Georgia Spine and Sports Rehab
Dr. Joseph A. Krzemien

WELCOME TO OUR OFFICE
PATIENT INFORMATION FORM

NAME _____ DATE OF BIRTH _____ AGE ____ SEX☐ M ☐ F

ADDRESS _____ CITY _____ STATE____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL _____

SOCIAL SECURITY NUMBER _____ EMAIL ADDRESS _____

Check One☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated Name of Spouse: _____

PREFERED METHOD OF CONTACT: ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ EMAIL

MAY WE LEAVE A MESSAGE REGARDING YOUR HEALTHCARE AND/OR APPOINTMENT? ☐ YES ☐ NO

EMPLOYER _____ POSITION _____

EMPLOYER ADDRESS _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ CONTACT #_____

IF PATIENT IS A MINOR DO YOU AUTHORIZE GEORGIA SPINE AND SPORTS REHAB TO TREAT SAID MINOR WITHOUT A PARENT/GUARDIAN PRESENT FOR FUTURE APPOINTMENTS? **SIGNATURE:**_____

WHAT SCHOOL DO YOU ATTEND?_____

COMPLETE THE FOLLOWING SECTION IF SOMEONE OTHER THAN PATIENT IS FINANCIALLY RESPONSIBLE:

RESPONSIBLE PARTY_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE_____ WORK PHONE_____ CELL_____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____

EMPLOYER_____ POSITION_____

Who is Responsible for Your Bill, You and ☐ Spouse ☐ Health Insurance☐ Auto Insurance ☐ Workman's Comp ☐ Attorney

Personal Health Insurance (Name) _____ Policy ID _____ Group #_____

PLEASE GIVE YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE TO THE RECEPTIONIST FOR INSURANCE BILLING PURPOSES

I HEREBY GIVE CONSENT FOR THE ABOVE NAMED DOCTORS TO TREAT ME. THIS MAY OR MAYNOT INCLUDE THE NEED FOR X-RAYS. IF X-RAYS ARE NEEDED I WILL BE INFORMED BY THE DOCTOR FIRST. I AGREE TO ACCEPT FINANCIAL RESPONSIBILITY FOR ANY CHARGES INCURRED. I ALSO HEREBY ASSIGN TO THE ABOVE NAMED DOCTORS ALL BENEFIT PAYMENTS PROVIDED BY MY HEALTH INSURANCE COMPANY, AUTO INSURANCE COMPANY OR A SETTLEMENT FROM MY ATTORNEY FOR SERVICES DESCRIBED. I GIVE GEORGIA SPINE AND SPORTS REHAB PERMISSION TO TREAT ME IN AN OPEN ROOM WITH OTHER PATIENTS. I AM AWARE OTHER PERSONS MAY OVERHEAR SOME OF MY HEALTH INFORMATION. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM OR PENDING LEGAL CASE. I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF GEORGIA SPINE AND SPORTS REHAB'S FINANCIAL AND HIPAA POLICY.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY_____ **DATE**_____

MEDICAL/SURGICAL HISTORY:

Purpose of This Appointment: _____

Have you received chiropractic care before? ☐ YES ☐ NO

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 This Condition ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date and Time of Accident _____ Haveyoumade a report of your accident to your employer? ☐ Yes ☐ No

Major accidents or falls in the past? _____

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

GENERAL

☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of Sleep
☐ Loss of Weight
☐ Nervousness
☐ Numbness
☐ Sweats

MUSCLE/JOINT/BONE

Pain, Weakness, Numbness in:

☐ Arms☐ Hips
☐ Back☐ Legs
☐ Feet☐ Neck
☐ Hands☐ Shoulders

GENITO-URINARY

☐ Blood in Urine
☐ Frequent Urination
☐ Lack of bladder control
☐ Painful Urination

GASTRO-INTESTINAL

☐ Appetite Poor
☐ Bloating
☐ Bowel Changes
☐ Constipation
☐ Diarrhea
☐ Excessive Hunger
☐ Excessive Thirst
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal Bleeding
☐ Stomach Pain
☐ Vomiting
☐ Vomiting Blood

CARDIO-VASCULAR

☐ Chest Pain
☐ High Blood Pressure
☐ Irregular Heart Beat
☐ Low Blood Pressure

☐ Poor Circulation
☐ Rapid Heart Beat
☐ Swelling of Ankles
☐ Varicose Veins
☐ History of Blood Clotting

