ASPINWALL CHIROPRACTIC CLINIC, LLC
CERTIFIED REHAB OF GEORGIA

302 S. GREENWOOD ST.
LAGRANGE, GA 30240
PH: 706-884-8360, FAX: 706-884-0265

TITLE (CIRCLE ONE): MR. MRS. MS. MISS. DR. TODAYS DATE:______________________________

FIRST NAME:______________________________ LAST NAME: ___________________________________

MIDDLE NAME: ___________________________ NICK NAME: ___________________________________

DOB:_______________ SSN: ___________________________ GENDER (CIRCLE ONE): MALE / FEMALE

ADDRESS: ____

CITY: ____ STATE: _________________ ZIP: _____________

HOME PHONE: ________________________________ CELL: ______________________________________

DO YOU WISH TO RECEIVE TEXT REMINDERS OF YOUR APPOINTMENTS? YES / NO

EMAIL: ____

MARITAL STATUS: SINGLE MARRIED OTHER ARE YOU HIV POSITIVE? YES / NO

SPOUSE NAME / PHONE #: ____ / ________________________

EMPLOYMENT: EMPLOYED / SELF EMPLOYED / F/T STUDENT / RETIRED / DISABLED / OTHER

EMPLOYER: ____ PHONE #: ___________________________

PREFERRED LANGUAGE: ____

*EMERGENCY CONTACT (OTHER THAN SPOUSE): ____

RELATIONSHIP: _________________________________ PHONE#: __________________________________

IS YOUR PAIN DUE TO A MOTOR VEHICLE ACCIDENT? YES/NO IF YES, DATE OCCURRED: ________

PRIMARY COMPLAINT / PLEASE DESCRIBE YOUR PAIN: _______________________________________

____

WHEN DID SYMPTOMS BEGIN?: ____

PLEASE LIST CURRENT MEDICATIONS: _________________, _________________, _________________,

_________________, _________________, _________________, _________________, _________________,

ALLERGIES: __________________, __________________, ___________________, ___________________.

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CONSENT, AUTHORIZATION AND FINANCIAL POLICY

Thank you for choosing Aspinwall Chiropractic Clinic, LLC / Certified Rehab of Georgia as the provider(s) for your healthcare needs. Please read the following summary of our financial policy and authorizations and sign where indicated. You may also ask for a copy of the Aspinwall Chiropractic, LLC and/or Certified Rehab of Georgia financial policy.

TREATMENT AUTHORIZATION
I consent to treatment for myself and/or the minor to which it pertains. I authorize James R. Aspinwall, D.C., David P. Dresselhaus, D.C., or Kevin Baerwalde, P.T. and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. **I also certify that no guarantee has been made to the results that may be obtained.**

Name of Patient printed: ____

Signature of Patient/Parent/Legal Guardian: ______________________________________

PAYMENT AUTHORIZATION: I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance, worker's comp, auto insurance, third party, my adjustor or attorney directly to the appropriate physicians of Aspinwall Chiropractic / Certified Rehab of Georgia.

SIGNATURE: ____

FINANCIAL POLICY
Payment is expected at the time of service and charges are ultimately your responsibility. Your benefits coverage is based on your plan with your insurance carrier; therefore it is your responsibility to know your benefits. While filing of claims is a courtesy we provide our patients, it is not our responsibility to coerce the responsible parties to pay the full benefits to which you are entitled. Each insurance company policy is unique in services covered, amounts allowed for services, as well as the amount you are contracted to pay. Your insurance is a contract between you and your insurance company; we are not a party to that contract. You may also be responsible for what your insurance company or attorney does not pay in accordance with timely payment laws, or procedures that are routinely covered but rejected as not medically necessary by your policy.
All charges are your responsibility whether your insurance company does or does not pay. We accept cash, check and most major credit cards, including Care Credit. Please note: Returned checks are subject to a $25.00 charge.

PATIENT SIGNATURE: ________________________________ DATE: ______________

****We will contact your insurance carrier to verify your coverage, but until we receive an actual payment, this in only an estimate of what they will pay. If you feel your coverage is different than what is quoted, please investigate, and let us know immediately.****

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HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

The right to inspect and copy your information; the right to request corrections to your information; the right to request that your information be restricted; the right to request confidential communications; the right to a report of disclosures of your information; the right to a paper copy of this Notice; the right to file a complaint if you feel your privacy has been violated.

As a provider of medical services we may on occasion mail you a card, call you on the telephone at the phone number(s) you have provided and/or leave a message for you to call our office.

We want to assure you that your medical protection health information is secure with us. This Notice contains information about how we will insure that your information remains private.

Please list the name(s) of any person(s) with proper identification you would like to have access to medical information:

1.______________________________ 2.______________________________ 3.______________________________

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge *Aspinwall Chiropractic Clinic / Certified Rehab of Georgia* will make available to me a copy of the NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights, that I may contact Dianna Holton or Alacia Watson, Privacy Officers. I further understand that ***Aspinwall Chiropractic Clinic / Certified Rehab of Georgia*** will offer me updates to this NOTICE OF PRIVACY PRACTICES, should it be amended, modified or changed in anyway.

PATIENT'S NAME:____ DOB:________________________

SIGNATURE OF PATIENT OR REPRESENTATIVE:____

RELATIONSHIP IF OTHER THAN PATIENT:_____________________________________ DATE:___________

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ADDING COLLECTION FEES TO ACCOUNT BALANCES:

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.3%), attorney fees and/or court cost, if such be necessary.

CONSENT TO CONTACT DEBTORS VIA THEIR CELL PHONES:

You agree, in order for us to service your account or to collect monies you may owe, Aspinwall Chiropractic Clinic, LLC / Certified Rehab of Georgia and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Aspinwall Chiropractic Clinic, LLC / Certified Rehab of Georgia, Its employees and/or agents may contact me/us as described above.

____________________________________ ____________________

Responsible Party Signature Date