WELCOME TO OUR OFFICE

PATIENT: ____
Last Name First Middle Nickname

ADDRESS: ____
House #/Street City State Zip

E-MAIL ADDRESS: ____________________ DATE OF BIRTH: ____________ AGE____

☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed M: _____ F: _____

☐ HOME TELEPHONE: ____________________ ☐ CELL: ____________________
(*Please check appropriate box to indicate the primary phone where you'd like us to contact you*)

SS#: ____________________ # /AGE OF CHILDREN: ____________________

ARE YOU PREGNANT? Y / N DUE DATE: ___/___ OB/MIDWIFE: ____________________

PRIMARY CARE DOCTOR____________________________ LAST SEEN: ____________

REFERRED BY: ____

OCCUPATION: ____________________ EMPLOYED BY: ____________________

SPOUSE: ____________________ EMPLOYED BY: ____________________

NAME OF PRIMARY INSURED: ____________________________ D.O.B: ____/____/______

PATIENT RELATIONSHIP TO PRIMARY INSURED: SELF / SPOUSE / CHILD

PATIENT'S PRIMARY INSURANCE: ____________________ ID#: ____________________

IS YOUR CONDITION RELATED TO WORK INJURY? Y / N AUTO ACCIDENT? Y / N
IF YES, ATTACH WORKMENS'S COMPENSATION OR AUTO INSURANCE INFO.

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? ____________________

PHONE#: ____________________ RELATIONSHIP TO THE PATIENT: ____________________

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Atlas Chiropractic will prepare any necessary forms to assist me in collecting from my primary insurance carrier and that any amount authorized to be paid directly to Atlas Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE: ____________________________ DATE: ____________________

GUARDIAN SIGNATURE: ____________________________ DATE: ____________________

Atlas Chiropractic
179 Hanalei Dr, Suite 3
Morgantown, WV 26508

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:________________________ **Last Name:**________________________

Email: ________________________________ **Primary Care Doctor:** ____________________________

___ **Yes** ____**No** May we send a thank you card to the individual that referred you to our office.

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

Patient Signature: ____ Date: _______________

For office use only
Height: ________ Weight: ________ Blood Pressure: _____/_____ Pulse: _____

ATLAS CHIROPRACTIC, PLLC
179 HANALEI DRIVE, SUITE 3
MORGANTOWN WV 26508
(304) 598-3000

Advanced Beneficiary Notice

On occasion, situations may arise where your insurance (or its administrator for authorization) considers that a service being provided at Atlas Chiropractic is not covered since it is billed by a chiropractor or its not medically necessary in their opinion. I understand that services deemed not medically necessary are not covered by my insurance. It is my choice to receive these service(s) and I am willing to bear the entire cost of these services. I release the provider from having to submit a claim to my insurance for these services.

(98940) CMT 1 to 2 regions	$40	(98943) CMT extremity	$30
(98941) CMT 3 to 4 regions	$50	(99202) Examination	$90
(97012) Mechanical Traction	$18	(99211) OV Brief	$25
(97014) Electrical Stimulation	$20	(99212) OV level II	$40
(S8990) Maintenance EMS	$30	(97110) Therapeutic Ex	$30
(72100) AP/LAT Lumbar Xray	$75	(99429) EMS Maintenance	$20
(72040) AP/LAT Cervical Xray	$70	(97140) Manual Therapy	$7-$30
(97810) Acupuncture	$40	(S8990) CMT Maintenance	$40
(S8948) Cold Laser Therapy	$15	(L3020) Orthotics $147.50	$295

______________________ ______________________

Patient signature Date

____

Print name

ASSIGNEMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photo copy of this assignment shall be considered as affective and valid as the original.

______________________ ______________________

Patient signature Date

RELEASE OF INFORMATION

I authorize any doctor, hospital, employer, to other person to whom a signed or photo-copy of this authorization is delivered to furnish any information, reports or copies of records which may be requested by Atlas Chiropractic or its representatives. I also permit Atlas Chiropractic to release any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case; and hereby release this clinic of any consequence thereof.

______________________ ______________________

Patient signature Date

______________________ ______/______/______

Print name Date of Birth

Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company.

