SANDY PLAINS CHIROPRACTIC CLINIC

2697 SANDY PLAINS ROAD, MARIETTA GA 30066 | 770-971-1355

PERSONAL INJURY QUESTIONANAIRE

NAME: _____ PHONE: (_____) _____

ADDRESS:_____ CITY/STATE/ZIP: _____

AGE: _____ DATE OF BIRTH: _____/_____/_____ SEX: _____ SS# _____-_____-_____

EMPLOYER'S NAME/ADDRESS: _____

YOUR AUTO INSURANCE CO: _____ POLICY # :_____
AGENT'S NAME: _____ PHONE: (_____) _____
NAME ON POLICY (if other than self):_____ MedPay? □ Yes □ No □ I don't know

RESPONSIBLE PARTY'S NAME/ADDRESS: _____
INSURANCE CO: _____ POLICY # :_____
AGENT'S NAME: _____ PHONE: (_____) _____
POLICY HOLDER'S NAME (if different): _____

CLAIM ADJUSTER'S NAME: _____ PHONE: (_____) _____
CLAIM #: _____

ATTORNEY'S NAME: _____ PHONE: (_____) _____
ADDRESS:_____ CITY/STATE/ZIP: _____

INJURY INFORMATION

NATURE OF ACCIDENT: □ Auto (please bring copy of **accident report**) □ Work-related □ Other _____
DATE OF INURY: _____/_____/_____ TIME OF DAY IT OCCURED: _____
Please write a brief description of how your injury occurred: _____
_____
_____

Were there any witnesses? □ Yes □ No Witness Name(s): _____

Did you have any physical complaints BEFORE the accident? □ Yes □ No If yes, please explain: _____
_____

Describe how you felt:

- DURING the accident: _____
- IMMEDIATELY AFTER the accident: _____
- LATER THAT DAY: _____
- THE NEXT DAY: _____

What are your PRESENT complaints and symptoms? _____
_____

Do you have any congenital (from birth) factors which relate to this problem? □ Yes □ No If yes, please describe: _____
_____

Do you have any previous illnesses which relate to this case? □ Yes □ No If yes, please describe: _____
_____

Have you ever been involved in an auto accident before this one? □ Yes □ No If yes, please include dates and types of accidents and injuries: _____

_____

Were you given Emergency Medical Care at the accident site? □ Yes □ No

Did you to the hospital? □ Yes □ No If yes, please give details: _____

_____

Have you been treated by another doctor since the accident? □ Yes □ No If yes, please provide doctor's name, address and phone number: _____

What type of treatment did you receive? _____

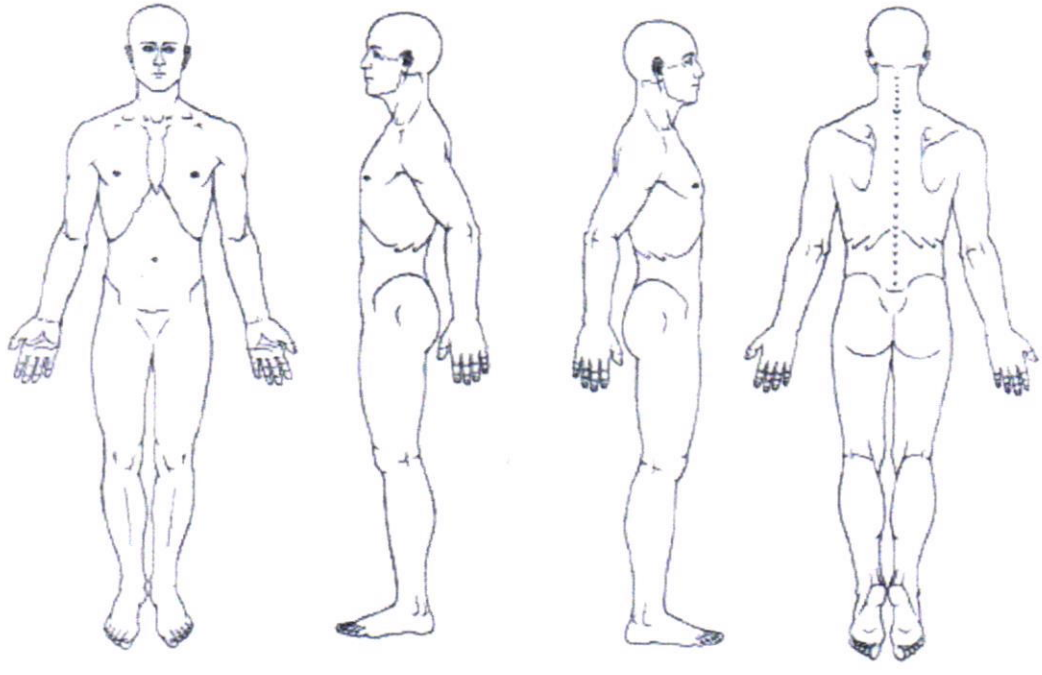
Are you experiencing any of the following SINCE the accident? (mark all that appy)

