



## Welcome

**OUR COMMITMENT:** to help you get well as soon as possible.

**OUR MISSION:** to provide the highest degree of quality care in a professional, ethical, and caring environment.

**OUR VISION:** to educate, motivate and assist you and your family to achieve optimal health.

Please complete this form as accurately as possible to help us to help you.

### **YOUR REGISTRATION INFORMATION**

<b>TODAY'S DATE:</b>		
<b>Name:</b>	<b>Date of Birth:</b>	<b>Age:</b>
Social Security Number:	<input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D
Street Address:		Apt #:
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Email:		
Occupation:	Employer:	
Name of Spouse:		
Children and Ages:		
1. _____	2. _____	
3. _____	4. _____	
How did you hear about our office?		
Please choose how you would like to receive reminders and practice updates/newsletters.		
<input type="checkbox"/> Email	<input type="checkbox"/> Text Message	<input type="checkbox"/> Call: _____ <input type="checkbox"/> Please do not email or text

### **YOUR HEALTH INFORMATION**

Reason for your visit today?
Date of onset?
What makes this worse?
What makes this better?
Is this condition getting: <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes
Is this condition interfering with: <input type="checkbox"/> Daily Routine <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Exercise

Have you had similar problems in the past:  Yes  No

If yes, when:

Have you had previous chiropractic care:

Yes

If yes, which Dr/ practice?

No

Other doctors who treated this condition:

**Surgery(s) Date(s):**

- 1.
- 2.
- 3.
- 4.

**Auto Accidents(s) Date(s):**

- 1.
- 2.
- 3.
- 4.

**Trauma / Falls / Fractures:**

- 1.
- 2.
- 3.

**Work or Personal Injuries:**

- 1.
- 2.
- 3.

**LOCATION OF PAIN:**

Please mark area & type of pain on the drawing using the codes listed below.

N-Numbness

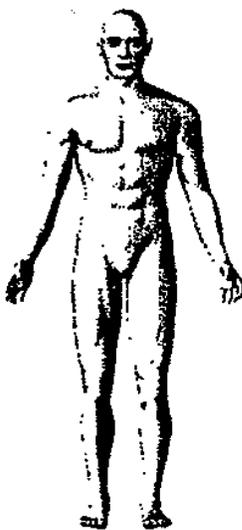
P-Pain

T-Tingling

A-Ache

S-Soreness

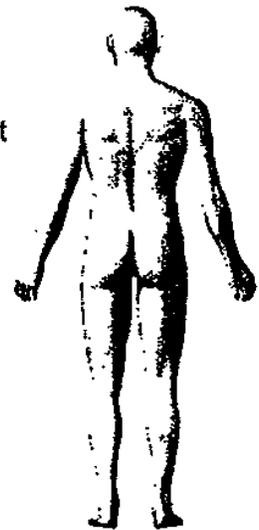
ST-Stiffness



Left



Left





**HAVE YOU HAD OR NOW HAVE ANY OF THE FOLLOWING CONDITIONS:**

- |                                    |  |   |   |   |
|------------------------------------|--|---|---|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Anemia         | <input type="checkbox"/> Respiratory disorder |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Chest Pain    | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Nervousness    | <input type="checkbox"/> Digestive disorder   |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Foot/Knee/Shoulder   | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Female problems      |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Mental Disorder      | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Male problems        |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Skin Problems        | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Thyroid              |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Lyme          | <input type="checkbox"/> Nutritional Problems | <input type="checkbox"/> Fibromyalgia   | <input type="checkbox"/> COVID                |

**Others:**

**DESCRIBE:**

**YOUR FAMILY HISTORY**

	Back	Neck	Arthritis	Heart	Cancer	Diabetes	Other
Mother	<input type="checkbox"/>						
Father	<input type="checkbox"/>						
Brother	<input type="checkbox"/>						
Sister	<input type="checkbox"/>						

