



Lefranc Chiropractic, LLC

Starting Care: Outline of What to Expect

- 1) All new patients are required to fill out the attached personal health history questionnaire, as well as a few basic compliance / HIPPA forms for the office.
- 2) Next, there will be a one-on-one consultation between you and your doctor to discuss your health problems. This is to help the doctor to fully understand your problems and concerns. This will be followed by a comprehensive physical exam to gain further insight into your problems, and determine their possible cause.
- 3) The doctor will decide if it is appropriate and safe to treat you on the first visit based on your exam findings and consultation. It is possible the doctor may determine that it is not advisable to treat you until further diagnostic testing such as X-ray, MRI, nerve conduction velocity test's, or further lab studies have been performed. The doctor will send you to the proper place for these tests. The patient will be asked to return at a later date to review the tests and/or lab results with the doctor.
- 4) Treatment recommendations and expectations will be set, and any questions you may have will be answered. If necessary, referrals to other health care providers will be made at this time.
- 5) Care will now begin, and further explanations will be given on how your treatment will be performed.
- 6) Care will continue until the maximum correction of your problem has been achieved. You will then have the choice to continue with maintenance/preventative care if you like.

PLEASE KEEP THIS FORM

Lefranc Chiropractic, LLC
6849 Peachtree Dunwoody Rd
Building 4, Suite 100
Atlanta, GA 30328
Phone # 404-990-4678



Lefranc Chiropractic, LLC

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 / Domestic Partnership / Widowed / Divorced / Single
Spouse's name _____
Gender: M / F # of Children _____ Names & Ages _____

General Health History

Please list any of the following:

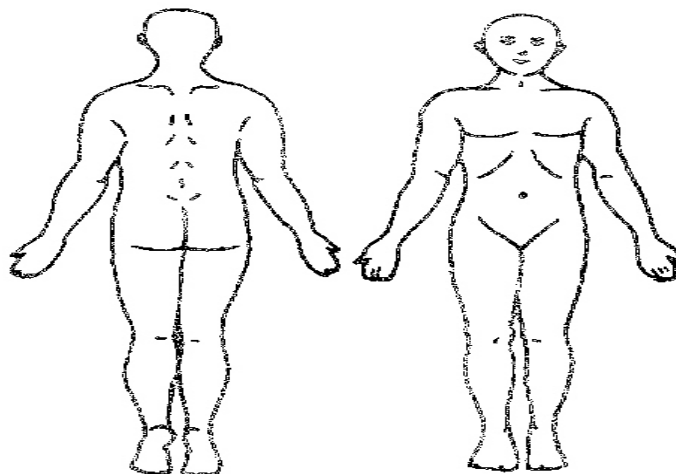
Surgeries _____
Current Medications _____
Vitamins / Supplements _____
Car Accidents / Trauma _____
Hospitalizations _____
Broken Bones _____

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? _____

Please place an "X" by each problem you have had in the past 6 months:

<p><u>Musculo-Skeletal</u></p> <p><input type="checkbox"/> Low Back Pain</p> <p><input type="checkbox"/> Pain Between Shoulders</p> <p><input type="checkbox"/> Neck Pain</p> <p><input type="checkbox"/> Arm Pain</p> <p><input type="checkbox"/> Joint Pain</p> <p><input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Walking Problems</p> <p><input type="checkbox"/> Knee Pain</p> <p><input type="checkbox"/> General Stiffness</p> <p><input type="checkbox"/> Elbow Pain</p> <p><input type="checkbox"/> Tension in Joints</p> <p><input type="checkbox"/> Tension Headaches</p>	<p><u>Digestive System</u></p> <p><input type="checkbox"/> Poor / Excessive Appetite</p> <p><input type="checkbox"/> Excessive Thirst</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Abdominal Cramps</p> <p><input type="checkbox"/> Weight Change (Unexplained)</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Excessive Gas / Bloating</p> <p><input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> Crohn's Disease / IBS</p>	<p><u>C-V-R System</u></p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Blood Pressure Problems</p> <p><input type="checkbox"/> Irregular Heartbeat</p> <p><input type="checkbox"/> Heart Problems</p> <p><input type="checkbox"/> Lung Problems</p> <p><input type="checkbox"/> Ankle Swelling</p> <p><input type="checkbox"/> Stroke (At any time)</p> <p><input type="checkbox"/> Heart Attack (At any time)</p>
<p><u>Nervous System</u></p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Pain Down the Arm / Leg</p> <p><input type="checkbox"/> Confusion (Unusual)</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Tingling in Hands / Feet</p> <p><input type="checkbox"/> Migraine Headaches</p>	<p><u>General</u></p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Insomnia / Lack of Sleep</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Headaches (General)</p> <p><input type="checkbox"/> High Stress</p> <p><input type="checkbox"/> Pregnant – Months _____</p>	<p><u>Family History</u></p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Stroke</p> <p>Please list who in your family has these problems.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>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:</p> <p>_____</p> <p>_____</p>		



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-

The care that is needed to alleviate your symptoms, but is not focused on correcting the cause of the problem. This is similar to drying a floor that has become wet from a leak, but not fixing the leak. “Relief Care” is a shorter process, but after a time, it is likely the symptoms will return.

Corrective Care-

The care that is needed to not only relieve your symptoms, but to also correct the underlying cause of the problem if possible. “Corrective Care” will likely continue past the time that you are free from your symptoms, but the goal here is to not have the problem return.

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

Name _____ DOB _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. 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 to 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 sees appropriate. If I do not agree to a treatment, I must notify the doctor ahead of time.

Sign Name _____ Date ____/____/____

Print Name _____

Consent to
treat minor _____ Date ____/____/____

Thank you!

Lefranc Chiropractic, LLC
6849 Peachtree Dunwoody Rd
Building 4, Suite 100
Atlanta, GA 30328

*THIS NOTICE PERTAINS TO PRIVACY MEASURES
PERFORMED AT LEFRANC CHIROPRACTIC, 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 Lefranc Chiropractic, 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 its 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 *Lefranc Chiropractic, LLC* 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. *Lefranc Chiropractic, LLC* 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 *Lefranc Chiropractic, LLC*. 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 *Lefranc Chiropractic, LLC* 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 _____