EYE, EAR, NOSE, THROAT

☐ Bleeding Gums
☐ Blurred Vision
☐ Crossed Eyes
☐ Difficulty Swallowing
☐ Double Vision
☐ Earache
☐ Ear Discharge
☐ Hay Fever
☐ Hoarseness
☐ Loss of Hearing
☐ Nosebleeds
☐ Persistent Cough
☐ Ringing in Ears
☐ Sinus Problems

☐ Vision-Flashes
☐ Vision-Halos

SKIN

☐ Bruise easily
☐ Hives

☐ Itching
☐ Change in Moles
☐ Rash
☐ Scars
☐ Sore that won't heal

MEN only

☐ Breast Lump
☐ Erection Difficulties
☐ Lump in Testicles
☐ Penis Discharge
☐ Sore on Penis
☐ Other:_____

WOMEN only

☐ Abnormal Pap Smear
☐ Bleeding between Periods
☐ Breast Lump
☐ Extreme Menstrual Pain
☐ Hot Flashes
☐ Nipple Discharge
☐ Painful Intercourse

☐ Vaginal Discharge
☐ Other:_____

Date of last Menstrual Period:

Have you had a mammogram?
☐ YES ☐ NO

Are you currently pregnant?
☐ YES ☐ NO

Do you take oral contraceptives?
☐ YES ☐ NO

Number of Children:

PLEASE TURN PAGE OVER TO COMPLETE FORM

CONDITIONS Check (√) symptoms you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

HOSPITALIZATIONS: (Women- Include Pregnancy History)

YEAR	HOSPITAL	REASON/OUTCOME

LIST ANY KNOWN ALLERGIES:

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

GEORGIA SPINE & SPORTS Rehab

FINANCIAL POLICY

1. STATEMENTS ARE MAILED OUT EACH MONTH. PAYMENTS ARE DUE 28 DAYS AFTER THE STATEMENT DATE UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE.

2. ACCOUNTS THAT HAVE NOT RECEIVED ANY PAYMENTS FOR 3 MONTHS WILL BE REFERRED TO A COLLECTION AGENCY. ADDITIONALLY, A 40% COLLECTION FEE MAY BE ASSESSED ON THE BALANCE.

3. **CO-PAYS/ CO-INSURANCE ARE DUE AT THE TIME OF SERVICE.**

4. PATIENT MEDICAL RECORDS ARE THE PROPERTY OF GEORGIA SPINE AND SPORTS REHAB. ANY PATIENT REQUESTING A COPY OF THEIR MEDICAL RECORD WILL BE CHARGED A FEE THAT FOLLOWS THE GUIDELINES SET BY GEORGIA STATE MANDATE.

5. ALL PATIENTS ARE RESPONSIBLE TO KNOW AND MONITOR THEIR INSURANCE BENEFITS. IMPORTANT THINGS TO PAY ATTENTION TO ARE CO-PAYS, DEDUCTIBLES, REFERRALS, NUMBER OF VISITS, NON-COVERED SERVICES, AND WHETHER THE DOCTOR IS IN-NETWORK WITH YOUR PLAN.

6. WE WILL BILL YOUR INSURANCE FOR YOU, AND WE ALLOW THE INSURANCE COMPANY 60 DAYS TO PAY US. IF THEY HAVE NOT PAID AFTER 60 DAYS, THE BALANCE WILL BECOME YOUR RESPONSIBILITY, AND YOU CAN FOLLOW UP WITH YOUR INSURANCE COMPANY FOR REIMBURSEMENT. PLEASE INFORM US IF YOUR INSURANCE HAS CHANGED TO PREVENT PAYMENT DELAYS.

7. ALL INSUFFICIENT FUND CHECKS WILL BE CHARGED A $25.00 FEE.

8. APPOINTMENT CANCELLATION FEE IS **$55.00** FOR ALL APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE OR MISSED APPOINTMENTS. _____ Initials APPOINTMENT CANCELLATION FEE IS **$65.00** FOR DECOMPRESSION APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS OR MISSED APPOINTMENTS. _____ Initials

9. ALL FINANCIAL ACCOUNT QUESTIONS SHOULD BE DISCUSSED WITH THE OFFICE MANAGER.

SPECIFIC AUTHORIZATIONS

1. I GIVE PERMISSION TO GEORGIA SPINE AND SPORTS REHAB TO USE MY ADDRESS, PHONE NUMBER AND CLINICAL RECORDS TO CONTACT ME WITH APPOINTMENT REMINDERS, MISSED APPOINTMENTS NOTIFICATION, BIRTHDAY CARDS, HOLIDAY RELATED INFORMATION, ABOUT TREATMENT ALTERNATIVES, OR OTHER HEALTH RELATED INFORMATION. INITIAL ____

2. I GIVE PERMISSION TO GEORGIA SPINE AND SPORTS REHAB TO LEAVE A PHONE MESSAGE ON MY ANSWERING MACHINE OR VOICE MAIL. INITIAL _____

I understand the above stated financial policy and Specific Authorizations of Georgia Spineand Sports Rehab. I have been given an opportunity to have all my questions answered regarding these policies. I agree to accept financial responsibility for any charges incurred.