______________________ ______________________

Patient signature Date

Name: ______________________________ **Date:** ______________

CHIEF COMPLAINT:

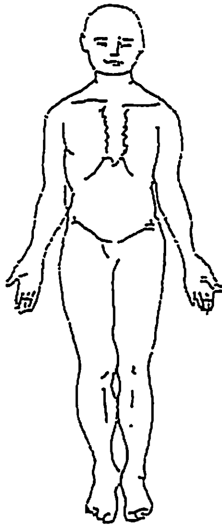
- What is the reason for your visit? ______________________________

HISTORY OF THE PRESENT ILLNESS:

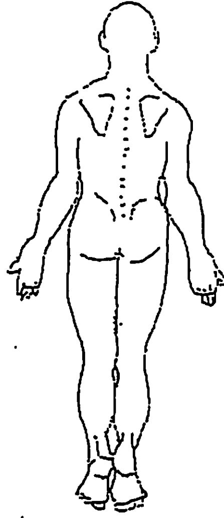
- For how long have you had this symptom or problem? When did it begin? ______________
- What activities have been affected by the condition? ______________
- Is the symptom or problem related to an inciting event, such as trauma, illness or other stress? › Yes › No
  Explain ______________________________
- Do you have pain? ☐ Yes ☐ No Did the pain/problem begin ☐ Gradually ☐ Suddenly
- Describe the pain: (Check all that apply.) ☐ dull ache/cramp ☐ burning ☐ sharp/stabbing ☐ tingling/numbness
  ☐ Other: (Describe) ______________________________

- Please mark the pain diagram below with an "X" to indicate the location of your pain. If the pain spreads, use arrows to indicate the direction in which the pain moves. (Example → → → → .....)

Pain Diagram



FRONT



BACK

- How severe is the pain today? (Circle) What is pain at worst (X)
  Scale: 1 2 3 4 5 6 7 8 9 10
  Tolerable Moderate Excruciating
- How long does the pain last? ☐ Constant ☐ Intermittent
- When does the pain occur?
  - ☐ In early morning upon awakening
  - ☐ At night disturbing sleep
  - ☐ Daytime/during work
  - ☐ Day of month ______________

☐ With movement: ☐ Positional:

☐ Bending ☐ Sitting

☐ Lifting ☐ Standing

☐ Walking ☐ Reclining

- Have you ever had anything like this before? ☐ Yes ☐ No

Explain ______________________________

- What makes the pain worse? ______________ · What makes the pain better? ______________
- Which diagnostic tests have you had for your current problem? (Check all that apply)
  ☐ None ☐ X-rays ☐ MRI ☐ CT scan ☐ Bone scan ☐ Bone Density ☐ Blood Test ☐ EMG
- Which treatments, if any, have you had for your current problem? (Check all that apply)
  ☐ Physical or occupational therapy ☐ Chiropractic therapies ☐ Acupuncture ☐ Joint injections
  ☐ Prescription and/or over-the-counter medications ☐ Herbal supplements ☐ Surgery ☐ Other treatment

- Have you ever been in a jarring accident or injury? ☐ Yes ☐ No Explain: ______________
- Have you ever been in a car accident? ☐ Yes ☐ No Please describe when, size of vehicle(s), and speed involved: ______________

____

MEDICAL / SURGICAL HISTORY:

- Do you have any medical conditions/ problems requiring medication? (Diabetes; heart; asthma; etc) ☐ Yes ☐ No

  List: ______________________________

  ____

- List any previous surgeries and dates.

  ____

  ____

- Have you ever been or currently treated with blood thinners? ☐ Yes ☐ Currently ☐ No

  Explain ______________________________

- Have you ever used or been prescribed steroids? ☐ Yes ☐ No

  If so, what type? ☐ Corticosteroids (cortisone, prednisone, etc.)

  ☐ Anabolic steroids (testosterone, as in body-building, weight-gain, etc.)

FAMILY HISTORY:

- Have any family members (including only blood-relatives) been diagnosed with any of the following illnesses?

