Georgia Sports Chiropractic

Please Print Clearly

Name: _____
Last First MI

"**Preferred Name**" to be called by: _____

Email: _____

Address: _____
Street City State Zip

DOB: _____ Age: _____ Sex: _____ SSN#: _____

Please check a box for the preferred # to call to confirm or reschedule appointments:

☐ Home# _____ ☐ Cell# _____ ☐ Work# _____

Occupation: _____ Employed By: _____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Chief Complaint:

1. Please describe how the injury/pain started:

2. Please describe current pain and any other symptoms:

3. Any previous treatment by another physician for the injury/pain listed above?

4. Any previous accidents or other athletic injuries?

Request for Payment of Benefits to Provider of Care

I hereby authorize _____ Insurance Company/Insurance Administrator to issue payment, by any available method, directly to Georgia Sports Chiropractic for benefits payable under my current policy, as partial or full payment toward professional services rendered. I acknowledge and agree to be personally responsible for any remaining balance of charges not covered by my policy or reduced through insurance negotiations.

Patient Signature: _____ Date: _____

How did you hear about us?:_____ Name of Referral: _____

Have you seen a Chiropractor before? _____ Was it this year? _____ How many times? _____

Name of Previous Chiropractor: _____

Medicines/Allergies:

What medications are you currently taking? (Drug name, dose, and times per day)
Write N/A if you are not taking any at this time:

Social History:

Smoker: ☐ Yes ☐ No If yes, how many packs per week: _____

Alcohol: ☐ Yes ☐ No If yes, how many drinks per week : _____

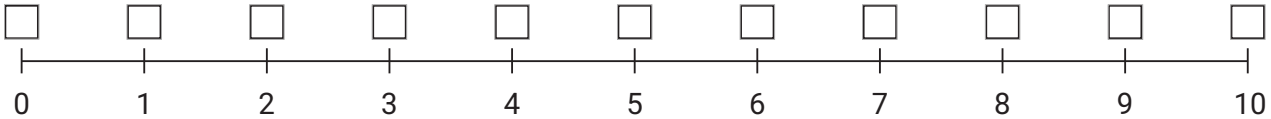
Past Medical History

1. Please list any medical conditions (Current or past) Not including your current injury:

2. Prior surgeries:

Numerical Rating Scale

Place a mark on the line that corresponds to your current pain level:



NO PAIN WORST PAIN EVER

Informed Consent for Treatment

Consent to Treatment I do hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various forms of physical therapy and diagnostic X-rays, upon myself (or upon the patient named below, for whom I am legally responsible). Such services may be rendered by the doctor of chiropractic and/or other licensed doctors of chiropractic who presently, or in the future, practice at the clinic or office listed below, or at any affiliated clinic or office.

Risks and Complications While spinal manipulation/adjustment is widely regarded as one of the safest and most effective therapies for musculoskeletal conditions, I acknowledge that certain risks and complications are associated with these procedures, including but not limited to the following:

- **Soreness:** I acknowledge that, similar to exercise, muscle soreness may occur during the initial course of treatment. I further recognize that bruising and soreness associated with soft tissue therapy are possible, but such effects are temporary and generally resolve within several days.
- **Dizziness:** Temporary symptoms, including lightheadedness, dizziness, and nausea, may occur. Such effects are recognized as common and are generally short in duration.
- **Fractures/Joint Injury:** If osteoporosis, degenerative disc disease, or other abnormalities are identified, this office will exercise heightened caution in the course of treatment. I further acknowledge that, in isolated cases, underlying physical defects, deformities, or pathologies — including weakened bones due to osteoporosis — may render a patient more susceptible to injury.
- **Stroke**: I acknowledge that strokes associated with chiropractic adjustments are rare. Published reports indicate that nerve or brain injury, including stroke, may occur at a frequency estimated between one in one million and one in ten million treatments.

Acknowledgment and Authorization I understand and accept that, as with the practice of medicine and chiropractic care, treatment carries inherent risks, including but not limited to those identified above. I recognize that it is not possible for the doctor to anticipate or disclose all potential risks or complications. I consent to rely upon the doctor's professional judgment in determining the course of treatment, based on the information available at the time, and in my best interest.

I confirm that I have read and understood this consent form, and that I have had the opportunity to ask questions regarding its content. I authorize this consent to extend to the entire course of treatment for my present condition and any future conditions for which I seek care.

Printed Name: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE OR DISCLOSE HEALTH FORMATION

This Notice is provided to you pursuant to federal law, including 45 C.F.R. § 164.520, and sets forth our privacy practices regarding your protected health information ("PHI"). While the law requires this disclosure, please be advised that our practice is committed to maintaining the confidentiality of your PHI at all times

Circumstances under which your PHI may be used or disclosed include, but are not limited to, the following:

- Disclosure to another health care provider or hospital when necessary for purposes of diagnosis, assessment, or treatment of your medical condition.
- Disclosure of PHI and billing records to third parties who may be legally or contractually responsible for payment of services rendered.
- Internal use of PHI within our practice for quality assurance, compliance monitoring, or other health care operations.

A comprehensive Notice of Privacy Practices, containing a detailed description of permissible uses and disclosures of PHI, is available for your review prior to execution of this consent. We reserve the right to amend our privacy practices as set forth in that Notice. In the event of such amendment, you will be notified in writing either at the time of treatment or by mail. Copies of the Notice are available upon request.

Right to Request Restrictions

You have the right to submit a written request that limits our use or disclosure of your PHI to specific individuals, entities, or organizations. While we are not legally obligated to accept such restrictions, any restriction we do agree to shall be binding upon us.

Right to Revoke Authorization

You may revoke this consent at any time by submitting a written revocation. Such revocation shall not be effective with respect to disclosures made prior to our receipt of your written request. If your authorization was required as a condition of obtaining insurance coverage, the insurer may retain rights to your PHI in connection with claim adjudication or contesting benefits.

ACKNOWLEDGMENT AND CONSENT

I acknowledge that I have read and understand this Notice of Privacy Practices and Consent. I agree to its terms and conditions. A copy of this consent will be provided upon request.

Printed Name: _____

Signature: _____ Date: _____