Patient/Guarantor Signature: _____ Date: _____

Staff: _____

VEHICILE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident _____ Time of Accident_____ AM____ PM____

Please describe the accident in your own words:_____

_____

_____

Were you the: ___ Driver ___Front Passanger ___Rear Passanger ___Pedestrian

How many people were in the accident vehicle? ___

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

_____

Driving conditions ___ Dry ___ Wet ___Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ___ Yes ___ No

If yes, what type ___ Lap ___ Shoulder

Was vehicle equipped with airbags? ___ Yes ___ No

if yes, did it/they inflate properly? ___ Yes ___ No

Did your head have a headrest? ___ Yes ___ No

If yes, what was the position of the headrest?

___ Low ___ Midposition ___ High

OTHER

Make and model of other vehicle?_____

Which direction was other vehicle headed?_____

_____

Speed other vehicle was traveling _____

IMPACT

Did your car impact another vehicle?

Yes ____ No ____

Did your car impact a structure?

Yes ____ No ____

If Yes, please explain _____

_____

Did any part of your body strike anything in the vehicle?

___ Yes ___ No If Yes, explain _____

_____

Was impact from:

___ Front ___ Rear ___Left ___ Right

Other _____

At the time of impact were you:

___ Looking straight ahead

___ Looking to the left

___ Looking Up

___ Looking to the right

___ Looking Down

Were both hands on the steering wheel?

___ Yes ___ No

Was your foot on the brake?

___ Yes ___ No

If yes, which foot was on the brake?

___ Right ___ Left

Were you: ___Braced for impact ___Surprised by impact

POLICE

Did the Police come to the accident site?	___ Yes	___ No
Were there any witnesses?	___ Yes	___ No
Was there a police report?	___ Yes	___ No
Was a traffic violation issued?	___ Yes	___ No

if yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ___ Yes ___ No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

_____

_____

_____

TREATMENT

Did you go to the Hospital? ___ Yes ___ No

When did you go? ___ Immediatley after accident ___ Next Day ___ 2 days or more after accident

How did you get to the hospital? ___ Ambulance ___ Private Transportation

Name of Hospital _____

Diagnosis _____

_____

SYMPTOMS AND INJURIES

Have you been able to work since this injury? ___ Yes ___ No

How many days have you missed? _____

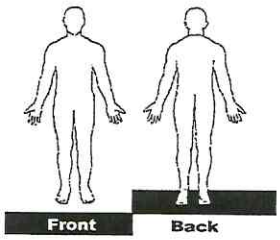
Prior to the injury were you able to work on an equal basis with others your age? ___ Yes ___ No

If you have had any of the following symptoms since your injury, please check below:

___Arm/shoulder pain	___ Feet/toe numbness	___ Neck Pain
___ Back Pain	___ Hand/finger numbness	___ Neck stiff
___ Back stiffness	___ Headaches	___ Shortness of breath
___ Chest pain	___ Irritability	___ Sleep difficulty
___ Dizziness	___ Jaw Problems	___ Stomach upset
___ Ear buzzing	___ Leg Pain	___ Tension
___ Ear ringing	___ Memory problems	___ Vision blurred
___ Fatigue	___ Nausea	

Is this condition getting progressively worse? ___ Yes ___ No ___ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ___ Sharp ___ Dull ___ Throbbing ___ Numbness
___ Aching ___ Shooting ___ Burning ___ Tingling
___ Cramps ___ Stiffness ___ Swelling
Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ___ Work ___ Sleep ___ Daily routine ___ Recreation

Movements that are painful to perform: ___Sitting ___ Standing ___Walking
___Bending ___Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change of health.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

GEORGIA SPINE & SPORTS Rehab

PERSONAL INJURY LETTER OF PROTECTION (LIEN)
MANDATORY OFFICE PROCEDURE

As a courtesy to our patients we will treat your injuries at no up front cost for you. We will use either the medical portion of your auto insurance or your health insurance to bill for all services. If you have no coverage for this accident and this accident is not your fault, **we will treat your injuries under a lien.** This entitles our office to receive all medical payments at the time of the settlement from your attorney.

