C1 SPINE LAB

PATIENT REGISTRATION & CONSENT

1. About You

Legal name (Last, First, Middle):	Preferred name:
Date of birth (MM/DD/YYYY):	Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex
Street address:	City / State / ZIP:
Mobile phone:	Email:
Emergency contact (name / relationship):	Emergency contact phone:

☐ Preferred contact: Phone ☐ Preferred contact: Text ☐ Preferred contact: Email ☐ Marital status (optional): _____

2. Today's Concern

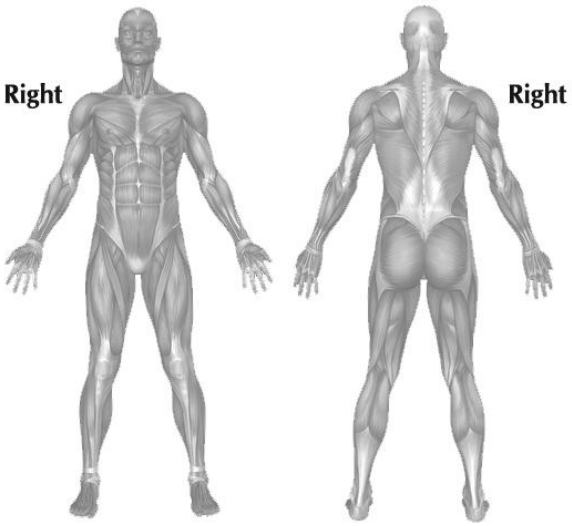
Main reason for today's visit _____

When did it begin?	Pain now (0–10):	Worst pain (0–10):
What makes it better?	What makes it worse?	Is it changing? ☐ Better ☐ Worse ☐ Same

☐ Neck pain
☐ Dizziness / vertigo
☐ Shoulder / arm pain
☐ Low back pain
☐ Balance difficulty
☐ Headache / migraine
☐ Jaw / facial symptoms
☐ Numbness / tingling
☐ Hip / leg pain
☐ Other: _____

What activities, work, sleep, or daily tasks are affected? _____

3. Symptom Map Mark all affected areas and label the sensation.



Use: A = aching B = burning
N = numbness P = pins/needles
S = sharp W = weakness

Does pain travel? ☐ No ☐ Yes
If yes, from: _____
to: _____

Additional notes:
_____
_____
_____

4. Health History

Check current or past conditions. Add details where requested.

- ☐ High / low blood pressure
- ☐ Pacemaker / implanted device
- ☐ Bleeding disorder / blood thinner
- ☐ Osteoporosis / bone weakness
- ☐ Seizure / fainting / loss of consciousness
- ☐ Kidney disease
- ☐ Autoimmune / inflammatory condition
- ☐ Numbness / progressive weakness
- ☐ Vision / speech change
- ☐ Anxiety / depression
- ☐ Heart disease / chest pain
- ☐ Stroke / TIA / blood clot
- ☐ Cancer / tumor
- ☐ Recent fracture / major trauma
- ☐ Diabetes
- ☐ Liver disease
- ☐ Current infection / fever
- ☐ Bowel or bladder control change
- ☐ Unexplained weight loss
- ☐ Other significant condition

Please explain any checked condition(s) _____

5. Medications, Allergies & Procedures

Current medications and supplements (include dose if known) _____

Medication, latex, or adhesive allergies and reaction _____

Surgeries, hospitalizations, fractures, or implants (type and year) _____

Primary care clinician / practice:	Phone (if known):
Other specialists currently treating you:	Reason:

6. Chiropractic & Injury History

Prior chiropractic care? ☐ No ☐ Yes – last visit / provider:	Result: ☐ Helped ☐ No change ☐ Worse
Prior spine disorder or treatment? ☐ No ☐ Yes – explain:	Use cane, brace, heel lift, or assistive device? ☐ No ☐ Yes
Current concern related to an accident or injury? ☐ No ☐ Yes	Date: _____ Type: ☐ Auto ☐ Work ☐ Home ☐ Other

If accident/injury, briefly describe what happened _____

Pregnancy / imaging safety If you could be pregnant, tell the doctor before any X-ray or modality. ☐ Not applicable ☐ No possibility ☐ Possible / pregnant

Urgent symptoms Tell the doctor immediately about new severe headache, chest pain, trouble speaking, fainting, sudden weakness, loss of bowel/bladder control, or other rapidly worsening symptoms.

