Active Life & Health Center

Our Address

Active Life & Health Center
6849 Peachtree Dunwoody Rd
Building B4, Suite 100
Atlanta, GA 30328
Phone # 770-522-9800

Basic Directions

We are located approximately half way between the intersection of Peachtree-Dunwoody RD & Abernathy RD and the North Springs Marta Station inside the Peachtreee-Dunwoody Park complex. Once in the complex we are in building B-4. To find Building B-4 follow the complex road as it goes through several curves until it open into a large parking area in the back. Once in the large parking area park anywhere you like and our office is the first door on the right once you enter building B-4. If you have any questions of you have any problems finding us feel free to call and someone will be happy to help.

Active Life & Health Center

Contact Information

Name _____ Address _____

City _____State ____ Zip _____ E-mail _____

Phone (H) _____ (W) _____ (C) _____

Birth date _____/_____/_____ S.S. # _____-_____-_____

Emergency Contact _____ Phone _____

About you

Employer_____ Type of work _____

(Circle One): Married / Single / Widowed / Divorced Spouse's name _____

Gender: M / F # of Children _____ Names & Ages _____
Referred by_____

General Health History

Please list any of the following:

Surgeries_____

Current Medications_____

Vitamins / Supplements _____

Car Accidents / Trauma_____

Hospitalizations _____

Broken Bones_____

Primary Problem

Reason for Visit _____ Rate severity on a scale of 1-10_____

Have you seen other doctors for this? Y / N Who? _____

Type of treatment _____ Results _____

When did the problem begin: _____ Have you had this problem before: Y / N When?_____

Is this problem related to (circle): Job / Auto Accident / Sports / Unknown / Other_____

Are there activities you cannot perform: _____

Musculo-Skeletal

__ Low Back Pain
__ Pain Between Shoulders
__ Neck Pain
__ Arm Pain
__ Joint Pain
__ Stiffness
__ Walking Problems
__ Knee Pain
__ General Stiffness
__ Elbow Pain
__ Tension in Joints
__ Tension Headaches

Nervous System

__ Numbness
__ Sciatica
__ Dizziness
__ Pain Down the Arm / Leg
__ Confusion (Unusual)
__ Fainting
__ Tingling in Hands / Feet
__ Migraine Headaches

Digestive System

__ Poor / Excessive Appetite
__ Excessive Thirst
__ Nausea
__ Vomiting
__ Diarrhea
__ Constipation
__ Hemorrhoids
__ Abdominal Cramps
__ Weight Change (Unexplained)
__ Heartburn
__ Excessive Gas / Bloating
__ Colitis
__ Crohn's Disease / IBS

General

__ Fatigue
__ Allergies
__ Insomnia / Lack of Sleep
__ Fever
__ Headaches (General)
__ High Stress
__ Pregnant – Months _____

C-V-R System

__ Chest Pain
__ Shortness of Breath
__ Blood Pressure Problems
__ Irregular Heartbeat
__ Heart Problems
__ Lung Problems
__ Ankle Swelling
__ Stroke (At any time)
__ Heart Attack (At any time)

Family History

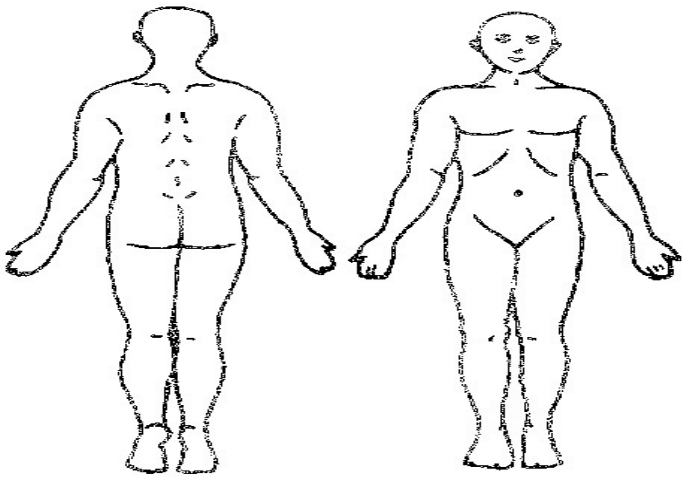
__ Cancer
__ High Blood Pressure
__ Heart Attack
__ Diabetes
__ Stroke

Please list who in your family has these problems.