- □ Neck pain
- □ Shoulder pain
- □ Chest pain
- □ Arm/elbow pain
- □ Wrist/hand pain
- □ Back Pain
- □ Upper back pain
- □ Mid back pain
- □ Low back pain
- □ Hip pain
- □ Knee pain
- □ Ankle/foot pain
- □ Anxiety
- □ Depression
- □ Irritability
- □ Nervousness
- □ Blurry vision
- □ Eyes bothered by light
- □ Dizziness
- □ Ringing/buzzing in ears
- □ Loss of Balance
- □ Loss of smell
- □ Loss of Taste
- □ Breathing problems
- □ Shortness of breath
- □ Constipation
- □ Diarrhea
- □ Digestive problems
- □ Stomach upset
- □ Urinary difficulties
- □ Face flushed
- □ Fainting
- □ Fatigue
- □ Fever
- □ Head seems heavy
- □ Headaches
- □ Memory loss
- □ Sleeping problems
- □ Sore throat
- □ Tension
- □ Cold feet
- □ Cold hands
- □ Cold sweats
- □ Numbness in fingers
- □ Numbness in toes
- □ Pins/needles in arms/hands
- □ Pins/needles in legs/feet
- □ Other: _____ _____

Since the injury occurred, are your symptoms: □ Improving □ Getting worse □ the Same?

Please mark on the diagrams below where you feel your pain. Use appropriate symbols represented below.

Numbness ---- Pins & Needles oooo Burning xxxx Aching **** Stabbing ////



Have you lost time from work AS A RESULT OF this accident? □ Yes □ No If yes, please complete the following:

- Last day worked: _____
- Type of employment: _____
- Present salary: _____
- Are you being compensated for lost work time? □ Yes □ No If yes, what? _____

Do you notice any activity restrictions as a result of this injury? □ Yes □ No If yes, please describe in detail: _____

_____

_____

Please describe any other pertinent information about your accident: _____

_____

Are you pregnant? □ Yes □ No □ Not applicable / Male

Have you ever seen a Chiropractor? □ Yes □ No

COMPLETE THIS SECTION IF THIS WAS AN <u>AUTO ACCIDENT</u>:

Were you the ... □ Driver □ Passenger / in the □ Front Seat □ Back Seat?

How many people were in the vehicle? _____ Were you wearing a seat belt? □ Yes □ No

What direction were you headed? □ North □ South □ East □ West On what street? _____

What direction was the other vehicle headed? □ North □ South □ East □ West On what street? _____

From where were you struck? □ Behind □ Front □ Left side □ Right side

Approximate speed of YOUR car: _____mph / Approximate speed of OTHER car: _____ mph

Were you knocked unconscious? □ Yes □ No If yes, for how long? _____

Were the police notified? □ Yes □ No

_____ _____ ____/____/____

Printed Name of Patient Signature of Patient or Parent/Guardian Date

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Sandy Plains Chiropractic
2697 Sandy Plains Rd.
Marietta, GA. 30066
Ph (770) 971-1355
Fax (770) 509-8559
www.sandyplainschiro.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes **When?**

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Age

Gender ○ Male ○ Female

Birth Date (MM/DD/YYYY)

Race
○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American
○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White
○ Decline to answer

Ethnicity
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Decline to specify

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Smoking Status (age 13 and over)
○ Never A Smoker ○ Former Smoker
○ Current Every Day Smoker ○ Current Some Day Smoker
○ Heavy Smoker ○ Light Smoker

