ALIGNED 4 LIFE
CHIROPRACTIC - MEDICAL - THERAPY - NUTRITION

Welcome to Aligned 4 Life

Our Goals:
1. Determine the cause of your pain.
2. Reduce your pain as soon as possible.
3. Reduce the long term effects of your injury.
4. To document your progress.
5. Refer you to the proper specialist or diagnostic test when needed.

- **Communication is very important**, so please feel free to ask questions. Aligned 4 Life has been in practice for 14 years and can answer most questions you may have. **Please ask questions!**
- It is very important that you follow all of the doctor's recommendations, this will allow for optimal healing. Home activities, nutrition, making your therapy appointments and avoidance of relapses are important for complete healing to occur. Remember healing takes time, but the sooner we get you out of pain the better.
- Most patients respond to care in 4 - 12 weeks. When it has been determined that your injuries are healed to a pre injury status, all of your records and reports will be released to your attorney or claims adjuster.
- Please provide us with the following info: Accident Report, Auto and Health Ins Cards, Valid ID, Attorney Info
- We are only interested in helping victims who have legitimately been injured. If you have not suffered a real injury, please be warned that making false statements about accidents or filing incorrect or misleading insurance claims is a felony punishable by fines and / or prison time.
- If you are not improving or your condition is worsening, a referral to the proper specialist or diagnostic test will be made. Patients are typically seen 3 times a week for 3 weeks until the pain is 50% improved. At the end of the 4th week your condition will be re-evaluated. Once the pain is relieved we will work to strengthen the area to ensure long term success.
- **Office hours:** Monday & Wednesday 9-6, Tuesday & Thursday 9-9, Friday 9-1, Saturday by Appointment ONLY.
- **Payment:** 1. Use your workers compensation, or med pay on **your** auto insurance. 2. Use your health insurance; many do not cover work or auto injury and they may ask to be repaid. 3. Pay for treatment each visit. 4. We will issue you credit and wait for the settlement of your case or if you have made arrangements with the other person's insurance company or your attorney. Please ask questions if you need help

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Please Complete The Below

1. Do you have med-pay or worker injury coverage? Yes • No • Unknown •

Insurance Company: ___________________________________ Claim#: __________________________

Insurance Phone # : ___________________________________ Adjuster: _________________________

2. Do you have health insurance coverage? Yes • No • Unknown •

Insurance Company: ___________________________________ Claim#: __________________________

Insurance Phone # : ___________________________________ Adjuster: _________________________

3. I do not have insurance and will be self paying each visit. Yes • No

4. I have an attorney:

Attorney Name: ___________________________________ Phone #: ____________________________

5. Accident Case #______________________ **County or Police Dept:**___________________________

PATIENT HISTORY

Date of Birth ___________________ **Age** _________________ **Social Security #** ____________________________

Last ____ **First** _________________________ **Middle Initial** ___________

Address ____ **City** _________________________**ST**________ **Zip** _______________

Phone (H) ______________ **(W)** __________________ **(C)** _________________**Email**______________________________________

Do you have Medpay coverage on your car insurance? Y N Do you have Health Insurance? Y N

Your Occupation _______________________ **Employer** ____

Where you involved in a accident?____________________ **If yes what kind? Auto Work related Slip and Fall Other:**_______________

Have you been to another doctor for this problem? Y N **Who/Where?** ____

Have you had any X-rays, MRIs or CT Scans for this problem?____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: ____

Date when symptom first appeared ________________________ **Did it begin:** ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? ____________________________ **What relieves the symptoms?** ___________________

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb **Does the Pain Radiate into your:** ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no **How often do you experience these symptoms?** ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) ____________________

Please list all previous treatments for this condition (give doctor's name and dates if possible) ___________________________________

____

____

SECONDARY COMPLAINT: ____

Date when symptom first appeared ________________________ **Did it begin:** ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? ____________________________ **What relieves the symptoms?** ___________________

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb **Does the Pain Radiate into your:** ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no **How often do you experience these symptoms?** ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) ____________________

Please list all previous treatments for this condition (give doctor's name and dates if possible) ___________________________________

____

Do you smoke? ☐yes ☐no If yes, how many packs per week? _________________

Have you ever smoked in the past? ☐yes ☐no If yes, when did you quit? ___________________

Do you take birth control? ☐yes ☐no **Have you ever taken birth control in the past**? ☐yes ☐no

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _________________

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? __________________

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _________________

Do you have a high stress level? ☐yes ☐no If yes, list reasons: ___________________________

