Today's Date:// File #	Primary Insurance
Patient Name:	Co. Name:
Patient Name: LAST FIRST MI	Address:
What Do You Prefer To Be Called:	
☐ Male ☐ Female	CITY STATE ZIP
Birthdate:// Age: SS#	Phone #:
Mailing Address :	Insured's SS#:
The mig / teat eoo .	Group # (Plan, Local, or Policy #)
CITY STATE ZIP	Insured's Name: Date of Birth://
Home Phone #:	Insured's Employer:
Work Phone #:Ext:	Secondary Insurance
Other Phone #s:	Co. Name:
E-mail Address:	Address:
Referred By:	
Employer: How Long?	CITY STATE ZIP
Employer's Address:	Phone #:
	Insured's SS#: Group # (Plan, Local, or Policy #)
CITY STATE ZIP	Insured's Name:
Occupation:	Relation: Date of Birth:/'/_
Status:☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Insured's Employer
Spouses Name:	
S.S.# Date of Birth	OCCOUNT INFO
Do you have children? ☐ Yes ☐ No How Many?	ACCOUNT INFO
	Person ultimately responsible for account
DED(C)	N FOR VISIT Name:
REASO!	T C K VISIT
	Relation:
The reason for this visit is a result of (Please Circle):	Billing Address:
work, sports, auto, trauma or chronic.	CITY STATE ZIP
(Evaloin what hamanad).	SINIE ZIF
(Explain what happened):	SSN:
	n +-
Please describe the pain & its location:	Work Phone #:
	Payment method: □ CASH □CHECK
When did condition begin?//	•
Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Co	-
Is this condition interfering with your (Please Circle):work, sleep	o, or daily routine
if so, please explain:	
Have you had this or similar conditions in the past? ☐ Yes ☐ N	l hereby authorize assignment of
If so, please explain:	my insurance rights and benefits directly to
Have you been treated by a Medical Physician for this condition	the provider for services religious. I fully
If so, where?	balance not paid by my insurance company (if
	oncrea at the onlock.
Have you ever been treated by a Chiropractor before? ☐ Yes	⊔ No
fso whom?	

			(2)			
4	IN EVENT OF E	MERCENCY	5	See next	page	į
Who should we contact?	?			adjacent body cha		
Relation:			affected a	areas:	\sim	
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Please Fill Out the information Below, and <u>circle</u> all that apply to the problems you experience (if you need help please ask the front desk)

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Main He	aith Concer	n 1)						
Onset	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
Date	Trauma Repetitive Unknown	Pain Numb Swelling	Sharp, Dull, ach- ing, throbbing, crushing, stabbing,		Ply	Cerv Mid Back Lumbar	Constant, Frequent Intermitt	Mild, Tolerable , Moderate ,
Flare Up/			local, radiating,		11. (1)	L/R Leg	Occasion	Severe,
Made	Work	Spasms Headache	hurning Migraine		≨{+}} ≩	L/R Arm Other	Infrequent	
Worse	Auto Insidious	Tension Tingling	tension, hormonal, sinus, Other	(1)		Other	% Awake Time	/10
Main Hea	alth Concer	n 2)						•
Onset	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
Date Flare Up/	Trauma Repetitive Unknown Post Surgical	Pain Numb Swelling Muscle	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating,			Cerv Mid Back Lumbar L/R Leg	Constant, Frequent Intermittent Occasion	Mild, Tolerable , Moderate , Severe,
Made Worse	Work Auto Insidious Other	Spasms Headach Tension Tingling	burning, Migraine, tension, hormonal, sinus, Other			L/R Arm Other	Infrequent % Awake Time	Disabling /10
Main Hea	ilth Concern	3)		ب	2 2			
Onset	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
Date	Trauma Repetitive	Pain Numb	Sharp, Dull, aching, throbbing,	Q	ور	Cerv Mid Back	Constant, Frequent	Mild, Tolerable
Flare Up/ Made Worse	Unknown Post Surgical Work Auto Insidious	Swelling Muscle Spasms Headach Tension	crushing, stabbing, local, radiating, burning, Migraine, tension, hormonal,			L/R Leg L/R Arm Other	Intermitt Occasion Infrequent % Awake	Moderate, Severe, Disabling
	Other	Tingling	sinus, Other	\mathcal{W}	MY		Time	/10

NOTES: (For Office Use Only)

Dahlonega Chiropractic Life Center

INSURANCE POLICY

In order to accommodate the need and requests of our patients, we are enrolled and participate in numerous insurance plans and networks so that our patients can take advantage of any in-network chiropractic benefits available. While we are pleased to be able to provide this service to you, it is impossible for us to keep track of all of the individual requirements for these plans. Each carrier and plan has different stipulations regarding its policies.

IT IS YOUR RESPONSIBILITY to contact your insurance company and find out whether or not our doctor is a participating physician with your particular insurance plan. Some insurance carriers have PPO, HMO, POS or indemnity status, and it is very possible that our doctor may participate in only one of these areas and not in all.

IT IS YOUR RESPONSIBILITY to give Dahlonega Chiropractic Life Center correct insurance information to obtain the proper referral or pre-authorization (if applicable). If you fail to do so, you are responsible for payment.

<u>IT IS YOUR RESPONSIBILITY</u> to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on your individual insurance policy.

IN THE EVENT THAT:

- 1. Insurance coverage is denied because we are not a participating physician in your plan;
- 2. Insurance coverage is not in effect on the date of your visit;
- 3. A non-covered service is performed or denied:

You will be billed directly for all charges related to your office visit.

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF YOU DO NOT HAVE INSURANCE, PAYMENT IN FULL IS EXPECTED UNLES OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENDERED.

AUTHORIZATION TO PAY DOCTOR/CLINIC

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT THE RESPONSIBILITY AS DESCRIBED.

I HEREBY AUTHORIZE & DIRECT PAYMENT OF ANY MEDICAL EXPENSE BENEFITS ALLOWABLE TO THE DOCTOR/CLINIC NAMED ABOVE AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED. I AGREE THAT A PHOTOSTATIC COPY OF THIS AGREEMENT SHALL SERVE AS THE ORIGINAL.

DOCTOR/CLINIC

Dahlonega Chiropractic Life Center
131 Mechanic Street / P. O. Box 599

Dahlonega, GA 30533
706-864-5362

SIGNATURE	DATE	



DR. G. TODD HOLUBITSKY 131 Mechanic St., P.O. Box 599 Dahlonega, Ga 30533 Ph. 706-864-5362 Fax:706-864-5761

AUTHORIZATION OF RELEASE

Date	
	UEST THE RELEASE OF ANY AND ALL CORDS AND X-RAYS OR COPIES OF SUCH. Y FOR MY
PATIENT NAME (Printed)	PATIENT DATE OF BIRTH
ADDRESS	-
CITY, STATE & ZIP	PATIENT SIGNATURE
ACK	NOWLEDGEMENT
	AT I HAVE RECEIVED A COPY OF THIS S AS OUTLINED BY THE H.I.P.P.A. PRIVACY 1003.
PATIENT SIGNATURE	