Address

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

City **State/Province** **ZIP/Postal Code** **Preferred Language**

Home Phone **Cell Phone** **Spouse's Name**

Email Address **Child's Name and Age**

Emergency Contact **Emergency Contact's Phone** **Child's Name and Age**

Your Occupation **Child's Name and Age**

Your Employer **Work Phone**

Address

May we contact you at work? ○ Yes ○ No

City **State/Province** **ZIP/Postal Code**

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

Primary Care Provider's Name

Insurance Carrier **Policy Number**

Insured's Last Name **Birth Date (MM/DD/YYYY)**

Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name **Insured's Middle Name (or Initial)**

Insured's Employer

Address

City **State/Province** **ZIP/Postal Code** **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical therapy ○ Ice
- ○ Surgery ○ Heat
- ○ Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical therapy ○ Ice
- ○ Surgery ○ Heat
- ○ Other _____

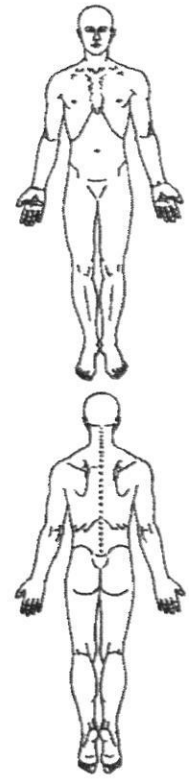
Additional Complaint
The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical therapy ○ Ice
- ○ Surgery ○ Heat
- ○ Other _____

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



1. What else should Sandy Plains Chiropractic know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

_____
Patient name

_____
Patient Number
(office use only)

_____
Doctor's Initials

Sandy Plains Chiropractic

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○ ○ Low energy

Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○ ○ PMS symptoms

Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○ ○ Weakness

Initials ____

Patient name _____

Patient Number (office use only) _____

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: _____

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

FAMILY

9. Family History

Some health issues are hereditary. Tell Sandy Plains Chiropractic about the health of your immediate family members.

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
_____		○	○			○	○

10. Are there any other hereditary health issues that you know about? _____

SOCIAL

11. Social History

Tell Sandy Plains Chiropractic about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

Doctor's Initials _____

Sandy Plains Chiropractic

12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? _____

14. How much sleep do you average per night? _____ **Hours**

15. What is the type and approximate age of your mattress and pillow? _____

16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Patient (or Guardian's) signature _____ Date (MM/DD/YYYY) _____

Consultation Notes

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

Sandy Plains Chiropractic

SANDY PLAINS CHIROPRACTIC CLINIC

DR MICHAEL MALLOY | DR BRENDAN MALLOY | DR JANET LEWIS
2697 SANDY PLAINS ROAD, MARIETTA GA 30066 | 770-971-1355

ATTENDANCE POLICY

Appointments are made to set aside designated time for the doctor to focus on each patient's specific needs. If you, the patient, are late for your appointment, you may have to wait for the next available opening or reschedule if there is no other availability that day.

If you are not able to be at your scheduled appointment, please call the office as soon as possible to cancel/reschedule the appointment. Sandy Plains Chiropractic Clinic (SPCC) reserves the right to charge a fee for any no-show/no-call appointments not cancelled/rescheduled at least 24 hours before the appointment time. A no-show/no-call fee is the responsibility of the patient and is not billed to insurance.

FINANCIAL POLICY – PERSONAL INJURY

At SPCC, we are committed to providing you with the best possible care and helping you to receive maximum benefits for your care. To achieve these goals, we will need your assistance and your understanding of our payment policy.

Please **initial** which payment option below you would like to use for your injury care:

- ___ Send claims to **MedPay** with patient's auto insurance company. (This option is dependent upon patient's coverage and maximum amount restrictions.) A signed Security Agreement form is required.
- ___ Send claims to **responsible party's insurance company**. Patient will pay $150 for the first visit, then $30 at each visit, which will be applied toward the final bill. The patient will pay the bill in full within ten (10) days of the of the liability claim settlement date or 90 days after the last treatment, whichever comes first.
- ___ Send claims to **patient's representing attorney** to obtain a security agreement/lien. This option may require a $30 fee at each visit which will be applied toward the final bill.
- ___ **Patient will pay** the amount due at each visit.

