complete chiropractic
1101 E. 51ST STREET
SAVANNAH GEORGIA
912.354.6767 FAX 912.353.7431

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ________________________________Date ____________SS/IHICI/Patient ID# _____________

First Middle Initial Last

Address__________________________City________________________State ______Zip ________

Sex: ❑ Female ❑ Male Birthdate____________________ E-mail ___________________________

Home Phone (___)_________________Cell Phone (____)_______Work Phone (____) ___________

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for years

Patient Employer/School Occupation____

Employer/School Address__________________City________________State _____Zip___________

Spouse or parent's name Employer Work Phone (_____) ____________________________________

Whom may we thank for referring you to us? ____

Person to contact in case of emergency ______________________ Phone (____) _______________

Responsible Party

Name of person responsible for this account ____

Relationship to patient Phone (___)____

Address________________________________City__________________State______Zip________

Name of employer____________________________ Work Phone (___) ______________________

Insurance Information

Name of insured Relationship to patient ____

Birthdate ______________Social Security # ___________________Date employed ______________

Name of employer___________________________________ Work Phone (__________)__________

Address _____________________________________City _______________________State ______

Insurance Co. Phone (____) __________Group # ____________________Employer # ____________

Insurance Co. Address____________________ City__________________ State ______ Zip_______

How much is your deductible?_________How much have you used?_____Max. annual benefit?_____

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured Relationship to patient____

Birthdate_______________Social Security #__________________________Date employed

Name of employer ___________________________________Work Phone (_____) ________________

Address_________________________________City______________ State_____________ Zip________

Insurance Co. Group #__________________________Employer #___________________

Insurance Co. Address__________________________City____________________State_______Zip___

How much is your deductible?_________How much have you used?______Max. annual benefit? ______

Symptoms

Reason for visit When did you first notice the symptoms?____

Is this condition getting progressively worse? ____

Where specifically is the problem(s) located? ____

Which activities are difficult to perform?❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting

❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?____

What treatment have you already received for your condition? _____________________________________

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other ______________________

Name and address of other doctor(s) who have treated you for your condition:___________________________

Health History

Check only those conditions which are applicable:

❑ AIDSIHIV
❑ Alcoholism
❑ Allergy Shots
❑ Anemia
❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Bleeding Disorders
❑ Breast Lump
❑ Bronchitis
❑ Bulimia
❑ Cancer
❑ Cataracts
❑ Chemical Dependency
❑ Chicken Pox
❑ Depression
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Fractures
❑ Glaucoma
❑ Goiter
❑ Gonorrhea
❑ Gout
❑ Heart Disease
❑ Hepatitis
❑ Hernia
❑ Herniated Disc
❑ Herpes
❑ High Cholesterol
❑ Kidney Disease
❑ Liver Disease
❑ Measles
❑ Migraine Headaches
❑ Miscarriage
❑ Mononucleosis
❑ Multiple Sclerosis
❑ Mumps
❑ Osteoporosis
❑ Pacemaker
❑ Parkinson's Disease
❑ Pinched Nerve
❑ Pneumonia
❑ Polio
❑ Prostate Problems
❑ Prosthesis
❑ Psychiatric Care
❑ Rheumatoid Arthritis
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Stroke
❑ Suicide Attempt
❑ Thyroid Problems
❑ Tonsillitis
❑ Tuberculosis
❑ Tumors, Growths
❑ Typhoid Fever
❑ Ulcers
❑ Vaginal Infections
❑ Venereal Disease
❑ Whooping Cough
❑ Other

Dates of last exams____

(*Women*) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

List any types of surgeries which you have had and the dates which they occurred:

Please list all medications you are currently taking: ______________________________

Allergies: ____

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)____

What vitamins do you currently take?_____________________________________

What kind of other nutritional supplements do you take (if any)?_________________________

Do you smoke? ❑ No ❑ Yes How much per day?______________________________

How much liquor do you consume on a weekly basis? ___________________________

How much coffee or caffeinated beverages do you consume on a daily basis?________________

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with_________________________

Name of Insurance Company(ies)

and assign directly to Dr._______________________all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ____________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ____________________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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ASSIGNMENT OF BENEFITS AND PROMISE TO PAY FOR SERVICES

I hereby assign all my medical benefits available for the services rendered below to the undersigned Doctor. I will direct payment of these services rendered to this office address, I also authorize the information necessary to process this claim to be released to the company processing this claim. This same information cannot be released to an outside consultant working to evaluate my claim without my expressed written consent. I also acknowledge that I am wholly responsible for any difference in payment between the insurance benefits and the total health care bill for the services rendered, I have agreed with this provider of health care to make payment to him on this balance of aforementioned services, I understand that I am responsible for any costs of collection if I fail to pay my bill, including but not limited to, court costs, attorney fees and certified letter expenses, Photocopies of this Assignment of Benefits and Intent to pay the Doctor are considered to be true and correct as the original agreement drafted by both the Doctor his patient.