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Please list any medications or vitamins you are currently taking:

____

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____

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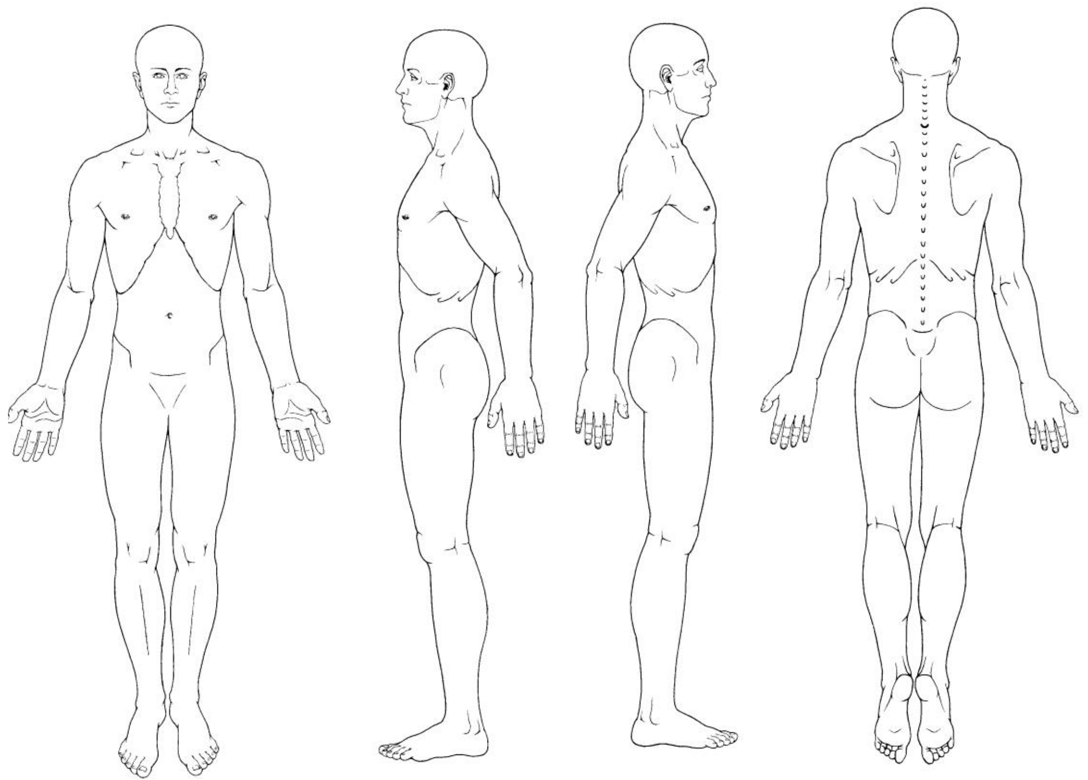
____

PATIENT SIGNATURE ____ **DATE** ______________

PATIENT HISTORY

Please mark off the areas of your complaint on the diagram above with the following indicators:

P = pain
N = numbness
T= tingling
BBB= burning
C= cramping
X = other



Please list all surgeries, injuries, accidents, falls, etc: ____

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Please check if you have had any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ MS	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease
☐ Vaginal Infections	☐ Venereal Disease	☐ Whooping Cough	☐ Rheumatoid Arthritis	
☐ Other:				

PATIENT SIGNATURE ____ **DATE** ____________________

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office hereby authorize Aligned4Life and whomever they may designate as assistant(s) to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that pay amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account.

Patient's Signature____Date_________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature____ Date_________________

REQUEST FOR PAYMENT OF BENEFIT TO PROVIDER OF CARE

I, authorize ____ Insurance Company/Insurance Administrator to pay by check and for it to be mailed directly to Aligned4Life any expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered.

Patient's Signature____ Date_________________

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Aligned4Life or whomever they may designate administer chiropractic care, as he deems necessary to ____.

Patient's Signature________________________________ _____________Date_________________

How We Protect Your Private Health Information

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I consent to the use or disclosure of my protected health information by this office for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that **Aligned4Life** may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above states purposes. My signature on this document is evidence of this consent.

I understand I have a right to request a restriction as to how my personal health information is used or disclosed to carry out treatment, payment or health care operations at the practice. This office is not required to agree to the restrictions that I may request. However, if this office agrees to a restriction that I request, the restriction is binding.

