Schantz Chiropractic, P.C.
600 Houze Way Ste. A1
Roswell, GA 30076-1345
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www.RoswellChiro.com

NEW PATIENT GET-TO-KNOW-YOU FORM *(please print or complete on-line)*

First Name:______________________M.I._____Last Name:_________________________

Preferred Name:___________________

Address:____City:________________________

State:______Zip:__________

Birthdate:______/______/______ Age_______ Gender: □ Male □ Female □ other ____________

Cell Phone:__________________________ Secondary Phone:________________________

Email:____

(We use text-message appt. reminders & e-mails for practice updates and alerts. You may opt-out any time.)

Marital Status: (check one) □ Single □ Married □ Other __________________

Children?: □ Yes □ No How Many:______

Preferred Language(s)____

Occupation:_______________________

Employer:________________________ or School (if full-time student) ________________

City _____________________ State _________

Emergency Contact: Name __________Relationship _____ Address __________Phone __________

Parents/Guardians (for minors) Name(s) _______________ Address(es)____________ Phone(s) __

How did you find out about our practice? □ Word-of-mouth □ Internet search □ Insurance plan

□ Health care provider □ other___________.

Who should we thank for referring you? ________________________________.

Initial___________

REASON FOR VISIT

□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □ Sciatica □ Hip/Knee or Foot Pain

□ Shoulder/Arm/Wrist Pain □ Joint/Nerve Disturbance □ Stress Disorder □ Wellness Care

□Other ____________________________

List any events, conditions or activities that may have contributed to your complaints?

____

When did this complaint begin? ______/______/______ Is it getting worse? □ Yes □ No □ Constant

□ Comes and goes

Have you had this or similar complaint in the past? □ Yes □ No If "Yes",
when?____

On the scale below, please circle the severity of your main complaint right now:

Mild (1 2 3) Moderate (4 5 6) Severe (7 8 9) Unbearable (10)

What aggravates this complaint(s)? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs /Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward Bending backward / Twisting / Reaching /Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:____

What relieves this complaint(s)? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching/ Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:________________________

Which of these activities are compromised by this complaint(s)?: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel /Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:___________________

List any other physicians or healthcare professionals that you have seen for these problems.

______________________ ________________________ ____________________ _________________

Initial___________

Have any of these symptoms emerged since the onset of your complaint(s)?

Double Vision ☐Yes ☐No Difficulty Walking or Balancing ☐Yes ☐No

Dizziness/Vertigo ☐Yes ☐No Difficulty Speaking or Swallowing ☐Yes ☐No

Passing Out ☐Yes ☐No Numbness on one entire side of body ☐Yes ☐No

Nausea/Vomiting ☐Yes ☐No

CHIROPRACTIC CARE: □ None □ Infrequent □ Occasional □ Frequent. Chiropractic techniques that you favor? □ Traditional (twist/ crack) □ Instrument (No twist/crack) □ Cox® Technic □ other ____________

ACCIDENTS & INJURIES **DISEASES & MEDICAL CONDITIONS**

____
____

____
____

SURGERIES & MEDICAL PROCEDURES **HOSPITALIZATIONS & TREATMENT PROGRAMS**

____
____

____
____

List current prescription medications, OTC medicines, nutritional supplements. □ none.

1. 5.

2. 6.

3. 7.

WOMEN ONLY: Currently Pregnant? □ Yes □ Unsure □ No. Menopause? □ No □ Unsure □ Yes

SOCIAL HISTORY

Physical activity level? □ Infrequent □ Light □ Moderate □ Strenuous □ Competitive.

Do you currently smoke or use tobacco of any kind? □ Yes □ No □ Never

Are alcohol and/or substance abuse becoming any issue for you? □ no □ maybe □ yes

What is your current stress level? □ Mild □ Moderate □ High □ Worst Ever

Initial___________

INSURANCE OR PRIVATE PAY INFORMATION

Type of Insurance: □ Health □ Traditional Medicare (Part B) □ Medicare Advantage (Part C)

□ Med-Pay Automobile Coverage □ Other ___________

Primary Insurance Carrier:_______________________________

Policy#_________________ Group #_____________ Claim# (for Auto or Work Comp.)__________________

Name of Policy Holder:________________________ Relationship to Patient:____________

ASSIGNMENT/AUTHORIZATION/RELEASE *(check one box & sign please)*

□ **Health/*Medicare Advantage (Part C) /Automobile Med-Pay/Special Assignment.** I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Schantz Chiropractic, P.C., all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that co-pays & payment for non-covered services and goods are payable at the time of each visit or in advance, for mutual convenience. I understand that I am financially responsible for all charges, whether or not paid by insurance, with the exception whereby the negotiated rate for services of my health plan is less than the usual & customary fee schedule of this office.

