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.

- Last Name, First Name: _____
- Date of Birth: _____ Sex: ☐ Male / ☐ Female
- Street Address: _____
- Phone Number: ( )_____ Email:_____

- Is this visit due to an accident? ☐ Yes / ☐ No
- If yes, Date of Accident _____
- Type of Accident? ☐ Auto / ☐ Wok related / ☐ Home / ☐ Other

_____

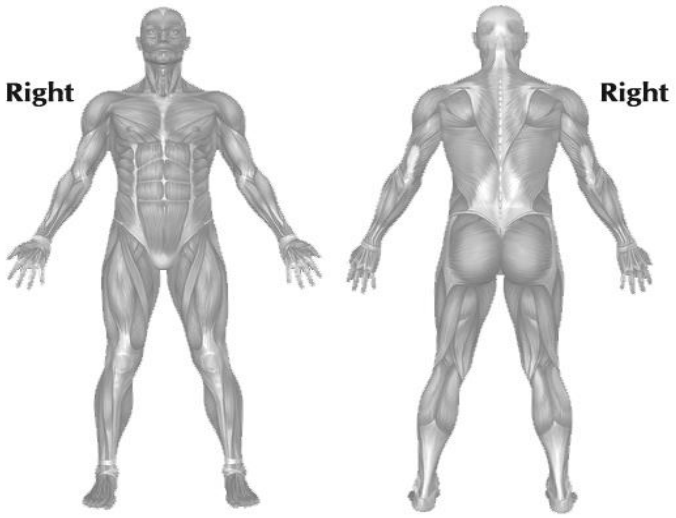
- If Accident, please describe in your own words how it happened:

_____
_____
_____
_____

- Please describe your Major Complaint with your own words:

_____
_____
_____
_____
_____

- 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: ⊙⊙⊙



- 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: _____

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 and 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 UNCERSTNAD 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: _____

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: _____

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: _____

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:_____

Date: _____

Treatment agreement for Shortwave Diathermy and BEMER therapy system

I agree that I was fully explained about contraindications and precautions for Shortwave Diathermy therapy information (based on Auto Therm 390 Instruction Manual by Mettler Electronics corp. page 21 and page 22) and safe use of the BEMER therapy system by the doctor, Chuel Hong Park D.C. or the staff at Atlas Clinic LLC. (d.b.a C1 Spine Lab) at 2810 Peachtree Industrial Blvd., Suite E, Duluth, GA 30097.

I have read and understood clearly the following list of contraindications that prohibit Shortwave Diathermy or BEMER therapy system on my body.

A list of contraindications that prohibit Shortwave Diathermy

All metal jewelry, clothing that includes metal, such as zippers or buttons, accessories containing metal, Malignant tissue, Severe / excessive edema, Metallic implant, Cardiac pacemaker, Over wet dressing, Acute inflammation, Infected open wound, Unreliable patient, Impaired thermal sensation, Recent radiotherapy, Pregnancy, Severe cardiac abnormality, Blood pressure abnormality, Anesthetic area, Tuberculosis, Tendency of bleeding, Reproductive organ

A list of contraindications that prohibit BEMER therapy

For patients who wear active medical implants (e.g., pacemakers, defibrillators, brain stimulators, muscle stimulators) or implants intended for drug delivery (e.g., drug pumps), the use of the BEMER therapy system could lead to malfunctions in these devices.

Therefore, it will be my own responsibility solely if there is any injuries or problems due to Shortwave Diathermy therapy and or BEMER therapy by neglecting above information.

☛ Patient's Signature:_____
Patient Date: _____