I understand I have a right to review this office's Notice of Privacy practices prior to signing this document. This office's Notice of Privacy has been provided to me. This Notice of Privacy Practices describes the type of uses and disclosures of my protected health care information that will occur in my treatment, payment of my bills or in the performance of health care operations of this office. The Notice of Privacy Practices for this office is also provided upon request at the main administrative desk of this office. Notice of Privacy Practices also describes my rights and this office's duties with respect to my protected health information.

This office has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the Privacy Officer at 404-383-1110 and request a hard copy to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that this office or **Aligned4Life** have taken action in reliance on this consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding the Privacy Policies, and all my questions have been answered fully and satisfactorily.

____________________	____________________	__________
Patient Printed Name	Patient Signature	Date
____________________	____________________	__________
Witness Printed Name	Witness Signature	Date

Aligned4Life

Verification of Non-Pregnancy

Date: ______________________

Name: ____

Address: ____

____

Telephone#: ____

Date of Birth: ____

By my signature on this form, I, __________________________, do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.

Patient Signature: ____

Witness: ____

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ACCIDENT INJURY REPORT

Date of Accident__________________________ Day of Week _____________ Time of Accident ___________ a.m. p.m.

Accident Type: Work Related______ Traffic________ Slip & Fall________ Other (describe)_______________________

WORK RELATED ACCIDENT

Employer________________________ Location__________________ Type of business___________________________

Was any equipment, machinery and/or object related to accident? What kind?_____________________________________

Was accident reported to supervisor and/or employer?________ Has a Workers Compensation claim been filed?_______

MOTOR VEHICLE ACCIDENT

What kind of vehicle(s) was(were) involved in accident? Truck____ Car_____ Motorcycle_____ Other________________

Were you: Driver____ Passenger____ Seat location: Front seat___ Back Seat___

Was your vehicle moving when accident occurred? _____ MPH? __________ Number of people in your vehicle________

Did your vehicle hit other vehicle(s)? No_______ Yes________ Where?____

Did other vehicle(s) hit your vehicle? No_______ Yes________ Where?____

Were you struck from: Behind_______ Front_______ Left side_______ Right side_______

Were you surprised by the accident? No____ Yes_____ Was your head turned? No____ Yes____

Did any part of your body hit the inside of the car? No____ Yes____ If so where?___________________________________

Did you get any cuts or bruises as a result of the accident? No____ Yes____

Did your seat break? No____ Yes____ Was there more than one impact? No____ Yes____

Were police notified? No____ Yes____ Were tickets issued? No____ Yes_____ To whom?_______________________

Have you missed work due to accident?____

Approximately how much damage was done to your vehicle?____

Was your car able to be driven away from the accident scene? No____ Yes____

Did your car roll over? No____ Yes____

Fully describe accident in your own words:____

____

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Did you go to your PCP or an Urgent Care Facility? No____ Yes____ If so, where_________________________________

Were you taken to the hospital after the accident? No____ Yes____ If so, where________________________________

Were you given any prescriptions or Medicine? No____ Yes____ If so, what kinds_____________________________

Accident Injury Report

Did you have any physical complaints BEFORE THE ACCIDENT? Please describe fully______________________________

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____

Do you notice any activity restrictions as a result of this injury? No____ Yes____ Describe in detail__________________

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Have you ever been involved in an accident before? No____ Yes____ List dates, types and injuries of previous accident:

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Additional
Information:____

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IT IS THE POLICY OF Aligned4Life Wellness LLC,, TO FILE ANY AND ALL AVAILABLE, APPLICABLE INSURANCE ON AN ACCIDENTAL INJURY PATIENT, INCLUDING 1.) ALL GROUP HEALTH, 2) PATIENT'S AUTOMOBILE, AND 3) 3RD PARTY INSURERS FOR WHICH WE HOLD A VALID ASSIGNMENT OF BENEFITS FROM THE PATIENT. FINANCIAL ARRANGEMENTS ARE BASED UPON PROJECTED INSURANCE BENEFITS AND A SIGNED LIEN FROM YOUR ATTORNEY. <u>WE DO NOT BILL 3RD PARTY INSURERS UNTIL TREATMENT IS COMPLETED AND ALL OTHER BENEFITS HAVE BEEN APPLIED.</u>
I UNDERSTAND THE ABOVE AND AGREE TO COOPERATE FULLY IN PROCESSING THIS ACCIDENT CLAIM.

Patient/Guardian Signature____ Date_________________________