Patient Re-Activation Form – New Condition

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss (check one) Gender: ☐ Male ☐ Female Date: _____ /_____/_____

First Name: _____ Middle Initial: _____ Last Name: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Preferred contact method: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Email:_____

Primary Doctor: _____ City:_____ State:_____

When did your symptoms start or condition worsen? _____

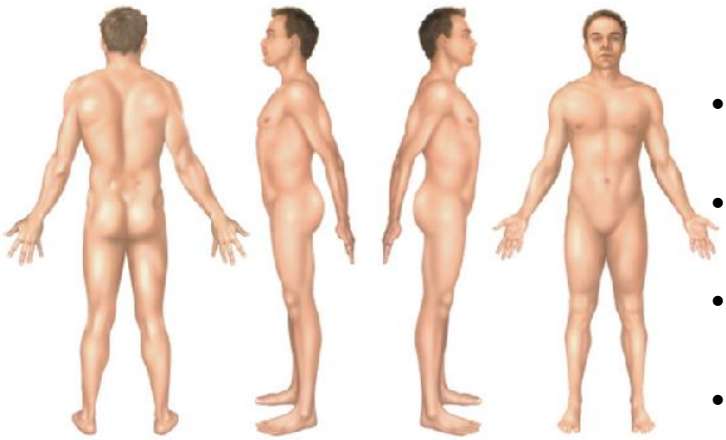
What do you believe is causing your symptoms? _____

_____

Describe your symptoms. (Deep, Aching, Stiff, Sharp, etc.): _____

_____

Please mark where your pain/symptoms are:



Please Grade your pain on a scale of 0-10:
And
[0= No Pain, 10= Extreme Pain]

Choose how Frequent the pain is present:

- **Neck: 0 1 2 3 4 5 6 7 8 9 10**
  - **Seldom - Intermittent - Frequent - Constant**
- **Upper/Mid Back: 0 1 2 3 4 5 6 7 8 9 10**
  - **Seldom - Intermittent - Frequent - Constant**
- **Lower Back: 0 1 2 3 4 5 6 7 8 9 10**
  - **Seldom - Intermittent - Frequent - Constant**
- **Other:_____**
  - **0 1 2 3 4 5 6 7 8 9 10**
  - **Seldom - Intermittent - Frequent - Constant**

Circle the activities that aggravate your condition:

- sitting
- stooping
- coughing
- looking up
- lying face up
- chores
- carrying
- opening jars
- standing
- lifting
- straining
- look down
- driving
- exercise
- pulling
- reading
- recreation
- walking
- sleeping
- reaching
- movement
- typing
- stairs
- running
- picking up objects
- bending
- sneezing
- twisting
- rest / sleeping
- scooping
- shopping
- sit to stand
- reaching behind
- throwing
- writing
- sports activities

Circle activities that relieve your condition:

- sitting
- leaning for support
- ice
- rest
- standing
- not moving
- topical gel
- stretching/ exercise
- lying down
- movement
- ibuprofen
- adjustment
- knees bent
- heat
- prescribed medication

Have you ever had an auto accident or work injury? □ Yes □ No

- **If so, □ Past Year □ Past 5 Years □ Over 5 Years**
- **If so, did you receive treatment? □ Yes □ No**
- **If so, please list treatment.**

_____

_____

Have you seen any other providers for this condition? □ Yes □ No List below who and when.

_____

_____

Have you had any surgeries in the past 5 years? □ Yes □ No List type and the date.

_____

_____

Are you currently taking any medications? □ Yes □ No List below.

_____

_____

Have there been any changes to your health since your last office visit? □ Yes □ No

- **Smoked/chewed tobacco? □ Yes □ No**
- **Allergies to Medications? □ Yes □ No**
- **Diagnosed with Hypertension? □Yes □No**
- **If Yes please explain changes below:**
- **Spinal Surgery □ Yes □ No**
- **Diagnosed with Diabetes? □ Yes □ No**
- **Diagnosed with Cancer? □ Yes □ No**

_____

_____

Have you had any imaging taken since the last time you were seen in our office? □ Yes □ No
List below when and where:

_____

For staff use (below):

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____

Patient Name: _____ Pt. #:_____

Authorization, Consent and Release

I consent and authorize the providers of Atlantic Chiropractic Associates, P.A. to examine and/or treat me / my child/legal dependent, if patient is a minor, today and during future office visits.

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me / my dependent during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay benefits directly to Atlantic Chiropractic Associates, P.A., for the services rendered. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all co-pays, deductibles, and any other subscriber liabilities at the time that services are rendered, as are allowable.

_____ _____

Signature of Patient or Parent/Guardian of Minor Patient Date

Financial Policy

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.** For your convenience, we accept Visa and MasterCard.

Your Insurance

We have made prior arrangements with many insurers and health care plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event that your health coverage plan determines a service to be "not covered," **you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not participate, **payment is expected at the time that services are rendered**. We will provide you with a receipt from our office for you to submit to your insurance carrier. Your insurance company should then send the payment directly to you.

Missed Appointments

In order to provide the best possible service and availability to all our patients, there may be a $15.00 fee for any doctor appointment not canceled at least 24 hours in advance. Also, due to the scheduling of massage therapy, there may be a fee of 75% of our regular massage charges for appointments not canceled at least 24 hours in advance. Please call us as early as possible if you know you will need to reschedule your appointment. More than three (3) "no show" appointments without a valid reason may result in discharge from our practice.

I have read and understand the financial policy of the practice; and, I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Acknowledgment of Privacy Practices

Our practice is committed to protecting privacy and confidentiality. With my consent, Atlantic Chiropractic Associates, P.A., may use and disclose Protected Health Information (PHI) about me or my dependant to perform treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices of Atlantic Chiropractic Associates, P.A. for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

_____ _____

Signature of Patient or Parent/Guardian of Minor Patient Date