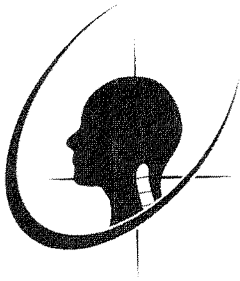


ATLAS SPINE AND BALANCE

855 Sunset Dr., Suite 4 • Athens, GA • 706-543-5212

APPLICATION FOR CARE

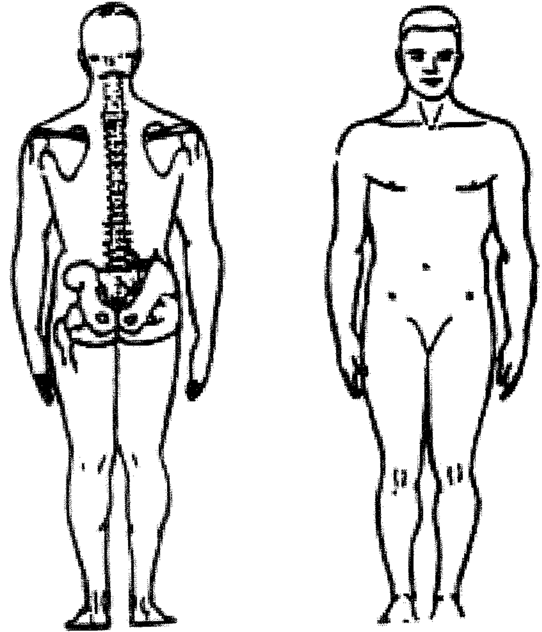
PATIENT: ______________________________ DATE: __________

Address: ______________________________________ Home Phone: ____________________
City __________________ State _____ Zip ___________ Work Phone: ____________________
Email: ____ Cell Phone: ____________________
SSN # _______-____-_______Birthdate _____/____/_______ Marital Status: S M W D

Who do we need to thank for the referral? ____
Your Employer ________________________ Occupation ___________________ Years on Job______
Employer Address _____________________________ City ______________ State ____ Zip_________
Do you have Medicare? Yes____ No____
Emergency Contact: ______________________________________ Phone:___________________
Name of Primary Care Physician: ______________________________ Phone:___________________

COMPLETE THESE DIAGRAMS

If you are in pain, please mark the approximate location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity that brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.



PRIMARY COMPLAINTS

____

____

____

Is your condition due to an accident? Yes____ No____
Date of Accident __________________
Type of Accident? Auto _____ At Work ____ At Home _____
Other
____

Have you ever been in an Auto Accident?
Past Year ___ Past 5 Years ___ Over 5 Years___ Never___

I (we) agree to pay for services rendered to the above patient as charges are incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that If I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable.

Payment will be made via: Cash • Check • Credit Card (circle one: M/C Visa Amex Disc)

Patient or Guardian Signature ____________________________________ Date ________________

Notice to new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Review of Systems

Patient Name: ______________________ Patient File #: ___________ Today's Date: _____/_____/_____

INSTRUCTIONS: Please fill out all the sections. If none of the conditions apply, select "None."

Constitutional:
- ☐ **None**
- ☐ Chills
- ☐ Daytime Drowsiness
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Eyes/Vision:
- ☐ **None**
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Itching *(around the eyes)*
- ☐ Photophobia
- ☐ Tearing
- ☐ Wears Glasses or Contacts

Ears, Nose and Throat:
- ☐ **None**
- ☐ Bleeding
- ☐ Dental Implants
- ☐ Dentures
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dizziness
- ☐ Ear Drainage
- ☐ Ear Infection*(s)*
- ☐ Ear Pain
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injury *(history of)*
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Rhinorrhea *(runny nose)*
- ☐ Sinus Infections
- ☐ Snoring
- ☐ Sore Throats
- ☐ Tinnitus *(ringing in the ears)*
- ☐ TMJ Disorder

Cardiovascular:
- ☐ **None**
- ☐ Angina *(chest pain or discomfort)*
- ☐ Chest Pain
- ☐ Claudication *(leg pain or achiness)*
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Orthopnea *(difficulty breathing while lying)*
- ☐ Palpitations *(irregular or forceful heartbeat)*
- ☐ Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- ☐ Shortness of Breath
- ☐ Swelling of Leg*(s)*
- ☐ Ulcers
- ☐ Varicose Veins

Gastrointestinal:
- ☐ **None**
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice *(yellowing of the skin)*
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber *(quality)*
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool
- ☐ Consistency Vomiting
- ☐ Vomiting Blood

Respiration:
- ☐ **None**
- ☐ Asthma
- ☐ Coughing up blood
- ☐ Shortness of Breath
- ☐ Sputum Production
- ☐ Wheezing

Endocrine:
- ☐ **None**
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Skin:
- ☐ **None**
- ☐ Changes in Nail Texture
- ☐ Changes in Skin Color
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia (numbness, prickling, or tingling)
- ☐ Rash
- ☐ History of Skin Disorders
- ☐ Skin Lesions or Ulcers
- ☐ Varicosities

Nervous System:
- ☐ **None**
- ☐ Dizziness
- ☐ Facial Weakness
- ☐ Headaches
- ☐ Limb Weakness
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors
- ☐ Unsteadiness of Gait

Allergy:
- ☐ **None**
- ☐ Anaphylaxis *(history of)*
- ☐ Food Intolerance
- ☐ Itching
- ☐ Nasal Congestion
- ☐ Sneezing

