ATLANTA SPINE CENTER
"Dedicated to your well-being."

Dr. Roberto A. Vargas
Dr. Vicky L. Yarns

OPTIMUM HEALTH THROUGH CHIROPRACTIC CARE

Patient Information

Thank you for choosing our practice for your chiropractic needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

Name _____ Soc.Sec #: _____

Street Address _____ City _____ State _____ Zip _____

Sex: ◯ Female ◯ Male email address: _____

Birth date: _____ Home Phone # _____ Work Phone # _____

Do you prefer to receive calls at: ◯ Home ◯ Work ◯ Cell ◯ Either Cell # _____

Are you: ◯ Minor ◯ Married ◯ Divorced ◯ Widowed ◯ Single ◯ Separated ◯ Partner

Your Employer: _____ Occupation: _____

Business Address: _____ City _____ State: _____ Zip _____

Spouse/parent's name: _____ Workplace _____

Work phone #: _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone #: _____

Responsible Party

Name of the person responsible for this account: _____

Relationship to patient: _____

DESIRED METHOD OF PAYMENT/Authorization

◯ Cash ◯ Check ◯ Credit Card

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. (The following statement pertains to personal injury cases only) I also understand that I am fully responsible for all charges over and beyond contracted amount that my in network insurance company pays due to the fact that it is a personal injury case.

_____ _____

Signature Date

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PATIENT HISTORY

Patient Name _____

COMPLAINT(S): List in order of severity

1) _____

Date when symptom first appeared _____

How often are you experiencing the symptoms?

◯Constant 76-100% ◯Frequent 51-75%

◯Intermittent 26-50% ◯Occasional 11-25% ◯Rare 10%

Describe any recently related accident or fall _____

_____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

◯Sharp ◯Dull ◯Aching ◯Burn

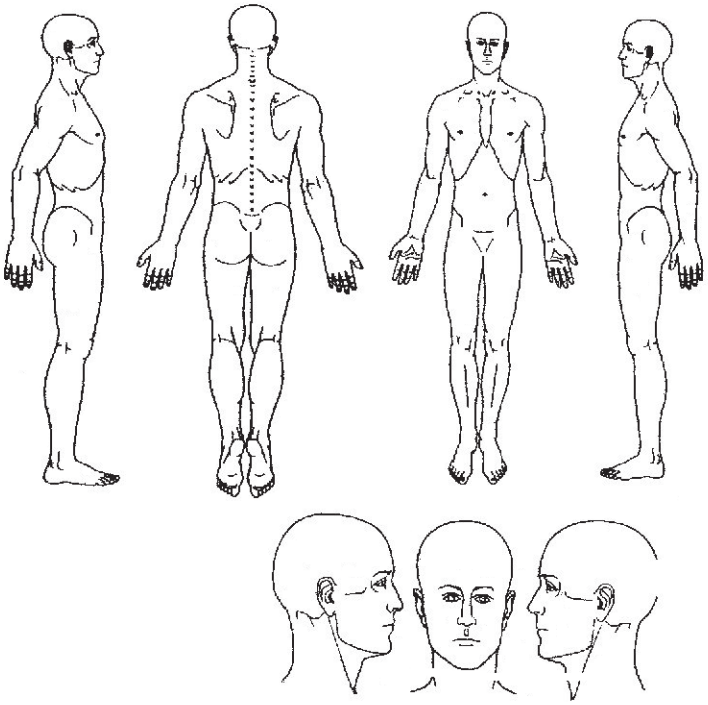
◯Throb ◯Numb ◯Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 ——— 5 ——— 10

Please mark your areas of pain on the figures below



2) _____

Date when symptom first appeared _____

How often are you experiencing the symptoms?

◯Constant 76-100% ◯Frequent 51-75%

◯Intermittent 26-50% ◯Occasional 11-25% ◯Rare 0-10%

Describe any recently related accident or fall _____

_____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

◯Sharp ◯Dull ◯Aching ◯Burn

◯Throb ◯Numb ◯Other _____

Where does the pain radiate to? _____

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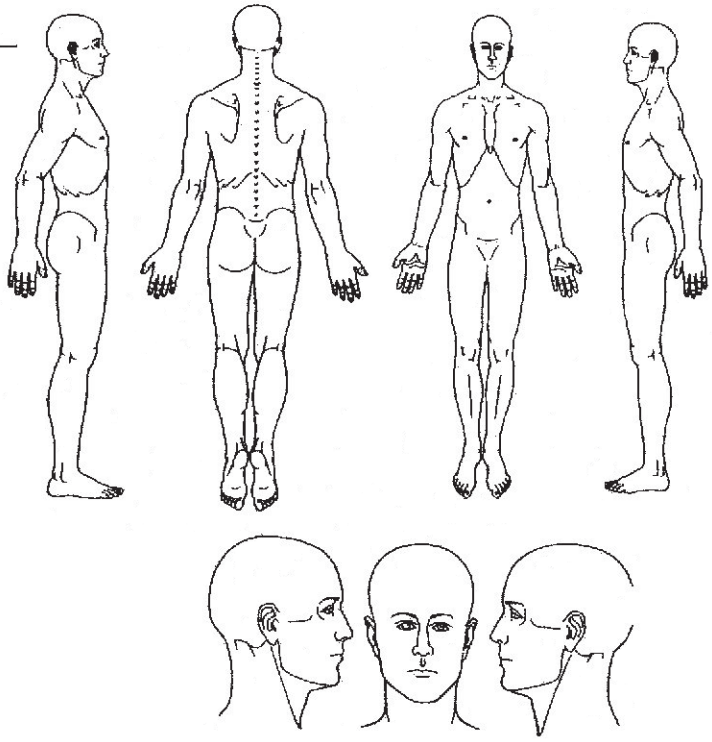

_____ _____

Patient Signature Date

_____

Patient Name

What treatment have you already received for your condition?