Please read and **initial** below:

- ___ SPCC **does not** file to major medical insurance for personal injury claims.
- ___ If massage therapy/neuromuscular therapy is part of the healing process, the patient will pay half of the therapy fee at time of service. Cancellations must be received at least 24 hours prior to the appointment time. Failure to follow this policy will result in the patient paying the full service fee.

If payment is due, it is expected when services are rendered, unless previous arrangements are made. SPCC accepts cash, check, debit cards and credit cards (Visa, MasterCard, Discover, American Express). There will be a $25 fee for any returned checks. We will file claims while you are under reactive care.

While the filing of claims is a courtesy we extend to our patients, **all charges incurred are ultimately and fully the patient's responsibility**. The patient will pay the bill in full within ten (10) days of the of the liability claim settlement date or 90 days after the last treatment, whichever comes first.

By signing below, I consent to SPCC's Attendance Policy and Financial Policy as stated above and acknowledge that I have been provided access to SPCC's Notice of Privacy Practices.

_____

Printed Name(s) of Patient/Family

_____ _____/_____/_____

Signature of Patient or Parent/Guardian Date

Sandy Plains Chiropractic Clinic

2697 Sandy Plains Road, Marietta GA 30066 | 770-971-1355
Dr Michael Malloy | Dr Brendan Malloy | Dr Janet Lewis

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS • PERSONAL INJURY

Provider: Patient Name: Date:

In consideration of Sandy Plains Chiropractic Clinic's (SPCC) undertaking to render care for me, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster to process any claim for reimbursement of charges incurred by me at your treatment facility.
2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider authority to affix my necessary signature as noted below to obtain medical information from any hospital, medical provider, etc, as it relates to the care being provided by my chiropractic doctor.
3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any insurance company which may become obligated to pay me any sums. The Patient(s) grant(s) to the Provider a Limited Power of Attorney to receive funds, negotiate any drafts or checks, and execute any documents related to payment for services rendered to me.
4. ASSIGNMENT OF RIGHT TO SUE: In the event that any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to execute said action either in my name or your name as you otherwise resolve the said claim as you see fit. **I understand that whatever amounts you do not collect from said insurance proceeds or legal settlement (whether it be all or part of what is due) shall be paid by me.**
5. RIGHT TO LIEN: I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by SPCC. I also irrevocably instruct my attorney to pay this office in full for services rendered to me for my accident-related injuries from any proceeds or settlements, claims, or judgement regarding said injuries. My legal counsel or successor or any representative is to pay the doctor/clinic before distributing any proceeds to me. I instruct said legal counsel or representative not to attempt to reduce by means of negotiation my doctor's bill for services that have been provided to me for the accident/injury/illness, which I have agreed to pay in full.
6. RIGHT TO INFORMATION: I irrevocably authorize my attorney or successor or legal representative, insurer, or any other party regarding my care or case to release financial information about the proposed settlement, settlement/verdict payments, or amounts owed included, but not limited to, other providers or legal representatives, liens, billing amounts, and balances. I also instruct all representatives to include all financial information from all facets of my case, including, but not limited to, third-party, uninsured motorists, and underinsured motorists.
7. STATUTE OF LIMITATIONS: I irrevocably waive the statute of limitations regarding my doctor's right to recover from me directly.

8. I hereby acknowledge that I am receiving (or about to receive) health care services, and I am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor(s) or if I have not engaged the services of an attorney, payment for services rendered by the above-named doctor(s) will be made on a current basis and my account paid in full immediately. In any event, I hereby promise to pay my bill in full within ten (10) days from the date that my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.
9. DELINQUENT PAYMENT: If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all court costs, attorney's fee, service of process fees, and any reasonable additional costs incurred in order to collect or that are associated with collecting monies due on the patient's account.
10. NO SURPRISE ACT: The chiropractic provider fees are derived from the Medical Fees in the United States by the Physicians Medical Information Corporation. They have been geographically modified and are billed at the 75th percentile. A good faith estimated cost for the items and services that would be furnished by this provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services will be provided after my first visit. I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible, out-of-pocket limit, or be covered. I am giving up some consumer billing protections under federal law. I may get a bill for the full charge for these services or have to pay out-of-network cost-sharing under my health plan. I irrevocably consent in accident cases to have balances applied toward liens or letters of protection with my attorney. With my signature I acknowledge that I am consenting of my own free will and am not being coerced or pressured.
11. I understand that this document is irrevocable and may not be rescinded, and that my attorney shall not honor any such recession. I hereby instruct that in the event another attorney is substituted in my case, the new attorney honor this lien as inherit to the settlement, judgement, verdict, or any other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on-demand, to provide the status of such litigation to the provider or his/her attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact the provider before disbursement of any funds to ascertain any outstanding balances due and owing.

