HEALTH POINT
Chiropractic & Wellness
1720 Mount Vernon RD. Suite B
Dunwoody, GA 30338
678-580-2485

Intake Form

Title: (Circle one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ **Date:** _____

First Name _____**Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** □ Male □ Female

Marital Status: □ Single □ Married □ Other

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Employer Data

Employer _____

Your Occupation _____

Spouse Data

First Name _____ **Middle Initial** ____ **Last Name** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Spouse Date of Birth _____/_____/_____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Fibromyalgia	☐ Asthma	☐ Osteoporosis	☐ Other:

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular Procedure	☐ Cervical Spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar Spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic Spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-Intestinal	☐ Uro-Genital	☐ Hernia
☐ Breast Augmentation	☐ Other:		

Allergies: (Check all that apply to you)

☐ Mold	☐ Seasonal	☐ Milk or Lactose	☐ Animal
☐ Chemical	☐ Sulfites	☐ Wheat or Gluten	☐ Other:

Social History: (Check all that apply to you)

Caffeine Use:	☐ Occasional	☐ Often	☐ Never
Drink Alcohol:	☐ Occasional	☐ Often	☐ Never
Exercise:	☐ Occasional	☐ Often	☐ Never
Drink Water:	☐ <64 Oz/Day	☐ >64 Oz/Day	☐ Never
Cigarettes:	☐ <1 pack/Day	☐ >1 Pack/Day	☐ Never
Sleep:	☐ <8 hours/Night	☐ >= 8 hours/Night	☐ Insomnia
Other:			

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease:	☐ Parent	☐ Sibling
Hypertension:	☐ Parent	☐ Sibling
Stroke:	☐ Parent	☐ Sibling
Thyroid:	☐ Parent	☐ Sibling
Other:		

Occupational Activities: (Check one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Construction	☐ Daycare or Childcare	☐ Healthcare	☐ Food Service Industry
☐ Manual Labor	☐ Executive	☐ Other:	

Patient Name_____Date_____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all current medications being taken _____

_____

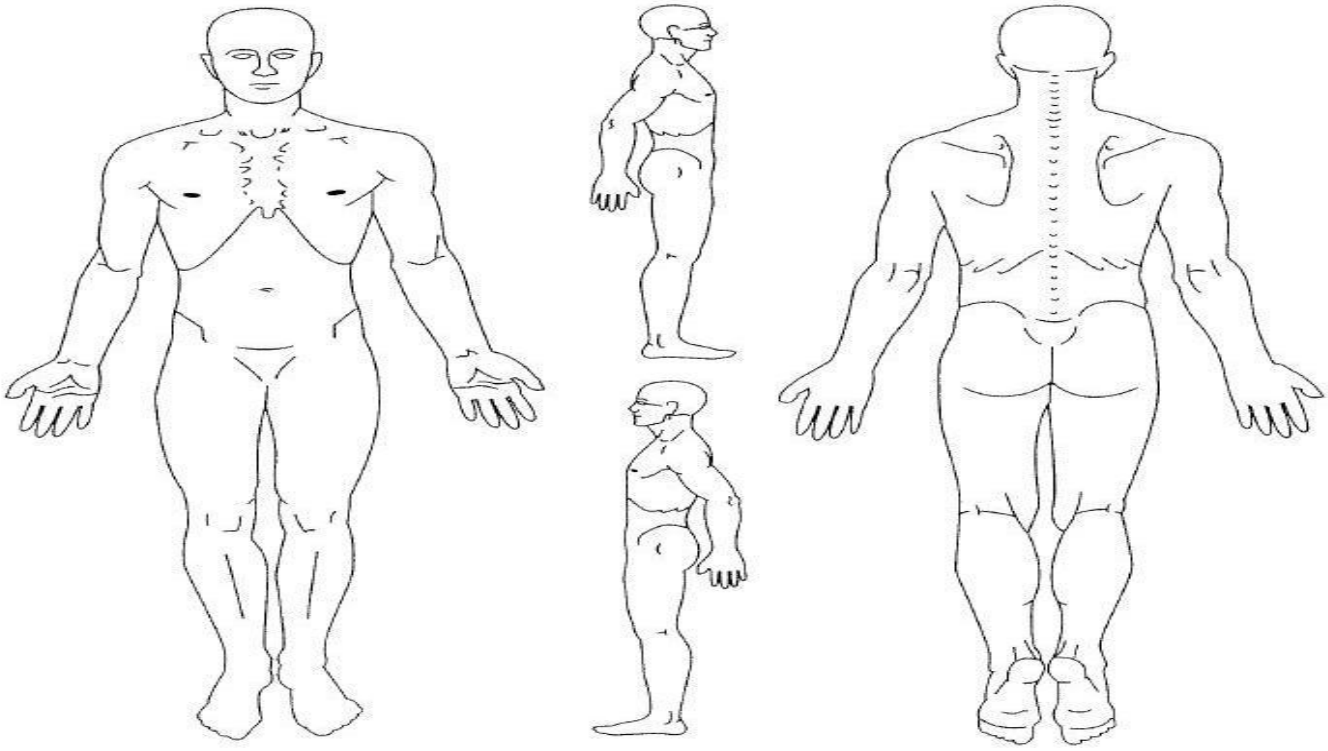
How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