  ☐ Heart disease ______________________________

  ☐ High blood pressure ______________________________

  ☐ Stroke ______________________________

  ☐ Diabetes ______________________________

  ☐ Nerve problem ______________________________

  ☐ Cancer ______________________________

  ☐ Genetic or inherited disorder ______________________________

  ☐ Blood disease or Anemia ______________________________

  ☐ Other ______________________________

REVIEW OF SYSTEMS

Patient Name: ______________________________ **Date:** ______________

Are you currently or have you ever experienced any of the following:

Constitutional Systems:	Present	No	Past
Fever / Chills	☐	☐	☐
Weight loss or gain	☐	☐	☐
Fatigue	☐	☐	☐
Night sweats	☐	☐	☐
Skin:			
Rashes or color changes	☐	☐	☐
Itching or dryness	☐	☐	☐
Excessive hair loss	☐	☐	☐
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
Eyes:			
Loss of vision / fluctuating vision	☐	☐	☐
Distorted vision or haloes	☐	☐	☐
Eye pain or soreness	☐	☐	☐
Ears, Nose, Mouth, Throat:			
Hearing difficulty	☐	☐	☐
Ringing or buzzing in ears	☐	☐	☐
Sinus congestion / post-nasal drip	☐	☐	☐
Nosebleeds	☐	☐	☐
Dryness/hoarseness	☐	☐	☐
Cardiovascular:			
Chest pains	☐	☐	☐
Palpations	☐	☐	☐
Leg cramps with walking	☐	☐	☐
Leg swelling / edema	☐	☐	☐
Respiratory:			
Cough	☐	☐	☐
Shortness of breath	☐	☐	☐
Wheezing	☐	☐	☐
Endocrine:			
Heat or cold intolerance	☐	☐	☐
Excessive thirst or hunger	☐	☐	☐
Allergy/Immunology:			
Allergies	☐	☐	☐
Autoimmune / Collagen disease	☐	☐	☐

Gastrointestinal:	Present	No	Past
Difficulty Swallowing	☐	☐	☐
Vomiting / Nausea	☐	☐	☐
Heartburn / Upset Stomach	☐	☐	☐
Constipation	☐	☐	☐
Genito-Urinary:			
Urinary frequency	☐	☐	☐
Urinary pain or burning	☐	☐	☐
Urinary bleeding	☐	☐	☐
Urinary incontinence	☐	☐	☐
Prostate symptoms	☐	☐	☐
Obstetric/Gynecologic:			
Currently pregnant	☐	☐	☐
Breast masses or discharge	☐	☐	☐
Vaginal bleeding, discharge	☐	☐	☐
Musculoskeletal / Rheumatological:			
Joint pain, swelling, redness	☐	☐	☐
Muscle pain or cramps	☐	☐	☐
Neurological:			
Headaches	☐	☐	☐
Numbness or tingling	☐	☐	☐
Weakness or paralysis	☐	☐	☐
Tremor	☐	☐	☐
Balance loss, dizziness / falls	☐	☐	☐

Are you: ☐ Right-handed or ☐ Left-handed

Psychiatric:	Present	No	Past
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Difficulty sleeping	☐	☐	☐
Hematological/Lymphatics:			
Easy bruising / bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusions	☐	☐	☐
Swollen lymph nodes	☐	☐	☐
Lymphedema	☐	☐	☐

Other symptoms not listed above: ______________________________

SOCIAL HISTORY:

- Marital status: ☐ Single ☐ Married ☐ Life Partner ☐ Separated ☐ Divorced ☐ Widowed
- Do you have children? ☐ No ☐ Yes Please list how many & current ages ______________
- Smoking history: › Never smoked › Ex-smoker › Current smoker

  # of packs per day ______ Date started smoking ______ Date stopped ______
- Caffeine consumption: ☐ None ☐ 1 cup/day ☐ 2-3 cups/day ☐ >3 cups/day
- Alcohol consumption: ☐ Never ☐ Occasionally ☐ Frequently ______________
- Any current or prior recreational drug use: ☐ Yes, type ______________ ☐ No

FUNCTIONAL HISTORY:

