Eastside Chiropractic, P.C.

1011 Woodridge Lane, Building 301

Watkinsville, Georgia 30677

Dr. Bryan Hooper

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. (Please Print)

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Sex: ☐ Female ☐ Male Date of Birth_____ Email_____

Home (_____)_____ Cell (_____)_____

Patient Employer/School_____ Occupation_____

Employer/School Adress_____ City_____ State_____ Zip_____

Spouse or Parents Name_____ Employer_____ Work Phone_____

Whom may we thank for referring you to us:_____

Person to contact in case of emergency:_____ Relationship to Patient: _____ Phone: (_____)_____

Responsible Party

Name of person responsible for this account_____

Relationship to patient:_____ Phone (_____)_____

Address_____ City_____ State_____ Zip_____

Name of Employer_____ Phone (_____)_____

Insurance Information (Please present your card to office staff)

Name of Insured: _____ Relationship to patient: _____

Insurance Co_____ Phone_____ Member ID#_____

Symptoms

Reason for visit:_____

When did you first notice the symptoms?_____

Is this condition getting progressively worse? _____

Where is the problem(s) located? _____

Which activities are difficult to perform? ☐Sitting ☐Standing ☐Walking ☐ Bending ☐ Lying Down

☐Other:_____

Type of Pain: ☐Sharp ☐ Dull ☐Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐Burning ☐Tingling

☐ Cramps ☐ Stiffness ☐ Swelling

Other:_____

Rate the severity of your pain: (1 for mild pain or discomfort, 10 for severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come or go? _____

Pain is relieved by: _____

What treatment have you already received for your condition? ☐Medication ☐Surgery ☐Physical Therapy ☐Massage

Name and contact information of other doctors who have treated you for your condition:_____

_____

Daily Habits

What type of exercise do you perform daily? ☐None ☐Moderate ☐Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work?)

_____

_____

What vitamins do you currently take?_____

What kind of other nutritional supplements do you take (if any)?_____

_____

Do you smoke? ☐Yes ☐No How much per day? _____

How much alcohol do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume daily? _____

Health History

Check only those conditions which apply

- ☐AIDS
- ☐Alcoholism
- ☐Allergy shots
- ☐Anemia
- ☐Anorexia
- ☐Appendicitis
- ☐Arthritis
- ☐Asthma
- ☐Bipolar
- ☐Bleeding Disorders
- ☐Breast Lump
- ☐Bronchitis
- ☐Bulimia
- ☐Cancer
- ☐Cataracts
- ☐Chemical Dependency
- ☐Chicken Pox
- ☐Congestive Heart Failure
- ☐COPD
- ☐Depression
- ☐Diabetes
- ☐Emphysema
- ☐Epilepsy
- ☐Fractures
- ☐Glaucoma
- ☐Goiter
- ☐Gonorrhea
- ☐Gout
- ☐Heart Disease
- ☐Hepatitis
- ☐Hernia
- ☐Herniated Disc
- ☐Herpes
- ☐High Blood Pressure
- ☐High Cholesterol
- ☐Hypertension
- ☐Kidney Disease
- ☐Liver Disease
- ☐Measles
- ☐Mental Health Problems
- ☐Methamphetamine Use/Exposure
- ☐Migraine Headaches
- ☐Miscarriage
- ☐Mononucleosis
- ☐Multiple Sclerosis
- ☐Mumps
- ☐Osteoporosis
- ☐Pacemaker
- ☐Parkinson's Disease
- ☐Pinched Nerve
- ☐Pneumonia
- ☐Polio
- ☐Prostate Problems
- ☐Prosthesis
- ☐Psychiatric Care
- ☐Rheumatoid Arthritis
- ☐Rheumatic Fever
- ☐Scarlet Fever
- ☐Schizophrenia
- ☐Stroke
- ☐Suicide Attempt
- ☐Surgeries
- ☐Thyroid Problems
- ☐Tonsillitis
- ☐Tuberculosis
- ☐Tumors, Growth
- ☐Typhoid Fever
- ☐Ulcers
- ☐Vaginal Infections
- ☐Venereal Disease
- ☐Whooping Cough
- ☐Other_____

Date of last physical exam_____

Women Only: Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking Birth Control Pills? ☐Yes ☐ No

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all current medications::_____

_____

Allergies: _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Bryan Hooper, Eastside Chiropractic, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Date

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Cancellation Policy

1. If a patient cancels an appointment less than 24 hours prior to the appointment time, they will be charged a $50 late cancellation fee even if the appointment is rescheduled. Appointments may only be cancelled/rescheduled by calling our office. **Cancellation messages will be accepted on our voice mail system which is date/time stamped and available 24/7.**
2. If a patient does not show up for a scheduled appointment, they will be charged a $50 no show fee. If a patient does not show up for a scheduled appointment three times, they will risk being dismissed from the practice.
3. Cancellation and no-show fees must be paid before receiving treatment.
4. The same rules apply to a massage therapist visit; however, the late fees will be $80 for a 60-minute massage and $120 for a 90-minute massage.
5. If a patient shows up 15 or more minutes late for an appointment, they will lose their appointment slot, incur the $50 fee, and need to be rescheduled.
6. If a patient is running less than 10 minutes late, they must call the office to make sure they can still be seen and may lose their appointment slot.

