Welcome To Back In Motion Chiropractic

PATIENT INFORMATION

Today's Date__________
Last Name__________
First Name__________
Middle Name __________
SS#__________
Address__________
City__________
State __________ Zip__________
E-Mail __________
Sex ☐ M ☐ F Age__________
Birth Date____/____/____
☐ Single ☐ Married ☐ Widowed ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ___years
Occupation__________
Employer/School __________
Language: ☐English ☐Spanish ☐Other:__________
Race: ☐Afr. Amer.☐Asian ☐Caucasian ☐Other:__________
Ethnicity: ☐ Hispanic/Latino ☐Other:__________
Spouse's Name__________
Birth Date____/____/____
SS# __________
Spouse's Employer__________
How did you hear about our office? __________

INSURANCE

Who is responsible for this account? __________
Relationship to patient __________
Insurance Co. __________
Subscriber's Name__________
Birth Date ____/____/____ SS#__________
Subscriber ID #__________
Group #__________
Is the patient covered by additional insurance?
☐ Yes ☐ No Insurance Co. __________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named insurance company and assign directly to Kenneth C. Morris, D.C., DACBSP 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.

Kenneth C. Morris, D.C., DACBSP 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 payable for related services.

____
Signature of Patient, Parent, Guardian, or Personal Rep.

____
Printed name

____
Date Relationship to patient

PHONE NUMBERS

Home Phone (____)__________
Cell Phone (____)__________
Best time and place to reach you__________

IN CASE OF EMERGENCY, CONTACT

Name__________
Relationship__________
Home Phone (____)__________
Cell Phone (____)__________

ACCIDENT INFORMATION

Is condition related to an accident ☐ Yes ☐ No
If Yes, Please obtain additional form from receptionist

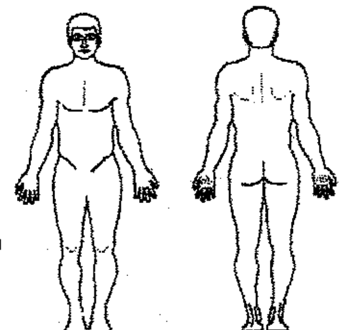
Type ☐ Auto ☐ Work ☐ Home ☐ Other
Date of accident __________

To whom have you made a report of your accident
☐ Auto Insurance ☐ Employer ☐ Worker Comp.

PATIENT CONDITION

Reason for visit__________
When did your symptoms appear?__________
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Rate the severity of your pain on a scale from 0 (No Pain) to 10 (Severe Pain) ____
Type of Pain: Mark all that apply ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling
How often do you have this pain? __________
Is it constant or does it come and go? __________
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities that are painful ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Please mark on the picture where your symptoms are located



PLEASE COMPLETE THE BACK SIDE OF THIS FORM

HEALTH HISTORY

What treatment have you already received for this condition?

☐ Medications ______

☐ Surgery ______

☐ Physical Therapy Name of Therapist ______ Phone Number (____)______

☐ Chiropractic Services Name of Chiropractor ______ Phone Number (____)______

Name of any other doctor you have seen for this condition ______ Phone Number (____)______

Date of last: Physical Exam______ Spinal X-Ray______ Blood Test______ Spinal Exam______

Chest X-Ray______ Urine Test______ Dental X-Ray______ MRI, CT Scan, Bone Scan______

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
ADD/ADHD	☐Yes ☐No	Diabetes	☐Yes ☐No	Miscarriage	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	Emphysema	☐Yes ☐No	Mononucleosis	☐Yes ☐No	Stroke	☐Yes ☐No
Alcoholism	☐Yes ☐No	Epilepsy	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No	Suicide Attempt	☐Yes ☐No
Allergy Shots	☐Yes ☐No	Fractures	☐Yes ☐No	Mumps	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Anemia	☐Yes ☐No	Glaucoma	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Anorexia	☐Yes ☐No	Goiter	☐Yes ☐No	Pacemaker	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Anxiety	☐Yes ☐No	Gonorrhea	☐Yes ☐No	Parkinson's Disease	☐Yes ☐No	Tumors/ Growths	☐Yes ☐No
Appendicitis	☐Yes ☐No	Gout	☐Yes ☐No	Pinched Nerve	☐Yes ☐No	Typhoid Fever	☐Yes ☐No
Arthritis	☐Yes ☐No	Heart Disease	☐Yes ☐No	Pneumonia	☐Yes ☐No	Ulcers	☐Yes ☐No
Asthma	☐Yes ☐No	Hepatitis	☐Yes ☐No	Polio	☐Yes ☐No	Vaginal Infections	☐Yes ☐No
Bladder Problems	☐Yes ☐No	Hernia	☐Yes ☐No	Prostate Problem	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Bleeding Disorder	☐Yes ☐No	Herniated Disc	☐Yes ☐No	Prosthesis	☐Yes ☐No	Whooping Cough	☐Yes ☐No
Breast Lump	☐Yes ☐No	Herpes	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Other Medical History ______	
Bronchitis	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No		
Bulimia	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No		
Cancer	☐Yes ☐No	Kidney Infection	☐Yes ☐No				
Cataracts	☐Yes ☐No	Liver Disease	☐Yes ☐No				
Chemical Dependency	☐Yes ☐No	Measles	☐Yes ☐No				
Chicken Pox	☐Yes ☐No	Migraine Headaches	☐Yes ☐No				
Depression	☐Yes ☐No						