7. Proposed Care

C1 Spine Lab may recommend a chiropractic history and examination, orthopedic or neurologic testing, posture or range-of-motion assessment, diagnostic imaging when clinically appropriate, chiropractic adjustments (including upper-cervical procedures), soft-tissue or mechanical therapy, therapeutic exercise, and certified electrical or therapeutic modalities. Only clinically appropriate services will be provided, and you may ask questions or decline any procedure.

8. Expected Benefits, Material Risks & Alternatives

Expected benefits. Chiropractic care is intended to improve joint motion and function and may reduce pain, muscle tension, or related symptoms. Results cannot be guaranteed.

Common or temporary effects. Soreness, stiffness, fatigue, dizziness, headache, bruising, or a temporary increase in symptoms may occur.

Less common or serious risks. These may include sprain/strain, aggravation of an existing condition, disc injury, fracture (especially with weakened bone), nerve injury, burns or skin irritation from a modality, and other injury. Serious neurologic injury or stroke after cervical manipulation has been reported and is very rare; the nature and degree of causal association remain debated. Tell the doctor immediately about unusual or worsening symptoms.

Alternatives. Reasonable alternatives may include no treatment, watchful waiting, evaluation by another chiropractor or other health professional, physical therapy, medication, injection, surgery, or another treatment approach. Choosing no care or delaying referral may allow a condition to persist or worsen.

Clinical judgment and referral. The doctor will determine whether proposed care is appropriate based on the available history, examination, and imaging. C1 Spine Lab may modify care or refer you when a condition appears outside chiropractic scope, training, or experience.

9. X-Ray & Modality Safety

X-rays. If imaging is recommended, the doctor will explain its purpose. X-rays involve ionizing radiation. C1 Spine Lab uses clinical judgment and reasonable exposure reduction. Inform us before imaging if pregnancy is possible.

Shortwave diathermy / therapeutic heat. Do not receive this therapy over or near metal or electronic implants, a pacemaker, malignancy, active bleeding, severe circulation or sensation impairment, acute infection, open wounds, or pregnancy. Remove metal jewelry and clothing items as directed and report excessive heat immediately.

PEMF / BEMER or other electrical modalities. Disclose pacemakers, defibrillators, neurostimulators, drug pumps, other active implants, pregnancy, serious cardiac conditions, bleeding risk, malignancy, or other major medical conditions before use. Device-specific precautions will be reviewed when applicable.

Your choice You may ask questions at any time, request an explanation of a recommended procedure, refuse a particular procedure, or withdraw consent for future care. Withdrawal does not affect care already provided.

10. Questions for the Doctor

Questions or concerns you want addressed before care _____

_____

_____

11. Self-Pay Financial Agreement

C1 Spine Lab is self-pay. The clinic does not bill, verify benefits, file claims with, or accept assignment from commercial insurance, Medicaid, workers' compensation, or other third-party payers. Payment is due at service unless a written arrangement is approved.

Payment is due when services are provided unless C1 Spine Lab approves a written payment arrangement. I remain responsible for all charges, including accident-related care, regardless of insurance, settlement, or reimbursement.

Fees are explained before non-emergency services. An itemized receipt is available on request; I am responsible for submitting it to any payer and C1 Spine Lab does not promise reimbursement.

Unpaid balances may be collected as permitted by law. I will promptly raise questions about a charge.

