Excel Chiropractic
285 Mount Vernon Hwy NE, Suite A • Atlanta, GA • 30328
Office: (770) 743-4393 • ExcelChiroAtlanta@gmail.com • www.ExcelATL.com

Dr. Ben Cohen, D.C.

Dear Patient:

We would like to provide you with a brief overview of what to expect in your first visit to our clinic.

Your initial visit will include a consultation, exam, and a full set of spinal x-rays. You will also be given some therapeutic treatment for your areas of complaint. The first visit will take approximately 45 minutes to an hour which will allow your doctor to address your areas of complaint and compile information regarding those areas through exam and x-rays. You will be asked to schedule a second visit to review your x-ray findings with your doctor. A second visit is required because your doctor will need to process the x-rays, review them along with your exam findings and compile a detailed report. During your report, the doctor will address your complaints and concerns and explain the cause. You will also be given recommendations for treatment and how these concerns may be addressed.

Because we are a multidisciplinary clinic, Excel Chiropractic provides chiropractic care, therapeutic exercises and modalities, and massage therapy. Each specialty is offered to address different issues while working together for the common goal of improving our patient's health.

Our front desk staff will be asking you for a copy of your insurance (if applicable), to provide a complimentary insurance benefits check. Our expert insurance department will be able to explain to you what financial options are available to you should you decide to seek treatment after your first two visits. Your insurance will not be charged for these first two visits. Our insurance department is simply providing the courtesy of verifying your benefits so that you may decide regarding any future treatment.

Excel Chiropractic providers bring extensive experience in treating the symptoms for which our patients come in. There is no obligation after you receive your first two visits to continue to treat here. Regardless of your decision for treatment, we sincerely hope that our patients have their concerns addressed. Should you decide to seek treatment, please feel assured that your health and results are what makes our practice a success!

We hope your experience on your first visits will be enjoyable and that our staff will answer the questions you have regarding your health. If you have any questions or concerns, please do not hesitate to ask a staff member.

Sincerely,

Dr. Ben Cohen and the Staff of Excel Chiropractic

NEW PATIENT APPLICATION

Welcome to Excel Chiropractic! Please thoroughly complete all questions. Thank you.

Name:_____ Today's Date:_____

Address:_____

City/State/Zip:_____ E-Mail:_____

Phone: Home _____ Work:_____ Fax:_____

Cell #:_____ Marital status: M/W/D/S

Birthdate: _____/_____/_____ Age:_____

How did you hear about our office? _____

Who may we thank for referring you? _____

Your prior Doctor of Chiropractic: _____

City, State: _____

Chiropractic adjusting techniques you've had success with: _____

Last time you went to previous Doctor of Chiropractic: _____

General Practitioner name: _____ Phone: _____

City, State: _____

Other Specialists you are currently under care with:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Occupation: _____

Employer name: _____ Phone: _____

Employer's address:_____

Spouse's name:_____

Spouse's employer:_____

Children's names & ages:_____

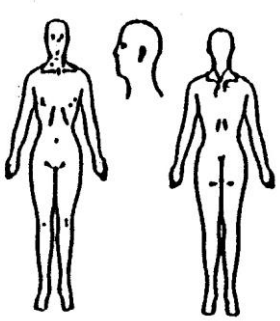
_____

Favorite hobbies or interests:_____

_____

Method of payment for first visit:
_____Cash _____Check _____Credit Card

Mark area(s) of Health Concerns



EXCEL CHIROPRACTIC

Health reasons for consulting our office:

1._____ 2._____

3._____ 4._____

Have you had same or similar problem(s) before?___Yes ___No
How long: _____ Please explain: _____
_____
Father/Mother/Brother/Sister/Children, with similar problems?
_____

Is this the result of an auto or work injury?_____If so, when? _____

Other symptoms:

- ❒ Headaches
- ❒ Neck Pain
- ❒ Sleeping Problems
- ❒ Back Pain
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Chest Pains
- ❒ Dizziness
- ❒ Face Flushed
- ❒ Neck Stiff
- ❒ Pins & Needles in Legs
- ❒ Pins & Needles in Arms
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Shortness of Breath
- ❒ Fatigue
- ❒ Depression
- ❒ Light Bothers Eyes
- ❒ Loss of Memory
- ❒ Ears Ring
- ❒ Fever
- ❒ Fainting
- ❒ Cold Sweats
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Diarrhea
- ❒ Feet Cold
- ❒ Hands Cold
- ❒ Stomach Upset
- ❒ Constipation
- ❒ Loss of Balance
- ❒ Buzzing in Ear
- ❒ Other_____ _____

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.
_____
Other doctors who have treated this problem:_____
_____

Surgery you have had (ALL):_____
Accidents/Trauma (ALL): _____
Medication(s) you currently take:_____

Is there any chance you are pregnant? No_____ Yes_____
Have you received X-rays in the past 6 months? No____ Yes____ If yes, when?_____

What do you understand chiropractic care to be?
_____
Do you know what a subluxation is? Yes or No If yes, please describe:
_____
What daily rituals for spinal health do you presently practice?
_____
Have you ever been diagnosed with cancer?___ If so, what type?
_____
Do you have health (crisis care) insurance?_____ Name of company:_____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature:_____ Date:____/____/____

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

In the course of your care as a patient at Excel Chiropractic we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, email address and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- If you are not at home to receive an appointment reminder, a message may be left on your answering machine or via email. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care
- Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:
    - o If we are providing health care services to you based on the orders of another health care provider.
    - o If we provide health care services to you in an emergency.
    - o If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
    - o If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
    - o If we are ordered by the courts or another appropriate agency.
- Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.
- We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form please advise us in writing as to your preference.
- You have the right to inspect and/or copy your health insurance information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health-related information should be provided in writing.
- We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.
- We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all your health information in our files.
- Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provided the information and may no longer be protected by the federal privacy rules.
- If you have a complaint, or would like further information regarding our privacy notice, policies and practices you should direct your inquiry or complaint to: Dr. Ben Cohen, Privacy Officer for Excel Chiropractic.

CHIROPRACTIC AND MEDICAL INFORMATION DISCLOSURE FORM (PAGE 2)

- This office utilizes a “semi-open-adjusting” environment for ongoing patient care. “Semi-open adjusting” involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in a semi-open adjusting environment, other arrangements will be made for you.
- Since this office utilizes a “semi-open adjusting” environment, established patients occasionally request family members or friends, be present during their visits. It is the policy of this office to allow for this.
- This office utilizes the use of patient names in some of its interior/exterior designs of the office. For example, referral boards (acknowledging patients that have referred other patients), welcome boards which display patient names, testimonial books and website testimonials where patients have written personal health information as well as the benefits of their care in this office. It is our view that these kinds of material are what is known as “incidental disclosures”. If, however, you do not choose for your name to be displayed or disclosed on any of the above-mentioned materials please inform us in writing. While this entire authorization is valid for seven (7) years. It is the policy of this office to not disclose any information about you without your prior consent. This office will notify you via phone, email or personal communication prior to utilizing your name for any reason.

This notice is effective as of _____ (date). This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (please print) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____

Personal Representative Printed | Personal Representative Signature | Date

_____

Description of the authority to act on behalf of the patient

Excel Chiropractic
285 Mount Vernon Hwy NE, Suite A
ATLANTA, GA 30328
770-743-4393

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PHYSICIAN

Private, Group, Accident and Health Insurance

I hereby authorize and direct _____ Insurance Carrier to pay by check made out and mailed directly to:

Excel Chiropractic
285 Mount Vernon Hwy NE, Suite A
Atlanta, GA, 30328
770-743-4393

If my policy prohibits direct payment to my doctor then I hereby instruct and direct the check to be made to me and mailed as follows:

Excel Chiropractic
285 Mount Vernon Hwy NE, Suite A
Atlanta, GA 30328
770-743-4393

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and have I agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS AGREEMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of information pertinent to my case to any insurance carrier, adjuster, or attorney involved in this case.

_____ _____

Signature of Policyholder **Date**

_____ _____

Signature of Claimant if other than Policyholder **Date**