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking: ☐Never ☐Former ☐Current: Packs/Day______
☐ Alcohol Drinks/Week______
☐ Coffee/Caffeine Drinks Cups/Day______
☐ High Stress Level Reason______

Are you pregnant? ☐ Yes ☐ No Due Date______ **Menopause?** ☐ Yes ☐ No Began on:______

INJURIES/ SURGERIES

DESCRIPTION **DATE**

Falls ______

Head Injuries ______

Broken Bones ______

Dislocations ______

Surgeries ______

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
______	______	______
______	______	______
______	______	______
______	______	______

PLEASE REVIEW AND SIGN ALL ATTACHED POLICY FORMS

Auto Related Accident

Name:____________________ Today's Date:____________________

Date & Time of accident:____________________am/pm

Were you the:

☐ Driver ☐ Front Passenger ☐ Rear Passenger

If a traffic violation was issued, to whom was it issued?

____

Number of people in your vehicle?____________________

Did the police come the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing your seatbelt? ☐ Yes ☐ No

Was the vehicle equipped with air bags? ☐ Yes ☐ No

If yes, did they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest?

☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact?

☐ Another vehicle Other:____________________

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, please describe:____________________

____

Make & Model of the vehicle you were occupying:____________________

____

Name & location / street on which you were traveling:

____

In which direction were you headed?

☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle?____________________

Did the impact come from the:

☐ Front ☐ Rear ☐ Right ☐ Left Other:____________________

During the impact, were you facing

☐ Forward ☐ Right ☐ Left

Were you: ☐ Aware of ☐ Surprised by the impact

If accident vehicle made impact with another vehicle:

Make & Model of the other vehicle:____________________

Direction the other vehicle was heading

☐ N ☐ S ☐ E ☐ W

Approx. speed of the other vehicle:____________________

In your words, please describe the accident:____________________

____

____

____

After Injury

Did the accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? ____________________

Please describe how you felt immediately after the accident:

____

____

Have you gone to a Hospital or seen any other Doctor?

☐ Yes ☐ No

When did you go? ☐ Immediately ☐ Next day ☐ 2+ days

How did you get there? ☐ Ambulance ☐ Private Transport

Name of Hospital and/or Attending Doctor: ____________________

____

Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S

Describe any treatment you received: ____________________

____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury?

☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw Problems
☐ Nausea	☐ Arm/Shoulder Pain	☐ Memory Loss
☐ Irritability	☐ Back Pain	☐ Headache(s)
☐ Fatigue	☐ Numb Hands/Fingers	☐ Stomach Upset
☐ Chest Pain	☐ Blurred Vision	☐ Back Stiffness
☐ Leg Pain	☐ Shortness of Breath	☐ Neck Pain
☐ Buzzing in Ear	☐ Ear Ringing	☐ Neck Stiffness
☐ Low Back Pain	☐ Numb Feet/Toes	☐ Tension

Other:____________________

Is your condition getting worse?

☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Please Continue on the Back

Indicate the degree of comfort while performing the following activities

	Comfortable	Uncomfortable (even if only sometimes)	Painful
Lying on Back	☐	☐	☐
Lying on Side	☐	☐	☐
Lying on Stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Recovery

To evaluate the effect that continuing work will have on your recovery phase, please complete the following:

How many hours are in your normal work day? ___________

Please indicate your daily job duties and any activities which you are occasionally asked to perform:

☐Standing ☐Driving ☐Operating Equipment
☐Sitting ☐Twisting ☐Typing
☐Walking ☐Crawling ☐ Bending
☐Lifting ☐Stooping ☐Work w/arms over head

Other:______________________________________

What positions can you work in with minimum physical effort and for how long?______________________________

____

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No

Attorney

Have you retained an attorney? ☐Yes ☐No

If so, whom? ______________________________

His/ Her phone number:__________________________

Additional Insurance

Type of insurance: ____________________________

Company Name:_______________________________

Address:_____________________________________

____

Phone #:_____________________________________

Insured's name:_______________________________

Insured's SS#:________________________________

D.O.B.______________________________________

Policy #:____________________________________

Claim #:____________________________________

Insured's Employer:____________________________

Agent's Name:_________________________________

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember that you are ultimately responsible for your account.