- Occupation ______________________________
- Are you currently working? ☐ Yes ☐ No

  If no, are you: ☐ Retired (formerly worked as): ______________

  ☐ Worker's Compensation

  ☐ Disabled (Explain) ______________

  ☐ None of the above ______________
- Do you require assistance in your daily activities? ☐ Yes ☐ No

  Please check all that apply below:

  Help with: ☐ bathing, ☐ dressing, ☐ cooking, ☐ cleaning, ☐ food shopping, ☐ laundry,

  ☐ Other ______________________________

  Help from: ☐ family members, ☐ home health aide, ☐ home attendant, ☐ visiting nurse?
- What are your Exercise/Recreational activities & how often, if any? ______________

  ____
- How much water to you drink each day?

  ☐ 12oz glass/bottle – How many per day? ______ ☐ 16oz glass/bottle – How many per day? ______

  ☐ other ______________ – How many per day? _____
- In what position do you sleep?

  ☐ back ☐ stomach ☐ side

  Hours/night ______________

ATLAS CHIROPRACTIC SPINAL CARE PRIVACY PRACTICE
EFFECTIVE APRIL 01, 2003

This notice describes how your health information may be used and disclosed and how you can obtain this information. Please review it carefully.

Protected Health Information (PHI) means any patient information relating to treatment, diagnosis, or payment that identifies a person.

Uses and Disclosures of Protected Health Information

We use PHI when we within our organization share, examine, or analyze a patient's chiropractic information. We disclose PHI when we release, transfer, or give access to PHI to other external persons or facilities. Except for the following circumstances we will not release your PHI without your written authorization.

- **Treatment-** We will use and/or disclose your PHI to provide chiropractic services, coordinate chiropractic care, and or help manage your health care and other medical services. For example, Atlas Chiropractic may discuss your PHI with another physician to better coordinate your chiropractic treatment while as a patient at Atlas Chiropractic. We may also disclose PHI to external persons or facilities that will be involved in your chiropractic treatment. For example, your primary care physician may need to be informed of aspects of the treatment you received here so that appropriate follow-up care is provided for you.
- **Payment** - Your PHI will be used and/or disclosed, as needed, to help obtain payment for your services. These uses/and or disclosures are often required to obtain payment from a third party. For example, your PHI may be released to your health insurance plan to determine which services may require pre-authorization and your PHI may be disclosed to obtain insurance authorization for such services before they are rendered.
- **Health Care Operations** – Your PHI may be used and/or disclosed, as needed, to aid us in everyday running of Atlas Chiropractic. We want to provide you and your family with the best quality of care. In order to help us do so, we may use your PHI for quality control reviews, internal performance reviews, training of new employees, and for other health care related activities. We may also use and/or disclose your PHI to provide information to you. For example; ***Continuation of treatment:*** We may use and/or disclose your PHI to ensure continuation of care by checking on your progress or notifying you of received test results. ***Treatment Options:*** We may use/or disclose your PHI to inform you of various treatment options/programs that may be of benefit to your care. ***Medical Benefit Services:*** We may use/or disclose your PHI to inform you of various medical benefit services in the community that may be of use to you, for example, chiropractic educational classes, health promotion services, and/or insurance benefit programs you may be eligible. ***Birthday Cards/Appointment Notices:*** We may use/or disclose your health information to provide you with an appointment reminder (such as voicemail messages, or leaving a message with a person at your residence, postcards, or letters). ***Open Room Adjusting:*** We may use/or disclose your PHI to treat you in an open adjusting treatment room, which may involve several patients being seen at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not be adjusted in an open-adjusting environment, other arrangements will be made for you. ***Sign In Sheet:*** We will use/disclose your PHI regarding the sign-in sheet. Your signature will appear within eyesight of other patients being treated on the same day.

Other Permitted/Required Uses and Disclosures – We may use and/or disclose your PHI to the appropriate authorities in the following situations without your authorization:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Your Rights Regarding Your PHI

You have the right to receive documentation of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be granted with your written authorization. If you provide a written authorization for release of your health information, you have the right to revoke that authorization in the future.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

You have the right to inspect, amend, and/or copy your health information for as long as the information remains in our files. Requests to inspect, amend, and/or copy your health information are required to be in written form.