It is mandatory for all patients being treated under a lien case (no insurance) to have some form of collateral to guarantee payment to this clinic. THIS OFFICE IS AUTHORIZED TO KEEP A COPY OF YOUR CREDIT CARD NUMBER ON FILE UNTIL YOUR CASE IS SETTLED AND OUR OFFICE IS PAID IN FULL. WE HAVE NO INTENTION OF CHARGING YOUR CREDIT CARD, UNLESS A PATIENT DENIES PAYMENT.

Credit Card Agreement:

At this time I, _____, authorize Georgia Spine and Sports Rehab to retain my credit card information to cover all medical expenses not paid by my settlement. I understand that Georgia Spine and Sports Rehab **will not charge my credit card** as long as all medical bills are paid. Georgia Spine and Sports Rehab agrees to only charge my credit card if I default on payments of medical bills. When my medical bills have been paid in full, Georgia Spine and Sports Rehab agrees to return all personal information.

_____ _____
Patient Signature Date

_____
Patient Printed Name

SS # _____

CC # _____ Exp.Date _____

_____ _____
Office Signature Date

GEORGIA
SPINE & SPORTS
Rehab

4325 South Lee St.
Buford GA 30518
Office: (770) 614-6551
Fax: (770) 831-5435

AGREEMENT OF ASSIGNMENT OF NET SETTLEMENT OR JUDGEMENT PROCEEDS

Patient _____
Attorney _____
Address _____
City _____ Zip _____
Telephone _____

I, hereby authorize and direct you, my attorney, to pay directly to the above named Health Care PROVIDER (herein after called PROVIDER), such sums as may be due and owing to said PROVIDER for health services rendered to me for reason of this personal injury cause of action and by any reason of any other bills, due said PROVIDER and to withhold such sums from any settlement, judgment or verdict that may be necessary to adequately protect said PROVIDER. I hereby also authorize that the settlement check may be made payable to the attorney, PROVIDER, patient and that no payments that are due to the PROVIDER can be made to me.

I, hereby further irrevocably create this assignment on my case and irrevocably assign with preference said assignment to the above named PROVIDER against any and all proceeds of settlement, judgment or verdict which may be paid to you my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said PROVIDER for all health care services rendered to me and this assignment is made solely for the PROVIDERS additional protection and in consideration to said PROVIDERS awaiting payment in the event this case is assigned by me to attorney not a signatory herein. I understand and agreed that all monies due said PROVIDER would be due and payable immediately. I further agree that the PROVIDER has only agreed to wait a period of twelve (12) month form the date of hereof for payment, and if not paid within the time, I understand that the PROVIDER may look to me for immediate payment.

I, the patient, further agree that if my attorney does not accept and sign this settlement, then I will use any attorney that the PROVIDER recommends.

I UNDERSTAND THAT THIS IS AN IRREVOCABLE ASSIGMENT

Date _____ Patient's Signature _____
Date _____ Attorney's Signature _____

4325 South Lee St
Buford, GA 30518
Office: (770) 614-6551
Fax: (770) 831-5435

Letter of Representation

Patient Name: _____

Date of Accident _____

Attorney Name _____

The above patient is being treated by our office for injuries sustained from a car accident. Our patient has informed us that you are representing him/her for his/her case. We would like to confirm that you are representing our patient so that we may forward medical records and billing appropriately.

Please check the appropriate box below and fax to (770) 831-5435.

[ ] Yes, I am representing the above patient.
[ ] No, I am not representing the above patient at this time.
[ ] Other,

_____

_____

Attorney Signature _____

Thank you,

_____
Office Manager

Personal Injury Settlement Agreement
Georgia Spine and Sports Rehab
4325 South Lee St.
Buford GA 30518

I, _____ hereby authorize my attorney to direct pay all outstanding medical bills to Georgia Spine and Sports Rehab. I understand that if my attorney reimburses me with any settlement amounts that I am held solely responsible to pay all medical bills to Georgia Spine and Sports Rehab.

Failure to pay all remaining medical bills may incur legal and collections action. I understand that this will be avoided assuming my attorney directly reimburses Georgia Spine and Sports Rehab, its full medical bills. I understand that this form will be faxed to my attorney's office.

_____ _____

Signature of Patient/Guardian Date