ATHENS UPPER CERVICAL CHIROPRACTIC

Attached you will find the necessary forms you **must complete** and **bring with you** on your scheduled appointment date. If you cannot fill this form out before your appointment, please arrive 15 minutes early to complete it.
(Please be sure to bring your identification card with you as well.)

**Please DO NOT have any caffeine, sugar, medications (except insulin and other life sustaining medications),
or nicotine, 1-2 hours before your appointment time.
These chemicals can alter the tests that will be performed.**

In the event you are not able to keep your appointment time, we require a minimum of a 24-hour notice of schedule changes. Please call our office as soon as possible so that we may give that appointment to someone on our waiting list. At that time we will gladly reschedule your appointment. *We have set aside special times for our new patient appointments and if you are unable to make it, we can allow another person to fill that appointment.*
Thank you for your consideration. If you have any further questions, please contact our office.

Dr. Adam Cave, and the AUCC Team

Contact Information:

Athens Upper Cervical Chiropractic

Phone: 770-271-8505 Fax:

Email: info@serenityfloatcenterga.com

3651 Mars Hill Rd, Ste.3200, Watkinsville, GA 30677

www.AthensUCC.com

Thank you for choosing our office. We are committed to providing you and your family with the highest quality of chiropractic care available so that you may heal quickly and enjoy an active and healthy, long life. We will be working together to help you and your family reach your health and lifestyle goals. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle throughout your lifetime.

We look forward to helping you and your family members achieve your health goals.

The following information is needed in order to better serve you. Please complete ALL questions.
If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date: _____ Referred by: _____

Name: _____

Cell Phone: _____ Home Phone: _____Office Phone: _____

Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Marital Status: M S W D No. of Children: _____

Occupation: _____ Years on Job: _____

Emergency Contact:

Name: _____ Phone Number: _____

Have you ever been to a Chiropractor? If so, when: _____ Who: _____

What for: _____ Outcome: _____

HEALTH STATUS & HISTORY

WHAT is your ***PRIMARY*** complaint: _____

WHEN did it ***FIRST*** begin: _____

Was it ***gradual*** or ***sudden***? Is it getting ***better*** or ***worse***: _____

Is there anything that makes it ***better***: _____ ***Worse***: _____

HOW would you describe it? *Sharp*? *Dull*? *Achy*? Other: _____

WHERE did it first begin, and does it travel to any other regions of the body? _____

_____

On a scale where 0 is no pain, and 10 is the worst pain you've ever experienced, rate your CURRENT pain level.

1 2 3 4 5 6 7 8 9 10

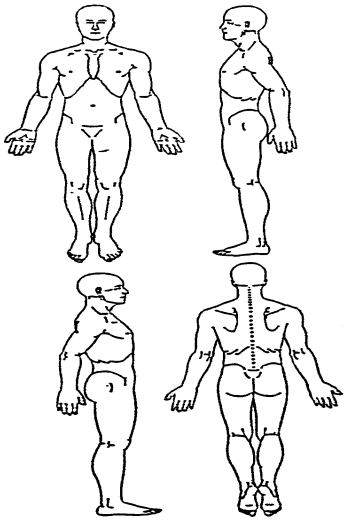
On the same scale, rate your pain at its LOWEST point.

1 2 3 4 5 6 7 8 9 10

At its WORST, how would you rate the pain?

1 2 3 4 5 6 7 8 9 10

Please mark the location of the problem, if you're having physical symptoms:



Stress level overall: Low Medium High Out of this world

List and Describe Other Current Health Problems:

1. _____
2. _____
3. _____
4. _____

Is there anything that these conditions keep you from doing: _____

_____

List ALL SURGERIES/PROCEDURES you have undergone (Include when it occurred and the outcome):

1. _____
2. _____
3. _____
4. _____

Prescription medication may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking (prescription and over the counter)?

1. _____ 2. _____
3. _____ 4. _____

Injuries can cause serious spinal problems. Have you been injured in the past or recently (sports, work, car accidents, cumulative trauma)? If so, please list and give dates:

1. _____ 2. _____
3. _____ 4. _____

Chiropractors are the only doctors trained to analyze, detect and correct Vertebral Subluxations (misaligned vertebrae causing Neurological Dysfunction, thus affecting how your body functions, heals and ages).

Vertebral Subluxations can happen in many ways. Please circle if you have had difficulties with any of the following:

Birth Process (Yours)	Auto Accidents	Trips, Falls
Birthing children (If you're a mom)	Work Injuries	Sickness, disease
Childhood Play	Environmental Toxicity	Other: _____
Growth Spurts	Sports Injuries	_____
Body Weight Changes	Intensive Training	

Are you experiencing difficulties with any of the following functions? Please circle Y or N, **if Y, please explain**.