Signed this _____ day of _____ 20___

Signature of Patient or Parent/Guardian _____

Signature of Witness _____

SANDY PLAINS CHIROPRACTIC CLINIC

2697 SANDY PLAINS ROAD, MARIETTA GA 30066 | 770-971-1355

SECURITY AGREEMENT & ASSIGNMENT OF AN INTEREST IN A PERSONAL INJURY CLAIM

TO: ☐ Attorney ☐Insurance Carrier
Company:_____
Address: _____
_____
Phone: _____

FROM: Sandy Plains Chiropractic Clinic
2697 Sandy Plains Road
Marietta GA 30066
770-971-1355 / Fax 770-509-8559
info@SandyPlainsChiro.com

RE Patient's records and Security Agreement & Assignment of and Interest in a Personal Injury Claim

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I do hereby authorize the Sandy Plains Chiropractic Clinic (SPCC) to furnish you, my attorney/insurance carrier, with a full report of case history, examination, diagnosis, treatment and prognosis of myself in regard to my **accident/illness which occurred/began on _____/_____/_____.**

I hereby give a lien to SPCC on any settlement and direct you, my attorney/insurance carrier, to pay directly to said clinic such sums as may be due and owing them for service rendered to me, and to withhold such sums from such settlement, claim, judgement or verdict as may be necessary to protect said clinic adequately. Prior to dispersing any such fees, it is the responsibility of the payor to verify with this office all outstanding balances.

I fully understand that I am directly and fully responsible to said clinic for all chiropractic bills submitted by them for service rendered me, and that this agreement is made solely for said clinic's additional protection and consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgement or verdict by which I may eventually recover said fee. I also understand and agree that I am responsible for any reasonable collections fees required to secure the clinic's payment.

I further understand that there is likely to be an outstanding balance at the end of my treatments. This balance may be due to uncovered expenses, such as orthopedic supplies and/or any medically necessary treatment beyond that authorized by my health insurance coverage. I agree to make any/all co-payments as per my health insurance contract.

_____	_____	____/____/____
Printed Name of Patient	Signature of Patient or Parent/Guardian	Date

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Attorney/Insurance Carrier,
Please sign, date and return to SPCC immediately. Keep a copy for your records.

The undersigned being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien and does agree to honor the same to protect adequately said above named clinic.

_____	_____	____/____/____
Printed Name of Authorized Representative	Signature of Authorized Representative	Date

Sandy Plains Chiropractic Clinic

2697 Sandy Plains Road, Marietta GA 30066 | 770-971-1355

INFORMED CONSENT TO CARE

You are the decision maker for your healthcare. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care that we recommend, the benefits and risks associated with the care, alternatives and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examination or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure. As with all types of healthcare intervention, there are some risks to care, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, health artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving healthcare or not. Patients who experience this condition often, but not always, present to the medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in 1 in 1,000,000 to 2 in 1,000,000 cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tracts was 1,219 events per 1,000,000 personas per year and risk of death has been estimated as 104 per 1,000,000 users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include but are not limited to: self-administered care, over-the-counter pain relievers, physical measure and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and healthcare as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Printed Name of Patient	**Signature** of Patient	____/____/____ Date
Printed Name of Parent/Guardian (if minor)	**Signature** of Parent/Guardian (if minor)	____/____/____ Date
	Signature of Witness	____/____/____ Date

Revised 12/17/24

SANDY PLAINS CHIROPRACTIC CLINIC

DR MICHAEL MALLOW | DR BRENDAN MALLOY | DR JANET LEWIS

2697 SANDY PLAINS ROAD, MARIETTA GA 30066 | 770-971-1355

HIPPA NOTICE OF PRIVACY PRACTICES

We may use and disclose your PHI (private health information) in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:

- You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.
- You have the right to inspect and obtain copies of your medical Information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)
- You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.
- You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.
- You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.
- You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

_____	_____	____/____/____
Printed Name	Signature of Patient or Parent/Guardian	Date