We are required by state and federal law to maintain the privacy of your file and the protected health information therein. We are also required to provide you with a copy of this privacy statement. We are also required by law to abide by the terms of this privacy contract.

We reserve the right to alter or amend the terms of this privacy statement. If this privacy statement is amended, we will notify you in writing as soon as possible. Any amendments will apply to all of your protected health information in our files.

If you have a complaint/inquiry regarding our privacy statement or our privacy practices, you should inquire with Dr. Clare McDaniel.

You also have the right to file a complaint with the Secretary of the Department of Health and Human Service. If you choose to file a complaint with this office or the Secretary of HHS, you are entitled to continue care without any discrimination from this office.

This statement is effective as of April 01, 2003. This statement and any amendments made hereto will expire seven years after the date upon which the record was signed. My signature below acknowledges that I have received a copy of this privacy statement.

____________________ ____________________

Printed Name Signature Date

***If you are a minor, or if you are being represented by another person**

____________________ ____________________

Representative's Printed Name Representative Signature Date

____

Description of the authority to act on behalf of the member.

Atlas Chiropractic, PLLC
Informed Consent

Patient Name:	Date:

Chiropractic healthcare is an art and a science that is primarily concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The doctor of chiropractic evaluates the patient using standard examination and testing procedures (such as orthopedic and neurological evaluation, labs, x-rays) along with specialized chiropractic evaluation. The chiropractic evaluation focuses on structural and/or functional abnormalities called "Intersegmental Dysfunction (ISD)". ISD exists when one or more vertebrae in the spine or bones in the extremity are misaligned sufficiently enough to result in damage or irritation to either the nearby nerves, joints, and/or tissues. The primary goal of chiropractic treatment is the removal of ISD. This is accomplished by performing a procedure unique to the chiropractic profession called an "adjustment". A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (e.g. heat, ice, electrical muscle stimulation, soft-tissue manipulation), nutritional recommendations, acupuncture and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed both common and rare side-effects/complications associated with chiropractic care.

One research study indicated that within the first 2 months of care, approximately half of patients report some "reaction" to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care [1]:

- Local discomfort (53%)
- Headache (12%)
- Tiredness (11%)
- Radiating discomfort (10%)

Most appeared within 4 hours of treatment and resolved within 24 hours.

Rare, Yet Possible Side-Effect/Complications

- Rib fracture
- Burns (if certain types of physiotherapy are used in your treatment)
- Disc herniation
- Cauda Equina Syndrome [2] (1 case per 100 million adjustments)

Over->

- Compromise of the vertebrobasilar artery (i.e. stroke) (1 case per 400,000 to 1 million cervical spine adjustments) [3]

In addition to national guidelines [4], our clinic has set criteria for how we manage our patients. Through questioning and examination, we will do our best to determine what risk, if any, chiropractic care may pose to you and advise you of those risks as well as the possible need for medical referral. We may also suggest alternate chiropractic or medical approaches if we detect absolute or relative contraindications to the standard chiropractic treatment.

1. **Senstad O, et al. . Frequency and characteristics of side effects of spinal manipulative therapy. Spine 1997;22:435-41**
2. **Shekelle PG, et al. Spinal manipulation for low-back pain. Ann Intern Med 1992;117(7):590-8.**
3. **Haldeman S, et al. Risk factors and precipitating neck movements causing vertebrobasilar artery dissection after cervical trauma and spinal manipulation. Spine 1999;(24):785-94.**
4. **Haldeman S, et al. Guidelines for chiropractic quality assurance and practice parameters. Aspen Publishers, 1997.**

I have read the previous information regarding risks of chiropractic care and my clinician has explained my risks (if any). I understand the purpose of my care and have been given an explanation of the treatment. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s).

PATIENT'S SIGNATURE ______________________________ **DATE** ______________

PARENT/GUARDIAN'S SIGNATURE ______________________ **DATE** ______________
(if appropriate)

DOCTOR'S SIGNATURE ______________________________ **DATE** ______________

Over->