○ Medication ○ Surgery ○ Physical therapy ○ Other_____

Name and address of other doctor(s) who have treated you for your condition:

_____

HEALTH HABITS: *How much per day or week?*

Tea, coffee _____ Liquor _____ Tobacco _____ Sugar, candy, ice cream _____

Exercise: 1)Type _____ Freq. _____ 2) Type _____ Freq. _____

Sleep: Hours per night _____ Do you sleep on your: ○ Back ○ Side ○ Stomach

Please describe your sleep _____

Special diets: _____

Dates of last exams: _____

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all medication you are currently taking: _____

What vitamins do you currently take? _____

Do you smoke? _____ How much per day? _____

What do your daily work habits include? (ex.: Sitting, standing, light labor, heavy labor, computer work)

_____

Do any of your activities aggravate your present complaints? _____

_____

HEALTH HISTORY

Check any of the following you have or had have:

○ HIV Positive	○ Goiter	○ Tuberculosis	○ Diabetes	○ Migraine Headaches	○ Pneumonia
○ Anemia	○ Gout	○ Thyroid problems	○ Diptheria	○ Measles	○ Osteoporosis
○ Appendicitis	○ Heart Disease	○ Ulcers	○ Eczema	○ Miscarriage	○ Rheumatic Fever
○ Arteriosclerosis	○ Herpes	○ Venerial Infection	○ Emphysema	○ Multiple Sclerosis	○ Scarlet Fever
○ Arthritis	○ High Cholesterol	○ Whooping Cough	○ Epilepsy	○ Mumps	○ Stroke
○ Cancer	○ Lumbago	○ Cold Sores	○ Alcoholism	○ Pleurisy	○ Tumors, Growths
○ Glaucoma	○ Small Pox	○ Allergies	○ Asthma	○ Chicken Pox	○ Mononucleosis
○ Anorexia	○ Depression	○ Fractures	○ Hepatitis	○ Herniated Disc	Other_____

_____

X-RAY CONFIRMATION

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____

Signed Date

I certify that I have read and understand the above information to the best of my knowledge. The above question have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X_____

Signature of Patient (or parent if a minor) Date

Financial Policy

Thank you for choosing The Atlanta Spine Center, Drs. Vicky Yarns and Roberto Vargas, as your chiropractic provider. We are committed to providing the best chiropractic and wellness care possible.

The following statement explains our Financial Policy that we ask you to read, sign, and return to us prior to your treatment.

All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
All applicable co-pays, personal balances, both current and prior, are due at the time of service.
We accept cash, check, Visa, MasterCard and American Express.

Regarding Insurance:
Our office participate with the majority of managed care plans.
We must emphasize that as chiropractic doctors our relationship is with you, not your insurance company. We file the insurance claim as a courtesy to our patients, but all charges are your responsibility from the date the services are rendered. It is important that you read and understand your health insurance policy and its requirements for coverage. We currently send claims to hundreds of plans and it is impossible for us to keep up with every change in coverage or requirements of each patient's specific plan. We will do our best to get a correct verification and coverage for you, but what they indicate over the phone is not always 100% correct.

Late Arrival:
Any patient who is late to their appointment may either be asked to reschedule or, if the doctor's time allows, be worked into the remaining schedule. If you anticipate a tardy arrival, please call if possible to see if the doctor will be able to accommodate the late arrival. Atlanta, as you know is a congested area, so please allow extra time for traffic and parking.

Missed Appointments:
Unless cancelled at least 24 hours in advance, it is our policy to charge $35 for a missed appointment (including massage therapy appointments). Please help us to serve you better by keeping scheduled appointments. This fee is not covered by insurance, so it will be your personal responsibility.

Returned Checks:
For checks returned to us unpaid by your bank, we will charge a $20.00 fee.

Collection Accounts:
Any patient balance that is not resolved by the office within 60 days is automatically forwarded to our collection agency. A twenty-three percent (23%) fee is attached to your bill and forwarded to the collection agency. Our collection agency will reserve the right to attach your account to any or all credit reporting services.

I have read the financial policy for The Atlanta Spine Center, Dr. Yarns and Dr. Vargas:

_____ _____ _____
Printed Name Signature Date

Date of Birth:_____ Name of Banking Institution:_____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Atlanta Spine Center, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment,
A means of communication among the many health professionals who contribute to my care,
A source of information for applying my diagnosis and surgical information to my bill,
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices for Protected Health Information that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent
The right to object to the use of my health information for directory purposes, and
The right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Atlanta Spine Center is not required to agree to the restriction requested. I understand that I may revoke this consent in writing except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Atlanta Spine Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Atlanta Spine Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail, or, if I agree, email).

I wish to have the following restriction to the use or disclosure of my health information:

_____
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept/decline the terms of this consent.

_____ _____
Patient's Signature Date

[ ] Consent received by_____ on _____. [ ] Consent refused by patient, and treatment refused as permitted.