Are You Pregnant? (Check) ☐ **Yes** ☐ **No**

Patient Name_____**Date**_____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



Average Pain Intensity:

Last 24 hours:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain
Past week:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain

Does anything improve your pain? Yes No **If Yes, please list:**_____

When did your symptoms begin? _____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What describes the nature of your symptoms?□

□ Sharp □ Ache □ Numb □ Shooting
□ Burning □ Tingling □ Throbbing □ Other:

Patient Name_____Date_____

Patient Name_____

Patient Phone #_____

Health Point Wellness Center
1720 Mount Vernon RD Ste B
Dunwoody, GA 30338
678-580-2485

It is Health Point Wellness Center's Policy that any cancelations or rescheduling of massages past 2 hours before the massage require the patient to PAY A LATE FEE OF $25. Any cancelations past an hour before the appointment, or missed appointments require the patient to pay Health Point Wellness IN FULL FOR THE APPOINTMENT.

By signing this agreement, the patient agrees to pay these fees if appointments are cancelled after the 2 hour policy, or if the appointment is missed. PATIENTS THEMSELVES ARE LIABLE FOR THIS CHARGE; WE WILL NOT BILL THIS TO INSURANCE REGARLESS OF COVERAGE.

Fees are as listed:

Canceling or Rescheduling:
2 hours or more before the appointment----------No Charge
2 hours or less beforehand----------$25.00
1 hour or less beforehand or no show----------Full Price of Massage

If the patient is late for their massage appointment, that amount of time is removed from their massage. (example: if late 15 minutes for an hour massage, the massage time will now be 45 minutes, but the patient is still required to pay for an hour) Please notify us if running late, or if you need to reschedule to a later time. Late fee may apply for rescheduling

Signature_____Date:_____

Printed Name:_____

Massage Agreement

PAYMENT POLICY

Thank you for choosing Health Point Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, this payment policy was advised. Please read, initial, ask any questions, and sign. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits. _____
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit. _____
3. PROOF OF INSURANCE. All patients must complete a patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. _____
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract. _____
5. COVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you. _____
6. ASSIGNMENT AND RELEASE. I certify that I, and/or my dependent(s), have insurance coverage with the above listed insurance company and assign directly to Health Point Chiropractic Center all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Health Point Chiropractic Center may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. We charge $5 per month for any balance that is over 60 days past due. Any additional charges due to collections will be your responsibility and added to the balance. _____
7. MISSED APPOINTMENT. Our policy is to charge $25.00 after **one** missed appointment not cancelled 2 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment**. _____

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**

PATIENT RECORD OF DISCLOSURES

In general, the HIPPAA privacy rule gives individuals the right to request a restriction on uses and disclosures at their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

○ Home Telephone_____
○ O.K. to leave message with detailed information
○ Leave message with call- back number only

○ Work Telephone
○ O.K. to leave message with detailed information
○ Leave message with call back number only

○ Written Communication
○ O.K. to mail to my home address
○ O.K. to mail to my work/office address
○ O.K. to fax to this number

○ Other_____
_____

Patient Signature

Date

Print Name

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entitles must keep records of PHI disclosures. Information provided below. If completed properly will constitute an adequate rerecord.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Date	Disclosed to whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key T= Treatment Records; P= Payment information O= Healthcare Operations
(3) Enter how disclosure was made F=FAX, P=Phone, E=Email, M=MAIL, O=Other

Informed Consent for Chiropractic Care

A patient, in coming to Healthpoint Chiropractic, gives the doctors of Chiropractic, Tracy Ivy James, D.C. and Thomas Voyda, D.C. permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or healthcare if she is aware that such care may be contradicted. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to attention of the Chiropractor Physician. The Chiropractic Physician provides a specialized, non-duplicating healthcare service.

I understand that if I am accepted as a patient by the physician at Healthpoint Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient
Signature:_____Date:_____

Doctor
Signature:_____Date:_____