privacy Notice to be current and in the best interest of a patient's privacy rights.
3. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
4. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
5. I understand that this Consent is valid for *seven years*. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
6. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.



I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.



Patient's Signature: \_\_\_\_\_ Patient Date: \_\_\_\_\_

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## CONSENT FOR MEDICAL TREATMENT

I, \_\_\_\_\_, hereby authorize and request C1 Spine Lab to provide such medical care and administer such diagnostic and/or therapeutic procedures and treatments as in the judgement of the physician in attendance are deemed necessary and advisable.

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat/ice application, and muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.

Side effects include, but are not limited to, soreness, inflammation, soft-tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulations) is debated. Additional information on side-effects, complications and effectiveness of spinal adjustments is available on request.



I understand and agree to this consent to treatment at C1 Spine Lab and by its physicians.

 Patient's Signature: \_\_\_\_\_ Patient Date: \_\_\_\_\_

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## CONSENT TO TREAT A MINOR

We require the consent of a parent or legal guardian to provide chiropractic treatment and therapies to patients under the age of 18. PLEASE NOTE we do not see patients under the age of 18 years old without an adult accompanying them and strongly encourage a parent or legal guardian to attend all visits.


Please sign the authorization below to allow us to care for your child.



 Patient's Signature: \_\_\_\_\_ Patient Date OF BIRTH: \_\_\_\_\_

I am the parent or legal guardian of the patient named above. I authorize and consent to the patient receiving chiropractic adjustments, procedures, and therapies as is considered necessary by the clinical staff at C1 Spine Lab.

Printed name of parent/guardian: \_\_\_\_\_

 Signature of Patient's Signature: \_\_\_\_\_ Patient Date: \_\_\_\_\_