_____
_____
_____

If there is any problem that is not listed above that you would like the doctor to know about, or may be important, please list in this box:

_____
_____



Please outline on the diagram the area of your discomfort

Most patients that come to our office have one of two objectives in mind concerning their health. Please let us know what kind of care you are expecting or desire to have by putting an "X" at the bottom of the box….

Relief Care-	**Corrective Care-**
Only the care that is needed to get rid of symptoms, but not focusing on the cause of the problem. Our goal is just to get you out of pain or discomfort. This is a shorter process, but after time it is possible the problems will return.	The goal is to not only relieve the symptoms, but to also correct the underlying cause of the problem if possible. This type of care may go on past the time that the patient is free of all symptoms.
_____	_____

If you are listed under someone else's insurance policy, please list the primary insured's name and

Birth Date Name _____ DOB _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to file such insurance on my behalf. However, I clearly understand and agree that all services rendered me are charged directly to me and I am ultimately personally responsible for payment.

I hereby authorize the doctor to treat my condition as he/she sees appropriate. If I do not agree to a treatment, I must notify the doctor ahead of time.

I understand that fees are paid for x-ray, but the physical x-ray films will remain as the property of the office until the statute of limitations for records is reached (3 years). After that time the films will be destroyed. Films may be signed out with the appropriate paperwork, but must be picked up and signed for in person.

Sign Name _____ Date ____/_____/_____

Print Name _____

Consent to
treat minor _____ Date _____/_____/_____

Thank you!

Active Life & Health Center LLC
6849 Peachtree Dunwoody Rd
Building 4, suite 100
Atlanta, GA 30328

THIS NOTICE PERTAINS TO PRIVACY MEASURES
PREFORMED IN ACTIVE LIFE & HEALTH CENTER LLC.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for Active Life & Health Center, LLC (the Practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent, and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the following address/phone number/fax number/e-mail address:

_____

The Practice may communicate confidential information about me to the following individual(s):

_____

_____ _____/_____/_____
Patient/Patient Representative Date

Terms of Acceptance ~ Informed Consent for Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.
Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae on the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Results: The purpose of chiropractic services is to provide health through the release of maximum nervous energy. Since there are so many variables, it is difficult to predict the time schedule and efficiency of chiropractic procedures. Sometimes the results are phenomenal. In some cases, there is a more gradual response, and occasionally the results are less than expected. Many people find results with chiropractic care, in turn we must admit that conditions which do not respond chiropractic, may come under the control of medical sciences. We will do our very best in determining if you need chiropractic care; however, we cannot be held responsible for a medical diagnosis, or be responsible for a medical referral.
We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the service of another health care provider.
Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct the vertebral subluxation.

I, _____, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction and I agree with the above statements. I therefore accept chiropractic care (including Chiropractic Examination, X-ray, and Adjustments) on this basis.

Signature_____ Date _____

Consent to evaluate and adjust a minor child

I, _____, being the parent of legal guardian of_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic evaluation (including X-ray examination) and care.
Signature
_____Date_____

AUTHORIZATION FORM

Patient Name _____ SSN: _____-_____-

RELEASE OF INFORMATION
I hereby authorize ***Active Life & Health Center*** to release medical and financial data to my insurance carriers and attorney. **INITIALS_____**

RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. ***Active Life & Health Center*** cannot accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or pre-certification procedures. I also understand that if I suspend or terminate my care and treatment, the fees for services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required for collection. **INITIALS_____**

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 ***Active Life & Health Center***. The undersigned states that he/she is the patient's legal guardian. **INITIALS_____**

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER
I hereby irrevocably authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to ***Active Life & Health Center*** for professional services rendered. NO OTHER THIRD PARTY, including attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office. **INITIALS_____**

SUBROGATION AND RIGHTS OF REIMBURSTMENT
If I, or one of my covered dependents receive benefits under my health insurance carrier, hereinafter referred to as Carrier, due to an injury or illness as a result of the acts of a third party. I agree to repay the Carrier any amount of money that I receive from third party or its insurer as compensation for such injuries up to the amount paid out by the Carrier. I understand that this includes the insurer or other agent or if I enter into any form of settlement regarding an accident which I or my covered dependents are injured as a result of the acts of a third party. I will do whatever is reasonably needed to secure the Carriers rights and shall do nothing to damage such rights. I will abide by this agreement only if my health insurance policy contains language that gives the health insurance carrier subrogation and rights of reimbursement. **INITIALS_____**

Signature _____ Date _____