12. Notice of Privacy Practices

I acknowledge that C1 Spine Lab offered me its Notice of Privacy Practices, which explains permitted uses of health information and my privacy rights.

☐ I would like a paper copy.

For office use only if acknowledgment is not obtained ☐ Patient/representative declined to sign or acknowledge ☐ Emergency/other good-faith reason: _____ Staff initials/date: _____

13. Minor Patient / Personal Representative

Complete only when someone signs for the patient.

Representative's printed name:	Relationship / legal authority:
If patient is under 18: ☐ Parent ☐ Legal guardian	Best phone number:

As parent or legal guardian, I authorize the evaluation and care described in this packet and will follow the clinic's adult-accompaniment policy.

14. One Master Acknowledgment & Signature

By signing, I confirm that my information is accurate; I consent to Sections 7–10; I accept the self-pay terms; and I acknowledge the Privacy Notice. I may ask questions or withdraw consent for future care.

Patient or authorized representative signature:	Date:
Printed name:	Patient date of birth:
Important Seek emergency care for severe or rapidly worsening symptoms. Signing does not waive legal rights or release negligent care.	

15. Start Here — Choose One Path

Complete the common packet first. Every motor-vehicle patient completes Pages 1–5. Then follow only the path selected below. Do not complete the page for the other path.

16. Accident & Claim Information

Accident date:	Accident location (city / state):
Your auto carrier:	Your claim number (if known):
Other driver / liability carrier (if known):	Liability claim number (if known):
Adjuster name (if known):	Adjuster phone / email (if known):
Health coverage: ☐ None ☐ Yes — plan name: _____	MedPay: ☐ No / unknown ☐ Yes — limit if known: _____

17. How Will You Handle the Claim?

☐ **PATH A — I am handling the claim myself.** I do not currently have an attorney. Review Page 6; no additional signature is required. I will provide claim updates and submit clinic receipts or records to the insurer myself.

☐ **PATH B — I have hired an attorney.** Skip Page 6. Complete the attorney information below and ask the attorney or firm to complete and sign Page 7 before deferred payment is approved or continued.

Attorney / law firm (Path B only):	Attorney phone / email:

18. Common Payment Direction & Limited Authorization

C1 Spine Lab is self-pay and does not bill, verify benefits, negotiate with, or promise payment by an insurer. The clinic may provide itemized statements and records. I remain responsible for all charges even if a claim is denied, delayed, reduced, closed, or produces no recovery.

I direct any attorney or other person holding my injury-claim proceeds to pay C1 Spine Lab's verified accident-related balance from my share of the recovery, up to the amount due. If an insurer sends treatment-related funds directly to me, I will notify the clinic and pay the outstanding balance within 10 business days. This direction does not transfer control of my legal claim.

I authorize C1 Spine Lab to disclose the minimum accident-related records, imaging reports, diagnoses, treatment dates, bills, and balances to the insurers, adjusters, responsible parties, or attorney identified above for documentation and payment. This authorization expires when the claim is resolved or two years after my last treatment, whichever is later, and may be revoked in writing except for prior reliance.

By signing, I select the checked path, confirm that I have read the applicable page, accept Sections 15–18 and the applicable Path A or Path B terms, and request any clinic-approved deferred payment. I will notify C1 Spine Lab within five business days if my claim, insurer, attorney, settlement status, or receipt of proceeds changes.

Patient / authorized representative signature:	Date:
Printed name:	Patient date of birth:

PATH A. Self-Represented / Direct Insurance Handling

For patients without an attorney If you selected Path A on Page 5, review this page and keep a copy. You do not need to complete another signature. If you later hire an attorney, notify C1 Spine Lab and have the attorney complete Page 7.

A1. What C1 Spine Lab Will Provide

- An itemized statement, receipt, or reasonably requested accident-related record, subject to applicable record fees and privacy rules.
- A current balance when requested so you can accurately communicate with an insurer or adjuster.
- Written confirmation of any payment received or any clinic-approved reduction or payment arrangement.

