Spine Arts Center

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

TODAY'S DATE:			
Name:	**Date of Birth:**		**Age:**
Social Security Number:	☐ Female ☐ Male	Marital Status:	☐S ☐M ☐W ☐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. _____			
Method of Payment: ☐ Self Pay ☐ Medicare ☐ Auto Accident/Personal Injury			
Whom may we thank for referring you to our office?			
Please choose how you would like to receive reminders and practice updates/newsletters. ☐ Email ☐ Text Message ☐ Call:_____ ☐ Please do not email or text			

YOUR HEALTH INFORMATION

Reason for your visit today?
Date of onset?
What makes this worse?
What make this better?
Is this condition getting: ☐ Better ☐ Worse ☐ Constant ☐ Comes and Goes
Is this condition interfering with: ☐ Daily Routine ☐ Sleep ☐ Work ☐ Exercise

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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:

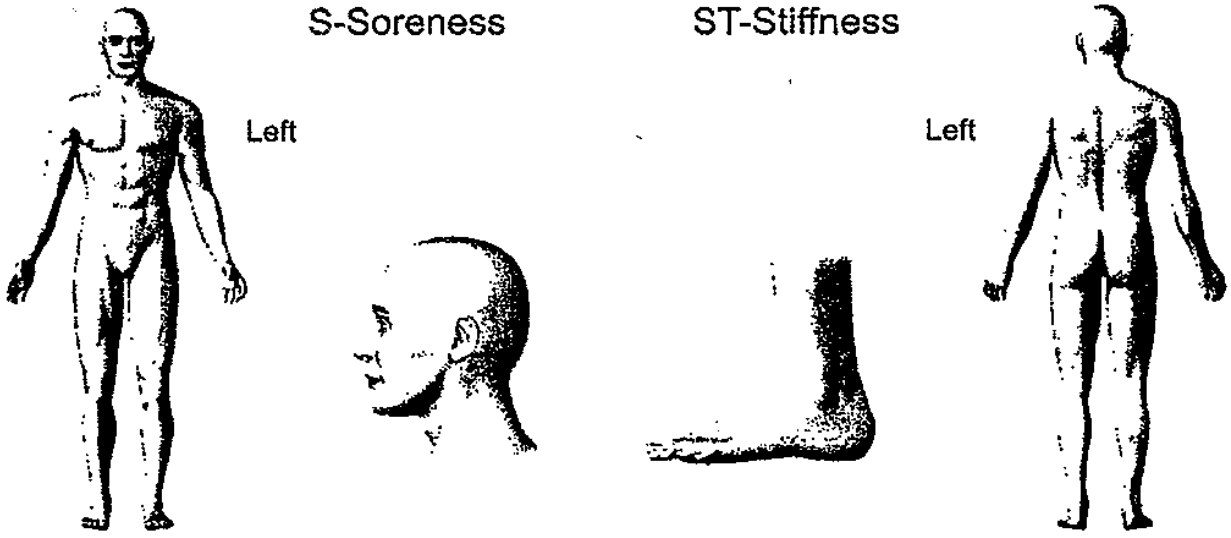
Surgery(s) Date(s): 1. 2. 3. 4.	**Auto Accidents(s) Date(s):** 1. 2. 3. 4.
Trauma / Falls / Fractures: 1. 2. 3.	**Work or Personal Injuries:** 1. 2. 3.

LOCATION OF PAIN:

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

N-Numbness
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness



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

☐ Neck Pain	☐ Heart Disease	☐ Epilepsy	☐ Anemia	☐ Respiratory disorder
☐ Back Pain	☐ Chest Pain	☐ Multiple Sclerosis	☐ Nervousness	☐ Digestive disorder
☐ Scoliosis	☐ Asthma	☐ Foot/Knee/Shoulder	☐ Diabetes	☐ Female problems
☐ Headaches	☐ Arthritis	☐ Mental Disorder	☐ Cancer	☐ Male problems
☐ Migraines	☐ Fatigue	☐ Skin Problems	☐ Sinus Problems	☐ Thyroid
☐ Allergies	☐ Lyme	☐ Nutritional Problems	☐ Fibromyalgia	☐Other:

DESCRIBE:

YOUR FAMILY HISTORY

	Back	Neck	Arthritis	Heart	Cancer	Diabetes	Other
Mother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐

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 in Cups:

Food Allergies: ☐ Yes ☐ No If yes please describe:

Favorite Foods:

Are You Presently: ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Weight Loss Diet ☐ Other

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

HABITS: Smoking*:* ☐ Yes ☐ No Alcohol*:* ☐ Yes ☐ No

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Caffeine: ☐ Yes ☐ No Soda: ☐ Yes ☐ No
EXERCISE: ☐ None ☐ Light ☐ Moderate ☐ Active ☐ Athlete List type(s) of Exercise: 1. 2.
LIST DAILY ACTIVITIES & HOBBIES: 1. 2.
HOW MANY HOURS DO YOU SLEEP? **Hrs** How would you describe the quality of your sleep? IS YOUR MATTRESS: ☐ Firm ☐ Medium ☐ Soft ☐ Memory Foam
DO YOU WEAR: ☐ Heel Lifts ☐ Arch Supports ☐ Prescription Orthotics ☐ Custom Shoes

YOUR HEALTH GOALS

☐ Atlas Alignment	☐ Live a Healthier Lifestyle	☐ Feel Better Quickly
☐ Nutritional Consult	☐ Acupuncture	☐ Exercise Program

_____

Name- Patient/Guardian (Please Print)

_____ **Date:** _____

Signed - Patient/Guardian (Signature)

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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, 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.

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Basic Fee Schedule

Comprehensive Spine Exam	**$185**	Initial Nutrition Evaluation	**$150**
Digital x-rays (Per view)	**$70**	Nutrition Follow-up	**$55**
Office Visit/Adjustment	**$100**	Muscle Stimulation Therapy	**$25**
CBCT	**$300**	Low Level Laser Therapy (LLLT)	**$25**
Initial Acupuncture Evaluation	**$100**	Acupuncture Treatment	**$65**

*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.

_____

Patient/Guardian (Please Print)

_____ Date: _____

Patient/Guardian (Signature)

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 to sign up or for further office information and articles.

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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.
- X-ray(s).
- Chiropractic adjustments
- Physiotherapy.
- Acupuncture.

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: _____

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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)

_____ Date: _____

Patient/Guardian (Signature)

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:

  _____

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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: _____ /_____