____

Signature Date

Back In Motion Chiropractic
Electronic Health Records Intake Form

In compliance with requirements for the government EHR program

First Name:__________________________ **Last Name:**__________________________

DOB: ___/___/______ **Gender (Circle one):** Male / Female **Preferred Language:** ___________________

Email address: ____________________________________@__________________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date:________________

Back In Motion Chiropractic
Kenneth C. Morris, D.C., DACBSP
Andrea Fjeldahl, D.C.
10515 Bells Ferry Rd Suite 100
Canton, GA 30114

Financial Policy

In order to accommodate the needs and requests of our patients, Back In Motion Chiropractic is contracted with numerous insurance companies. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending upon the type of contract your employer negotiated with that carrier on your behalf.

Providing quality chiropractic care for our patients is our primary concern.
We are happy to provide care for our patients, within their insurance contract guidelines, but we ask that our patients come prepared at the time of service to let us know what those guidelines are. In most of our contracts, Back In Motion's personnel are not permitted to interpret insurance benefits for the patient. We are expected and obligated to provide quality care to each insured person, but it is **the insured person's responsibility to understand their benefits.**

Should your insurance company require a **specialist referral** from your primary care physician before you can be seen by our physicians, it is your responsibility to obtain that referral **prior to your appointment.** You should bring the referral with you to your appointment. Our contracts with the insurance companies prohibit us from seeing you without a referral and billing them for the services. If you are seen without a referral, **you must be prepared to pay for all services in full at the time they are rendered.** *If a referral is required and you are unsure how to obtain one, please let the staff know and we will be happy to provide assistance.*

If you do not inform us of any special requirements in your insurance contract, *such as referrals or preauthorization for treatment,* and we subsequently order services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day, or if your contract contains a pre-existing clause, your insurance carrier will probably deny payment for services received and you will be responsible for paying for the denied services.
Please remember that you, the patient, are ultimately responsible for payment on your account.

Payment is expected on the day services are rendered. In the event that credit is granted, it shall be paid promptly in accordance with terms and agreements. Back in Motion Chiropractic may add one and one half percent (1 ½ %) per month to any balance owed and in the event of default to pay reasonable collection charges and/or attorney fees may also be applied.

All treatments and services rendered at Back In Motion Chiropractic will be billed according to our contracts with the insurance companies. **The act of waiving deductible, co-insurance, and co-pay amounts is strictly prohibited.** According to our insurance contracts as well as well as the insured's, if you have an insurance policy that covers chiropractic services, we are required to bill the services to the insurance policy. You may not elect to not use your insurance benefits. We are required to bill "self-pay" patients and insurance policies the same rates for all services.

With your cooperation and help, you should be able to receive all of the insurance benefits offered to you, and we will be able to concentrate on caring for your chiropractic needs.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO FINANCIAL RESPONSIBILITY AS DESCRIBED.

____ ____________________________
Patient/Guardian Signature Date

If Guardian, print name of patient ____

Back in Motion Chiropractic
Kenneth C. Morris, DC, DACBSP
Andrea Fjeldahl, D.C.
10515 Bells Ferry Rd, Suite 100
Canton, GA 30114

MISSED APPOINTMENT POLICY

Our appointment policy will include a charge of $30.00 for a missed appointment with **NO NOTICE GIVEN** to the office prior to any given time.

When possible, a notice of 24 hours is appreciated.

____ ____________________

Patient/Guardian Signature Date

If Guardian, print name of patient __________________________________

Back In Motion Chiropractic

Kenneth C. Morris, D.C., DACBSP

Andrea Fjeldahl, D.C.

10515 Bells Ferry Rd, Suite 100
Canton, GA 30114

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request had been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and agree to these policies and procedures.

______________________________ ____________________

Patient/Guardian Signature Date

If Guardian, print name of patient______________________________

Back In Motion Chiropractic

Kenneth C. Morris, DC, DACBSP
Andrea Fjeldahl, D.C.
10515 Bells Ferry Rd Suite 100
Canton, GA 30114

Release of Information Authorization

Patient Name:____

I hereby authorize release of my personal medical information to the following individual(s):

______________________________ ______________________
Name Relationship

______________________________ ______________________
Name Relationship

______________________________ ______________________
Name Relationship

______________________________ ______________________
Name Relationship

I hereby authorize the release of personal medical information on my voicemail at the following numbers:

(_____)_____-_______ (_____)_____-_______ (_____)_____-_______

This authorization will remain in effect until further notice and it is my responsibility to update this authorization if any contact information should change.

______________________________________ __________________
Patient/Guardian Signature Date