□* **Traditional Medicare (Part B).** I certify that I, and/or my dependents, have insurance with the above named insurance company. I authorize the use of my signature on all insurance submissions. Medicare regulations dictate that Schantz Chiropractic, P.C. must file my Medicare Part B claims for me, but Medicare does not require us to accept assignment on Part B claims or to file with secondary insurance plans**. I understand that payment for all covered or non-covered services and goods are payable at the time of each visit or in advance, for mutual convenience**. I understand that I am financially responsible for all charges, whether or not paid by insurance.

□ **Private Pay/Cash or Pre-Paid Discount Plan:** I either do not have health insurance that covers chiropractic care or that I exercise my right to not use Health Insurance and not to be bound by its limitations & exclusions. I understand that I am financially responsible for all services at the time they are rendered, unless I enroll in a **Pre-Paid Discount Plan** through this office.

> ***Attention all Medicare Patients*:** Medicare will consider for payment one procedure performed by a Doctor of Chiropractic- Manipulation of the Spine. Although Medicare recognizes that many other services fall under the Chiropractic Scope of Practice, such as examinations for new/established patients, x-rays/MRI, physiotherapies, therapeutic exercise, only spinal manipulation will be considered for reimbursement.

Person responsible for this account: ____

X____Date______________________________

Signature of Patient, Parent or Legal Guardian (if minor)

Schantz Chiropractic, P.C. **ACKNOWLEDGEMENT OF INFORMED CONSENT**

Patient Name (print): ____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment I use as a Doctor of Chiropractic is spinal manipulation or chiropractic adjustments. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" you knuckles. You may feel a sense of movement.

The material risks inherent in chiropractic adjustment. All healthcare procedures carry benefits & risks. Despite our best efforts to minimize risk, possibilities exist that a complication may occur. Most complications are temporary soreness, stiffness, spasm or increase in symptoms. Serious complications are rare and may include, but not limited to disk injury, fracture, burn from heat or electrical devices or injury to an artery in the neck causing or contributing to stroke. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Other treatment options, outside the scope of chiropractic. Treatment options for your condition may include: Prescription & over-the-counter drugs such as anti-inflammatories, muscle relaxants and opioids. Injections into muscles, joints or the spine. Spinal laminectomy, spinal fusion, artificial disk or joint replacement surgeries. Be aware that there are risks and benefits of these treatment options and you may wish to discuss these with a nurse, pharmacist, surgeon or physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions, chronic pain and disability. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

PLEASE CHECK THE APPROPRIATE BLOCK. SIGN BELOW, once you understand and consent to treatment.
[ ] Having been informed of the risks, I hereby give my consent to chiropractic treatment.
[ ] I wish to discuss this with the doctor before signing.

Signature: ____ **Date: ____/____/______**

Name, if signed by Parent or Guardian (print): ____

Schantz Chiropractic, P.C. **Rules & Consents**

Patient Name: ____

PRACTICE RULES

1. Be as forthcoming and upfront as you can regarding your medical history & current condition. It really helps us give you better care.
2. Stay current with your co-pays and financial arrangements with the office. If you run into trouble, talk to us sooner, rather than later. We will do what we can to help you get the care you need.
3. Chiropractic care works best when you follow a schedule of care with visits planned out ahead of time. Better to have an appointment and change it, than to have no appointment at all.
4. Call us if you are running late or need to reschedule an appointment. That frees up a time for another patient and helps us stay on-time.
5. If you are unhappy with us- Let **us** know. We can't see our blind spots. If you are happy with us-Let **others** know. Write an **on-line review or refer** a family member or friend.

Initial: _________

USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI). You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. **A copy of our Notice may be found in the magazine rack in reception area**. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice, at any time by contacting: Contact Person: Schantz Chiropractic P.C. Office Manager Telephone: 770-993-9287 Fax: 770-993-1203 E-mail: office.schantz@earthlink.net Address: 600 Houze Way Suite A1 Roswell, GA 30076.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Initial: _________

CONSENT FOR TREATMENT OF MINOR CHILD - Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of Schantz Chiropractic, P.C. The undersigned states that he/she is the patient's legal guardian.

Initial only if giving permission for your child to receive chiropractic care: _________

x____ ____
Signature of Patient, Agent, or Representative Printed Name

____ ____
Date Relationship to Patient

COPIES OF THIS FORM SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL 11/16/2019