**YOUR PERSONAL HABITS**

**MEDICATIONS:**  Pain     Arthritis     Muscle Relaxers     Anti-depressants  
 Sleep     Acid Reflux     Diabetes     Birth Control  
 Asthma     Heart     Cholesterol     High Blood Pressure  
 Thyroid     Lyme     Other:

**VITAMINS AND SUPPLEMENTS:**  Multiple Vit/Min     B Complex     Vitamin A     B1     B6     B12  
 C     D     E     K     CoQ10     Chondroitin/Glucosamine     MSM     Fish Oil     Calcium  
 Iron     Potassium     Magnesium     Other:

**DIET:** Do You Eat: *Fruits*  Yes  No    *Veggies*  Yes  No    *Fish*  Yes  No  
*Fast Food*  Yes  No    *Red Meat*  Yes  No    *Sweets*  Yes  No

Daily Water Intake: \_\_\_\_\_ Oz

Food Allergies:  Yes  No    If yes please describe:

Favorite Foods: \_\_\_\_\_

Are You Presently:  Ketogenic     Atkins     Paleo     Carnivore     Mediterranean     GAPS  
 Vegetarian     Vegan     Gluten Free     Weight Loss Diet     Other \_\_\_\_\_

How would you rate your overall diet? (1 = Poor /10 = Great)



<b>HABITS:</b> Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No Caffeine: <input type="checkbox"/> Yes <input type="checkbox"/> No      Soda: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>EXERCISE:</b> <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Active <input type="checkbox"/> Athlete List type(s) of Exercise: 1. 2.
<b>LIST OF DAILY ACTIVITIES &amp; HOBBIES:</b> 1. 2.
<b>HOW MANY HOURS DO YOU SLEEP? _____</b>  How would you describe the quality of your sleep?
<b>IS YOUR MATTRESS:</b> <input type="checkbox"/> Firm <input type="checkbox"/> Medium <input type="checkbox"/> Soft <input type="checkbox"/> Memory Foam
<b>DO YOU WEAR:</b> <input type="checkbox"/> Heel Lifts <input type="checkbox"/> Arch Supports <input type="checkbox"/> Prescription Orthotics <input type="checkbox"/> Custom Shoes

**YOUR HEALTH GOALS**

<input type="checkbox"/> Atlas Alignment	<input type="checkbox"/> Live a Healthier Lifestyle	<input type="checkbox"/> Feel Better Quickly
<input type="checkbox"/> Nutritional Consult	<input type="checkbox"/> Exercise Program	

\_\_\_\_\_  
**Name-** Patient/Guardian (Please Print)

\_\_\_\_\_  
**Signed -** Patient/Guardian (Signature)

\_\_\_\_\_  
**Date**



## **Financial Policy**

Thank you for choosing us as your chiropractic health care provider. Our goal is to provide you with the highest quality health care with integrity and skill in a caring environment. We want to make your financial arrangements as simple as possible. Please read this *financial policy* and ask us any questions you may have. **Please sign or initial in the spaces provided.**

### **Methods of Payment**

We accept all major credit cards (Amex, Visa, MasterCard, and Discover). Payment is also possible via cash or personal check.

### **Medicare**

- We accept Medicare. Our office will file your Medicare claims on your behalf; full payment is due at the time of service.
- Your charges will be based on the federally mandated Medicare fee schedule. Because we have chosen not to be a Medicare Participating Provider, you will receive reimbursement directly from Medicare.
- Medicare will automatically file your claims with your secondary insurance carrier.
- Please note that Medicare pays for **approved adjustments only**. They do not cover x-rays, CBCT, exams or other therapies. Charges not covered under Medicare will be your financial responsibility.

### **Auto Accident/Personal Injury Claim**

Please provide our staff with all information pertaining to any auto or personal injury claims including but not limited to: insurance company, claim number, adjustor or attorney contact information, and date of injury.

