

CONSENT FOR TREATMENT

Patient Name: _____ Date: _____

All patients in the State Of Georgia are required to approve of all services rendered by their doctor before any services are performed. Refusal to comply with Georgia Law releases your doctor of all liabilities and his/her right to refuse treatment.

I, _____, hereby request and give consent to my doctor to perform all necessary chiropractic examinations, adjustments, therapy, rehabilitation, and medical diagnostic x-rays. I understand that my doctor will consult with me before any procedures are performed, at which time, I will give him permission to perform all necessary procedures to treat my condition.

I understand that during my treatment that care may be rendered by other doctors at Horizon Health Care Group. I understand that I will be made aware of any such circumstances before being treated.

I understand that I have any opportunity to discuss with the doctor and/or with the office manager, the nature and purpose of my chiropractic care before any treatment is rendered.

Patient Signature _____ Date: _____

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patient's SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOUT AUTHORIZES **HORIZON HEALTH CARE GROUP** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- _____ (Initial) I give permission to Horizon Health Care Group to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.
- _____ (Initial) If Horizon Health Care Group contacts me by phone I give them permission to leave a phone message on my answering machine or voicemail.

(OPEN ROOM AUTHORIZATION)

- _____ (Initial) I give Horizon Health Care Group permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for the conversations.
- _____ (Initial) By signing this form you are giving Horizon Health Care Group permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing at anytime. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided service or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Immediate Response. The written notice must contain the following information:

Your name, social security number, and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Immediate Response for its own use/disclosure of PHI.
(Minimum necessary standards apply)

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Birth Date: _____ Age: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____ Sex: M F

Social Security _____ Driver's License No. _____ Email Address: _____

Check One: Married Single Widowed Divorced Separated

Business Employer: _____ Type of Work: _____

Business Address: _____

Name of Spouse: _____ Spouse's Social Security # _____

Type of Work: _____

Business Phone: _____

Names and Ages of Children: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare

Personal Health Insurance (Name) _____ Health Card # _____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

Other Doctors Seen For This Condition: Yes No Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No

Is Condition: Job Related Auto Accident Home Injury Fall Other: _____

Date of Accident: _____ Your Auto Insurance Company: _____ Time of Accident: _____

Have You Made a Report of Your Accident To Your Employer? Yes No

Drugs You Now Take: Nerve Pills Pain Killers / Muscle Relaxers Blood Pressure Medicine Insulin
 Other _____

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and outcome	Year of Birth	Sex of Birth	Complications, if any

Major Accident or Falls: _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos	<p>MEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other:
<p>MUSCLE / JOINT / BONE Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p>WOMEN only</p> <input type="checkbox"/> Abnormal Pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other:
<p>GENTO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			Date of last Menstrual period _____ Date of last Menstrual period _____ Have you had a mammogram? _____ Are you pregnant? _____ Number of Children: _____

CONDITIONS Check (✓) conditions you currently have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
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MEDICATIONS List medications you are currently taking.	ALLERGIES To medications or substances
Pharmacy Name _____ Phone _____	

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize this clinic to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. Furthermore, I understand that the Doctor's Office will assist me in making my collection. I authorize the direct payment to you of any sum, I now or hereafter owe you, by my attorney out of proceeds of any settlement of my case and/or any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me based in whole or in part upon the charges made for your services.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

_____ Date _____

Patient / Guardian Signature