As a courtesy to our patients we will be happy to file patient claims to their insurance companies but we are not required to, This does not guarantee that the insurance companies will pay these charges. There have been inconsistencies with different insurance agencies in the past. We strongly urge you to contact your insurance company and verify the coverage as well. Any unpaid claims or balances are the patient's responsibility, We will also verify insurance coverage as a courtesy to you, If you have any questions or need to set up a payment plan, please do not hesitate to ask.

Thank You,
Dr. Neal & Dr. Berkman

______________________________ ______________________
Signature Of Patient Date

______________________________ ______________________
Signature Of Doctor Date

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PRIVACY NOTICE

Complete Chiropractic is committed to maintaining the privacy of your protected health information (PHI) which includes information, about your health condition and the care and treatment you receive from us.

Consent- Complete Chiropractic may use and! or disclose your PHI provided that it first obtains a valid consent signed by you. The consent will allow BNC to use and/ or disclose your PHI for the purpose of:

Treatment- In order to provide you with the health care you require, NCWR will provide your PHI to those health care professionals. Whether on Complete Chiropractic's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, another physician treating you for low back pain needs to know that results of your latest physician examination by this office.

Payment- In order to get paid for services provided to you, Complete Chiropractic will provide your PHI to insurance companies who request it. For example, Complete Chiropractic may need to provide Medicare with information about health care services that were received in this clinic so that we can be properly reimbursed. Complete Chiropractic may also need to talk to your insurance plan about treatment you will receive so that it can determine whether or not it will cover that treatment expense.

Healthcare Operations- In order for Complete Chiropractic to operate with applicable law and insurance requirements and order for NCWR to continue to provide quality and efficient care, it may by necessary for us to compile, use and or disclose your PHI. For example, Complete Chiropractic may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

No Consent Required- Complete Chiropractic may use and/or disclose you PHI without a written consent from you in the following instances:

De-Identified Information: Information that doesn't identify you.

Business Associate: To a business associate if Complete Chiropractic obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is entity that assists us in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to Insurance companies or other payers.

Personal Representative: To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situation: For the purpose of obtaining or rendering emergency treatment to you provided that we attempt to obtain your consent as soon as possible, or to a public or private entity authorized by law or by charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Communication Barriers: If an inability to communicate occurs and we have been unable to obtain your consent in the exercise of our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

Public Health Activities: Such activities include, for example, information collected by public health authority, as authorized by law, to prevent or control disease.

Abuse, Neglect, Domestic Violence: If Complete Chiropractic is authorized by law to make such a disclosure; it will do so if we believe that the disclosure is necessary to prevent serious harm .
- Receive a paper copy of this Privacy notice form upon request
- Complain to Dr. Neal or Dr. Berkman if you believe your privacy right have been violated. To file a complaint with NCWR you must contact Dr. Neal or Dr. Berkman

To obtain more information on, or have your questions answered, you can contact the office staff, Dr. Neal, or Dr. Berkman.

NCWR's, REQUIREMENTS:
Is required by Federal Law to maintain the privacy of your PHI and to provide you with this Notice. Complete Chiropractic Is required to maintain a higher level of confidentiality with respect to certain portions of your medical information.

ACKNOWLEDGMENT FORM-
I have received notice of Privacy practice for Complete Chiropractic and I have been provided an opportunity to review it

Name: ________________________________ Signature:____________________________________Date: ________

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ACCIDENT QUESTIONNAIRE

Date:_________________________________

Injured Party: ___________________________

Member ID Number:______________________

Date of Occurrence:______________________

Dear ____,

(Patient)

In order to update our records and complete claims processing we are asking that you complete this questionnaire concerning your injuries.

Thank you for assisting our efforts in providing quality service,

Briefly describe the cause of injury: (e.g., location of accident/how it happened)

Name of other Insurance Company (e.g., auto, homeowners, workers camp)

Insurance Company
Address:____

(Street) (CIty) (Zip)

Policy Holder Name:______________________ Policy #_______________ Claim # _________

If you have retained an attorney, please provide the following Information:

Attorney Name:____

Address: ____

(Street) (CIty) (Zip)

Telephone Number: (_____) ___________________________

Identity of other parties who may be responsible for the injuries:

Name: Telephone Number:(_____) ___________________________
Address:____
Name of Insurance Company: _________________________Telephone Number:(______)_____
Insurance Company Address: ____

(Street) (CIty) (Zip)

Policyholder Name: ______________________Policy Number:___________________________
Adjuster Name: __________________________Claim Number:___________________________

_______________________________________ ____________________________

Signature of Patient Date

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INFORMED CONSENT IN THE STATE OF GEORGIA

The Medical Practice Act of 1987 regulates the practice of medicine in the state of Georgia. This act governs physicians licensed to practice medicine in all of its branches as well as Chiropractic Physicians who are licensed to treat human ailments without the use of drugs and without operative surgery. Patient care provided by physicians including Chiropractic physicians has known risks, which may include death, brain damage, quadriplegia, the loss of function of any organ or limb or disfiguring scars associated with such care and treatment. For your information the following is routinely furnished to all that consider Chiropractic in this clinic.