A2. What You Agree to Do

- Submit bills, receipts, records, and claim forms to the insurer yourself. C1 Spine Lab does not manage or negotiate your insurance claim.
- Give the insurer complete and accurate clinic information and ask it not to issue a settlement that omits known outstanding treatment charges.
- Tell C1 Spine Lab within five business days of a liability decision, settlement offer, claim closure, payment, change of adjuster, or attorney retention.
- If treatment-related funds are paid to you, protect and apply those funds to the verified clinic balance within 10 business days.
- Do not agree that the clinic reduced, waived, or released its balance unless C1 Spine Lab gives written approval.

A3. Optional Direct-Payment Request

Your request to the insurer Where the applicable policy and law permit, you request that benefits or claim payments designated for C1 Spine Lab services be issued directly to C1 Spine Lab. This request does not require the clinic to file a claim, accept insurer rates, or wait indefinitely for payment, and it does not guarantee that the insurer will pay the clinic directly.

A4. Deferred-Payment Limits

Any deferred payment must be approved by C1 Spine Lab in writing. It is not insurance billing or a promise to seek payment only from a settlement. Deferral ends after 18 months unless extended in writing, or earlier if the claim is denied, closed, abandoned, or resolved. The verified balance is then due within 30 days unless a written payment plan is approved.

A disputed amount must remain protected while the dispute is resolved. This agreement does not itself perfect a Georgia statutory lien; C1 Spine Lab may separately use lawful contractual or statutory remedies. A chiropractic lien under O.C.G.A. §§ 44-14-470 through 44-14-477 attaches to the injury claim, not to the patient's other property, and requires separate statutory steps.

Important The other driver's insurer is not your health insurer and may not pay medical bills as treatment occurs. Do not assume that a claim number, adjuster contact, or settlement discussion guarantees payment.

PATH B. Attorney / Firm Acknowledgment

Complete only when the patient selected Path B.

Client / patient:	Accident date:
Attorney name:	Law firm:
Attorney phone / email:	Claim number (if known):

Purpose The client directed payment of C1 Spine Lab's verified accident-related balance from the client's share of any recovery. C1 Spine Lab may rely on this acknowledgment when deciding whether to postpone collection.

By signing, the attorney and law firm acknowledge receipt of the client's direction and agree, to the extent permitted by applicable law and professional-conduct duties, to:

- Notify C1 Spine Lab if representation ends and when the claim settles, closes, or proceeds are received.
- Request a current itemized balance before disbursing the client's share of recovery.
- From client funds actually controlled by the firm, pay the undisputed verified balance and protect any disputed amount until lawfully resolved.
- Not reduce, waive, or release the clinic balance without C1 Spine Lab's written agreement.

Limits. This is not the attorney's personal guaranty, indemnity, or agreement to advance expenses. It applies only to client recovery funds actually received or controlled by the attorney or firm and remains subject to superior liens, lawful fees, court orders, and professional duties. If no recovery is received, the attorney and firm owe no payment from their own funds.

Attorney signature:	Date:
Printed name / law firm:	Georgia Bar no.:

Clinic Use Only — Georgia Protection Tracking

Compliance warning These signatures do not perfect a statutory lien. If the clinic elects that route, Georgia counsel should confirm every current notice, health-insurance submission/rejection, filing, and deadline requirement.

First accident-related treatment date:	90-day filing deadline reviewed:
Health coverage: ☐ None ☐ Yes	If yes, claim submitted / rejected dates:
15-day advance notice sent (date / method):	Recipients / delivery proof retained:
Gwinnett County filing / instrument no.:	Patient county filing / instrument no.:

Internal references: O.C.G.A. §§ 44-14-470 through 44-14-477. Retain notices, delivery proof, verified filings, insurer rejection, balances, payment communications, and any written reduction or release.