### **Please initial at asterisks\***

\* \_\_\_\_\_ **Payment:** I understand that payment is due at time of service unless other arrangements have been made *prior* to the service rendered.

\* \_\_\_\_\_ **Nonpayment:** Please note that any charges on your account are due at time of service. If you receive a letter regarding overdue unpaid charges on your account, please pay within 14 days to avoid further action.

\* \_\_\_\_\_ **Missed Appointments:** Our office reserves the right to charge \$85.00 for any missed appointments or appointments cancelled without **24 business hours** prior notification.

\* \_\_\_\_\_ **Late Policy:** If you are late by 10 min or more to your appointment, we will have to reschedule you and an \$85.00 fee will be applied.



### **Basic Fee Schedule**

Comprehensive Spine Exam	<b>\$195</b>	Initial Nutrition Evaluation	<b>\$235</b>
Digital x-rays (Per view)	<b>\$75</b>	Nutrition Follow-up	<b>\$85</b>
Office Visit/Adjustment	<b>\$135</b>	Muscle Stimulation Therapy	<b>\$45</b>
CBCT (Cone Beam CT imaging)	<b>\$400</b>	Low Level Laser Therapy (LLLT)	<b>\$45</b>
SoftWave (First visit Mapping \$95)	<b>\$250</b>		

\*Military Discount: Active-duty personnel (10%) on adjustments only.

Please ask the Front Desk for more information.

**I have read and understand the above financial policy. I agree to abide by its guidelines and understand that I am personally responsible for all services rendered to me by the doctors at Spine Arts Center.**

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\_\_\_\_\_  
Patient/Guardian (Please Print)

\_\_\_\_\_  
Patient/Guardian (Signature)

\_\_\_\_\_  
Date

## **Newsletters**

We make it a priority to educate our patients on the benefits of Atlas Orthogonal Chiropractic. We have a monthly newsletter for our patients. We ask that all patients visit our website:

[www.AtlasSpineArtsCenter.com](http://www.AtlasSpineArtsCenter.com) to sign up or for further office information and articles.



## REQUIRED SIGNATURES

### CONSENT TO CHIROPRACTIC HEALTH SERVICES (For new patients)

I consent to receive the following procedures performed by or under the direction of Dr. K. Christine Lim and/or Dr. Garry Krakos.

- Physical Examination
- CBCT
- Chiropractic adjustments
- Physiotherapy
- Nutrition Response Testing

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### RELEASE OF INFORMATION

I authorized Dr. K. Christine Lim and/or Dr. Garry Krakos to release any information or office records to my medical insurance company.

Name of Insurance Company: \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICARE SIGNATURE ON FILE

We are required by law to submit Medicare claims.

Please PRINT your name exactly as it appears on your Medicare Card: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

I request that payment of authorized Medicare benefits be made to me. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services to the Health Care Financing Administration and its agents.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### FEMALE PATIENTS ONLY

This is to certify that to the best of my knowledge I am **NOT** pregnant.

Date of last menstrual period: \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Acknowledgement of Receipt of “Notices of Privacy Practices”

\*\* Privacy Practices may be found on the website by the New Patient Paperwork, or you may ask for a copy during your visit to our office. \*\*

I hereby acknowledge that I have received a copy of this office’s “Notices of Privacy Practices”. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed on the NPP form.

\_\_\_\_\_

Patient/Guardian (Please Print)

\_\_\_\_\_

Patient/Guardian (Signature)

\_\_\_\_\_

Date

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### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our “Notices of Privacy Practices”, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other:

\_\_\_\_\_



## Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email address: \_\_\_\_\_

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

DOB: \_\_\_\_\_ Gender (Check one):  Male  Female Preferred Language: \_\_\_\_\_

Smoking Status (Check one):  Every day Smoker  Occasional Smoker  Former Smoker  Never Smoked

*CMS requires providers to report both race and ethnicity*

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

Ethnicity (Check 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 because of the nature and frequency of chiropractic care.)

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For office use only**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_