Nature And Purpose Of Chiropractic Procedures

The practice of Chiropractic includes many standard examinations, orthopedic and neurological testing, palpation, specialized instruments, laboratory tests, radiological examinations, physical therapy and related rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession. The Chiropractic Spinal Adjustment/Adjustments are made by Chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the Vertebral Subluxation Complex. This condition exists where one or more vertebrate in the spine is misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in Chiropractic health care is the removal of nerve interference caused by such subluxations. There is a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A Chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of a vertebra. Not only should you understand the benefits of Chiropractic in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom to contraindicate care, but should be considered in making the decision to receive Chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with some Chiropractic procedures may include musculoskeletal sprain, neurological deficits, osseous fracture, vertebral artery syndrome, including stroke and perhaps death through complicating factors.

AUTHORIZATION FOR CHIROPRACTIC CARE

By reading this letter I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care and the risks of the care,including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of care and treatment. I have read the above paragraphs. I understand the information provided. The information provided has been explained to me and all questions, which I have asked, have, been answered to my satisfaction. Having this knowledge, I knowingly authorize Dr. John T. Neal or Dr. Kevin A. Berkman to proceed with Chiropractic care and treatment.

Month of _________Day of _____Year of_____

____
Patient Signature

____
Doctors Signature

When a patient is a minor: Patient _____years of age. Patient's Name:__________________

Signature of Authorized person: ______________________Relationship to patient:_________

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Dear Patient,

We are not required to file patient claims to their insurance companies. Although, as a courtesy to our patients we will be happy to do so. This does not guarantee that the insurance companies will pay these Charges. We will also verify insurance coverage as a courtesy to you.

Complete Chiropractic strongly urges you to contact your insurance cartier verify coverage as well.

There have been inconsistencies with different insurance agencies in the past.

As of October 1, 2005, we will begin applying all charges to the patient if we have been unsuccessful in obtaining payment from your insurance company after 90 days. Any unpaid claims or balances are the patient's responsibility. If payment has not been made or arrangements have not been made, your bill will be given to our collection agency after 120 days. If you have any questions or need to set up a payment plan, please don't hesitate to ask.

It we are unable to verify your insurance at the time of service, you will be required to pay $50.00 before you leave. This will be applied toward any amount due by you for future visits (deductible, copay. etc ...)

Thank you,
Dr. John Neal & Dr. Kevin Berkman

Patient Signature:____Date: ___________

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I,____________________hereby authorize Complete Chiropractic to use and/or disclose to my general health practitioner, my referring physician, my attorney, my spouse and/or other family members the following specific health information: (Please check the appropriate boxes)

_____Complete Medical Record _____ X-Ray Reports ____________________Other

2. I understand this authorization is valid for five years from the date signed or until I revoke it in writing.

3. Please list anyone that you <u>DO NOT</u> want your protected health information disclosed to:

____

4. I acknowledge this authorization is voluntary.

5. I understand the authorizer may revoke this authorization in writing at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have an effect on disclosures occurring prior to the execution of any revocation.

6. I understand the information used or disclosed pursuant to this the recipient may be subjected to disclose authorization again. This information will no longer be protected by federal privacy regulations.

7. I understand my health care and payment for my healthcare will not be affected if I do not sign this form.

8. I understand t I may get a copy of this form after I sign it, if I ask for it.

9. I certify all of my questions were answered to my satisfaction, and I understand this authorization form and all of its contents.

Month of ____________________Day of _____Year of_____

__________________________________	__________________________________
Patient Name	Patient Signature
__________________________________	__________________________________
Signature of Legal Representative	Relationship

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What to Expect After a Chiropractic Adjustment

If you've been experiencing back pain, aches, migraine headaches and other physical, ailments that are affecting your health and well-being, it may be time to see a chiropractor. Chiropractic doctors work to restore spinal alignment; a misaligned spine may be triggering the pain reactions you are experiencing, and the chiropractor can work on different areas of the back and muscle groups to improve the condition.

While the adjustment process itself isn't very painful, many people experience some effects for hours and days after the treatment. Dental braces often hurt worse due to realignment and change being greatest in the beginning. The adjustment creates change that the body has to learn to adapt to. Here's what you can expect after your first chiropractic adjustment:

Common Effects After a Chiropractic Adjustment

There are dozens of different types of chiropractic adjustments that can be performed, and the chiropractor may not even touch the area that is causing pain. This is because chiropractors work primarily on the spinal column, and will manipulate and massage only the areas that are connected to the problem areas. The adjustment is often responsible for triggering the following responses and effects:

- Muscle aches
- Soreness
- Muscle tenderness
- Slight swelling
- Redness

You should not see any visible bruises, or significant swelling that lasts for more than 24 hours after the treatment. Adjustments that have not been performed properly may result in excessive swelling of the tissues, soreness and tenderness. If you do experience any of these problems in the post-treatment phases, you should make an appointment to see the chiropractor immediately for an evaluation.

Please sign stating that you have read and understand the above

______________________________ ______________________

Signature Of Patient Date