Bladder/Bowel function	Y or N	_____
Sleep	Y or N	_____
Energy	Y or N	_____
Concentration/Focus	Y or N	_____
Digestion	Y or N	_____
Mood	Y or N	_____
Menstrual Cramps	Y or N	_____
Strength/Balance	Y or N	_____
Flexibility	Y or N	_____
Headaches	Y or N	_____
Allergies	Y or N	_____
Posture	Y or N	_____
Blood Pressure	Y or N	_____
Weight Gain/Loss	Y or N	_____
Vision	Y or N	_____
Memory	Y or N	_____
Sexual function	Y or N	_____

As a result of Chiropractic Care, **MY GOALS ARE**: _____

_____

_____

For Office Use Only

1)_____

_____

_____

2)_____

_____

_____

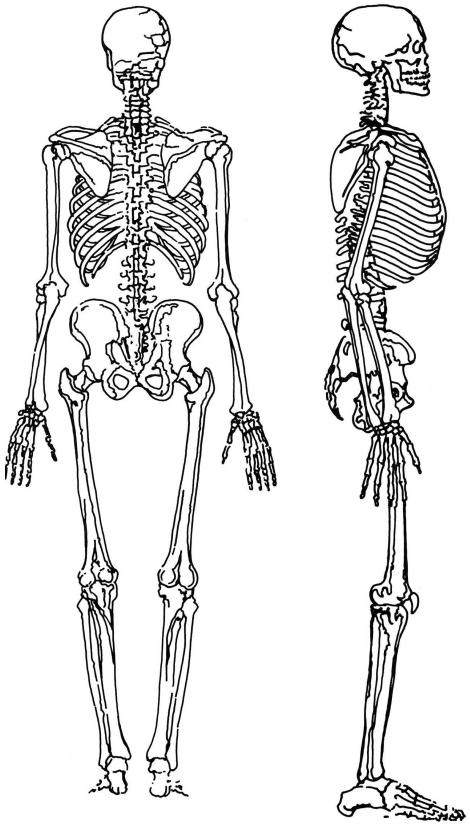
3)_____

_____

_____

Objective:

B/L Weight Scales L:_____ R:_____



TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supportive, open environment.

H. By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) (Date)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications. I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

(Signature) (Date)

X-Ray Imaging Consent

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests.

Patient Consent to X-Ray

I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests and x-rays.

_____ _____

Patient Signature Date

Females Only: Regarding Possibility of Pregnancy

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in any way.

_____ _____

Patient Signature Date

_____ _____

Witness Date

CONSENT FOR TREATMENT OF MINORS

I (We) being parent, guardian or custodian of _____, a minor the age of _____, do hereby authorize, request and direct the doctors and staff at Athens Upper Cervical Chiropractic to perform any exam, x-ray and chiropractic treatment for their condition as he deems necessary.

_____ _____

Parent, Guardian or Custodian Date

_____ _____

Parent, Guardian or Custodian Date

FINANCIAL OFFICE POLICY

1. All patients are on a direct pay basis.

2. The Doctor will give you an estimate of the fees for service before they are performed or rendered.

3. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.

4. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable within 2 weeks, regardless of any claims submitted.

5. This office accepts, Major Credit Cards, Cash and Personal Checks.

6. Patient understands that if they wish to stop care prior to utilizing all credits, any credit remaining will be refunded to the practice member within 2 weeks. Any balance remaining will be due within 2 weeks.

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

_____ _____

Patient Signature Date

Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any healthcare expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

_____ _____

Signature Date

Authorization to Pay/Release Is Granted to:

Athens Upper Cervical Chiropractic
3651 Mars Hill Rd. Ste3200
Watkinsville, GA 30677

INFORMED CONSENT FOR CHIROPRACTIC CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care includes: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another healthcare provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____

Date: _____

CANCELLATION & NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if a cancellation is necessary, you provide more than 24 hour notice. This will enable a person on the wait list to be scheduled in that appointment time.

Cancellations made with less than 24-hour notice are subject to a $50.00 cancellation fee, which is not applied towards your care plan. Patients who do not show up to their appointment without communication will be considered a NO SHOW and will be subject to a $50.00 fee.

The Cancellation and No Show fees are the sole responsibility of the patient and will be charged to the credit card on file.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. In this instance, fees are subject to review by our team and may be waived.

Athens Upper Cervical Chiropractic firmly believes that a good doctor/patient relationship is based upon clear communication respect for all parties involved. Thank you for your understanding and cooperation.

Patient Name: _____ Signature: _____

Date: _____