***** Dr. Hooper's cell phone cannot be contacted to schedule, reschedule, or cancel appointments.**

I have read and understand the policies stated above and agree to be bound by them by signing this document.

_____ _____

Patient's signature (or legal guardian) Patient's Printed Name

Date: _____

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Financial and Insurance Policy

It is the patient's responsibility to ensure that we have complete and accurate insurance and contact information when you check in for each visit. Any unpaid claims due to misinformation given to us will result in the patient being held financially responsible for services rendered.

1. Our office agrees to verify your insurance benefits and eligibility to determine what chiropractic treatments are covered under your policy. In addition, we verify any copay, deductible, or coinsurance that applies. **Verification of benefits does not guarantee payment.**
2. **Payment is due at time of service.** No exceptions. This includes copays, deductibles, and noninsurance charges.
3. **Patients with insurance:** We agree to bill only insurance companies with whom we are contracted and considered in-network. Discounts and other incentives we offer cannot be combined with insurance. After claims are filed and processed, **you will be billed for any remaining balance.** We expect bills to be paid within 30 days.
4. **Patients without insurance:** We offer non-insurance rates for uninsured patients.
5. **Personal Injury patients:** We do not accept liens. We will accept the non-insurance rate per visit or we will agree to file through your insurance company.
6. **Methods of payment:** We accept cash, checks, and all major credit cards. We do not accept postdated checks.
7. **Collections:** Accounts that are not paid within 30 days will be turned over to a collection service. Should you discontinue care for any reason, your entire balance will become due immediately.
8. **Cancellation fee:** No shows and appointments canceled in less than 24 hrs of the scheduled appointment time will be assessed a $50 late cancellation fee. Patients who no-show for appointments more than three times risk being dismissed from the practice.
9. **Dismissal:** We reserve the right to dismiss patients for excessive appointment cancelations, missed appointments without notification, and refusal to settle their account balance.

I have read and understand the policies stated above and agree to be bound by them by signing this document.

_____ _____

Patient's signature (or legal guardian) Patient's Printed Name

Date: _____

Eastside Chiropractic Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

For further information regarding this Notice, you may contact the Privacy Officer at (706) 310-1121.

How we may use and disclose medical information about you: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

Who Will Follow This Notice: This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

Policy Regarding the Protection of Personal Information: We create a record of the care and services you receive at the Practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny yourrequest to inspect and copy in certain extremely limited circumstances.

Right to Amend: If you feel the medical information we have for you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment and provide reason for denial in writing within 60 days.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or is required or authorized by law. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Restrict Disclosures to Health Plan: You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. One accounting per year will be provided for free. We will charge a reasonable cost-based fee if another is requested within 12 months.

Changes to this Notice: We reserve the right to change this notice.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Carole Huntsman, Practice Manager, at (706) 310-1121, 1011 Woodridge Lane Bldg. 301, Watkinsville, GA 30677. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Other Uses of Medical Information: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

Effective Date: 11/03/2020

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Privacy Policy and Consent

I, _____ (print patient name) acknowledge and agree to the following:

1. The Practice's Privacy Notice has been provided to me prior to signing this consent.
2. The Privacy Notice includes a complete description for the uses and/or disclosure of my protected health information necessary to be treated and to obtain payment for treatment.
3. The Practice reserves the right to change it privacy practices described in the notice in accordance with applicable law.
4. I understand the practice can require a new policy be signed at any time. A new signature will be required if the policy is revised. I also understand that I can revoke consent in writing for all future transactions. It will not be retroactively applied.
5. I understand that if I revoke this consent at any time, the practice has the right to refuse treatment.
6. I authorize Eastside Chiropractic to communicate appointment reminders via email or text messages to addresses and/or phone numbers I have provided. These messages will consist of a reminder for my booked appointment date and time. If I am unable to keep my appointment, I will call the office to reschedule. I realize that such communication is not always secure and these messages can be intercepted. I understand that Eastside Chiropractic will not communicate personal health information through this method. Text message charges from my cell phone provider may apply.

I have read and understand this policy and all my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Patient's signature (or legal guardian) Patient's Printed Name

Date: _____

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Informed Consent for Treatment

Chiropractic care can be associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. Some risks can include fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise professional medical judgement based upon the facts known to him to do what is in my best interest during the procedure. I have had the opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. The doctor will not be held responsible for any preexisting medically diagnosed conditions.

By signing this consent, I hereby authorize the physicians and staff at Eastside Chiropractic to treat my condition as deemed appropriate using chiropractic adjustments and procedures, including various modes of physical therapy. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment from the doctors at Eastside Chiropractic, PC.

I have read and understand this policy and all my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Patient's signature (or legal guardian) Patient's Printed Name

Date: _____