Hematology:
- ☐ **None**
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusion*(s)*
- ☐ Bruises easily
- ☐ Fatigue
- ☐ Lymph Node Swelling

Psychological:
- ☐ **None**
- ☐ Anhedonia *(inability to experience joy or enjoy life)*
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Change*(s)*
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Mood Change*(s)*

Female:
- ☐ **None**
- ☐ Birth Control Therapy
- ☐ Breast Lumps / Pain
- ☐ Burning Urination
- ☐ Cramps
- ☐ Frequent Urination
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Are you pregnant?
Yes / No

Male:
- ☐ **None**
- ☐ Burning Urination
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy or Dribbling
- ☐ Prostate Problems
- ☐ Urine Retention

Patient Signature:____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: ________________________ __________

Doctor Signature Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic, x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by **Atlas Spine and Balance** who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic: **Evan Greller D.C..**

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named herein and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment at **Atlas Spine and Balance.**

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Printed Name of Patient	Date of Birth
Signature of Patient	Date
Signature of Patients' Representative (if physically incapacitated)	Date
Witness to Patients' Signature	Date
Translated by	Date

Atlas Spine and Balance
855 Sunset Dr. Suite 4
Athens, GA. 30606

(706) 543-5212

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

PERMITTED DISCLOSURES:

1. Treatment purposes: Discussion with other health care providers involved in your care. 2. Inadvertent disclosures: Open treating areas mean open discussion, if you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room. 3. For payment purposes: To obtain payment from your insurance company or any other collateral source. 4. For Personal Injury purposes: To process a claim or aid in investigation.
5. Emergency: In the event of a medical emergency we may notify a family member listed on your Application For Care.
6. For public health and safety: In order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. Telephone calls, texts or emails and appointment reminders: We may call your home and leave messages regarding a missed appointment or update you of changes in practice hours or upcoming events.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. ______Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

• You may request a restriction on the use or disclosure of your Protected Health Information. • This office may or may not agree to restrict the use or disclosure of your Protected Health Information. • If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

____

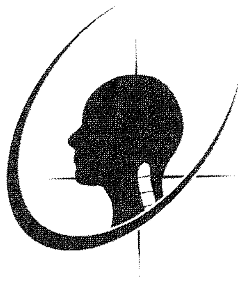
Patient or Legally Authorized Individual Signature   Date

____

Print Patient's Full Name   Time

____

Witness Signature   Date



ATLAS SPINE AND BALANCE

855 Sunset Dr., Suite 4 • Athens, GA • 706-543-5212
Evan M. Greller, D.C.

OFFICE FINANCIAL POLICY

❑ Payment is due at time of service rendered, acceptable in the form of cash, check, or major credit cards.

❑ This office may make payment plan arrangements on an individual basis. Any such plan will be discussed during your report of findings.

❑ We do not accept assignment; you are responsible for your entire bill. We are not a mediator between you and your insurance company and will not enter into any dispute with same, as your contract is between you and your insurance company.

❑ We do not accept assignment for Medicare but will file claims to Medicare for patient's reimbursement.

❑ If patient discontinues care for any reason other than discharged by the doctor, the full balance on the account is due immediately; regardless of any previous payment plans arranged.

❑ Our initial charge for the FIRST visit ranges from $125 to $425, dependent upon the number of x-rays the doctor will have to take. Treatments thereafter will be either a $55 or $70 charge, determined by the regions of the spine the doctor adjusts for that appointment. Additional therapies range from $25 to $85. Re-evaluation fees range from $55 to $70. Any additional x-rays taken during treatment will be $50 for each x-ray taken.

❑ If you have questions concerning this or any other matter, please speak with the receptionist prior to seeing the Doctor.

❑ FAILED APPOINTMENTS AND LATE CANCELLATIONS. When you have a scheduled appointment, the time has been reserved especially for your care. If you need to cancel or reschedule your appointment, we require at least a 24-hour notice to avoid a charge for our lost time. The amount charged for missed appointments and late cancellations is $45. This charge must be paid prior to scheduling another appointment.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature: ______________________________ Date: ______________________

Authorization for the Release of Medical Records

Patient Name: ______________________________ Date of Birth: ____________________

Please Print

I hereby request and authorize:

Atlas Spine and Balance
855 Sunset Drive, Suite 4
Athens, GA. 30606
(Ph) (706) 543-5212 (706) 850-8373 (Fax)
info@atlasspineandbalance.com

To Disclose Information to ☐ To Receive Information from ☐

Name/Provider: ____

Address: ____

City/State/Zip: ____

Phone: ______________________ Fax: ______________________

Information to be disclosed includes copies of:

**** ALLOW ACCESS TO PACS**

- ☐ Entire Record
- ☐ Progress Notes
- ☐ Physical Exam Forms
- ☐ Daily Chart Notes
- ☐ All of the above
- ☐ X-ray Reports
- ☐ X-Ray Films Number of Films: ________
- ☐ MRI/Reports
- ☐ Other, specify: ______________________________

The X-ray films represent a part of this patient's permanent records at this office; we require that you return them to our office (if applicable).

This authorization is for services rendered from: ________________ to: ________________.

1. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

2. I understand this authorization will expire in 90 days on ________________.

3. A copy of this authorization shall be considered as valid as the original.

4. Copies of X-ray films can be obtained upon request and will incur a reproduction cost.

Signature of Patient	Date	**OR**	Parent/Legal Guardian/Authorized Person	Date
Records Released to	Date		Relationship to Patient	
Witness	Date			