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: Monday, March 18, 2019			
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:

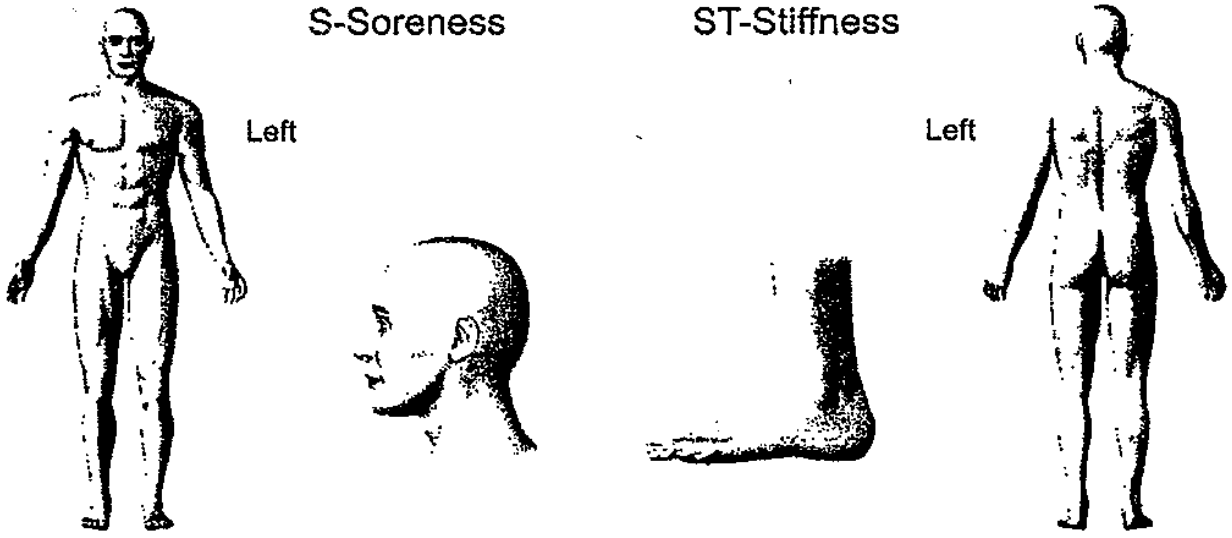
Surgery(s) Date(s): 1. 2. 3. 4.	**Auto Accidents(s) Date(s):** 1. 2. 3. 4.
Trauma / Falls / Fractures: 1. 2. 3.	**Work or Personal Injuries:** 1. 2. 3.

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)*

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HABITS: Smoking: ☐ Yes ☐ No Alcohol: ☐ Yes ☐ No 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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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:_____ /_____

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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.

Care Plans
A Care Plan is available to assist you in paying for your care. Payment in advance for ten adjustments gives you a 10% discount on all care plan covered charges. Purchase of ten visits for a second and third family member provides a discount of 15% and 20% respectively.

Family Plans
A Family Plan is available to provide chiropractic care for the entire family. This is an affordable way to keep everyone in the family in alignment and in optimal health. Ask our staff for details.

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*

***_____ Insurance:** We have chosen not to be in network with private insurance companies. However, our office will submit claims electronically to your insurance company on your behalf. Reimbursement will be paid directly to you from your insurance company based upon your individual policy. It is your responsibility to provide the front desk staff with up-to-date insurance information. There will be a one-time administrative fee of $20.
***_____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 $50 for any missed appointments or appointments cancelled without **24 hours** prior notification.

Spine Arts Center

Basic Fee Schedule

Comprehensive Spine Exam	**$185**	Initial Nutrition Evaluation	**$150**
Digital x-rays (Per view)	**$70**	Nutrition Follow-up	**$45**
Office Visit/Adjustment	**$85**	Muscle Stimulation Therapy	**$25**
Initial Acupuncture Evaluation	**$100**	Low Level Laser Therapy (LLLT)	**$25**
Acupuncture Treatment	**$65**		

*Care Plans and Family Plans are available. Please ask the Front Desk for more information.

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

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)

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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: _____

Spine Arts Center

Acknowledgement of Receipt of "Notices of Privacy Practices"

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:

_____

Spine Arts Center

Notice of Privacy Practices

(PATIENT COPY)

This notice describes how personal health information (PHI) may be used and disclosed and how you can get access to this information. Please review this document carefully. The privacy of your health information is important to us.

Your Rights:

- You can ask to see or get a copy of your health information and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- You can ask us to contact you in a specific way or to send mail to a different address. We will consider all reasonable communication requests, and must say "yes" if you tell us you would be in danger if we do not.
- You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- You can ask for a list of the times we've shared your health information for six years prior to the date you ask. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- You can complain if you feel we have violated your rights by contacting us using the information at the bottom of the page. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov. We will not retaliate against you for filling a complaint.

Your Choices:

- For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.
- In these cases, you have both the right and choice to tell us to: share your information with your family, close friends, or others involved in payment for your care, and share your information in a disaster relief situation. If you are unable to communicate your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission: marketing purposes and sale of your information.

Our Uses and Disclosures:

- We can use your health information and share it with professionals who are treating you.
- We can use and disclose your information to run out organization and contact you when necessary.
- We can use and disclose your health information as we pay for your health services.

- We may disclose your health information to your health plan sponsor for plan administration.
- We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.
- We can use or share your information for health research.
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- We can share health information in response to organ and tissue donation requests and work with medical examiners or funeral directors.
- We can use or share health information about you: for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you can change your mind at any time. Let us know in writing if you change your mind.
- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail you a copy.

Effective Jan 1, 2017

Privacy Office:

Dr. Garry T. Krakos
703-644-2222
info@atlasspineartscenter.com