ADVANCED INTEGRATIVE MEDICINE

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

I hereby acknowledge that I have received a copy of **Advanced Integrative Medicine**'s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative Date

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

_____

PRINTED Name of Patient or Legal Representative

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgtement of receipt of our Notice of Privacy Practices on the following date:_____ but acknowledgmenet could not be obtained because:

- ☐ Patient/Representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt at a later date)
- ☐ Communication barriers prohibited obtatining acknowledgement (Explain)

_____

_____

_____

_____

_____

_____

_____

- ☐ Other (Specify)

_____

_____

_____

_____

_____

_____

_____

5755 NORTH POINT PARKWAY SUITE 72 • ALPHARETTA, GA • 30022
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ADVANCED INTEGRATIVE™
MEDICINE

Acknowledgment of Financial Responsibility

Your insurance policy is a contract between you and your carrier. Most policies reimburse for at least some chiropractic and wellness care. But coverage varies from policy to policy with constant changes. All liability patients are responsible for keeping their insurance and attorney aware of changes in medical treatment in our facility for the most accurate reimbursement.

Our billing department will work diligently with your insurance company, attorney or any other party involved for reimbursement on your behalf.

I accept financial responsibility for my care. I instruct this office to deliver the care that, in their judgment, can best help me in the restoration of my health.

_____
Print Name

_____ _____
Patient Signature Date

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ADVANCED INTEGRATIVE™ MEDICINE

Advanced Integrative Medicine

Neck Pain Disability Questionnaire

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 — Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

Section 2 — Personal Care

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

Section 3 — Lifting

A I can lift heavy weights, without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned, for example, on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

Section 4 — Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

Section 5 — Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently
F I have headaches almost all the time.

After Vernon & Mior, 1991
Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

Section 6 — Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty concentrating when I want to.
D I have a lot of difficulty concentrating when I want to.
E I have a great deal of difficulty concentrating when I want to.
F I cannot concentrate at all.

Section 7 — Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

Section 8 — Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

Section 9 — Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hr. sleepless).
C My sleep is mildly disturbed (1-2 hrs. sleepless).
D My sleep is moderately disturbed (2-3 hrs. sleepless).
E My sleep is greatly disturbed (3-5 hrs. sleepless).
F My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 — Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D I am able to engage in a few of my usual recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

REVISED January 1, 1995

Comments: _____

_____

Patient Signature: _____ Date: _____

ADVANCED INTEGRATIVE™
MEDICINE

Advanced Integrative Medicine

Neck Pain Disability Questionnaire

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (please print): _____ Date: _____

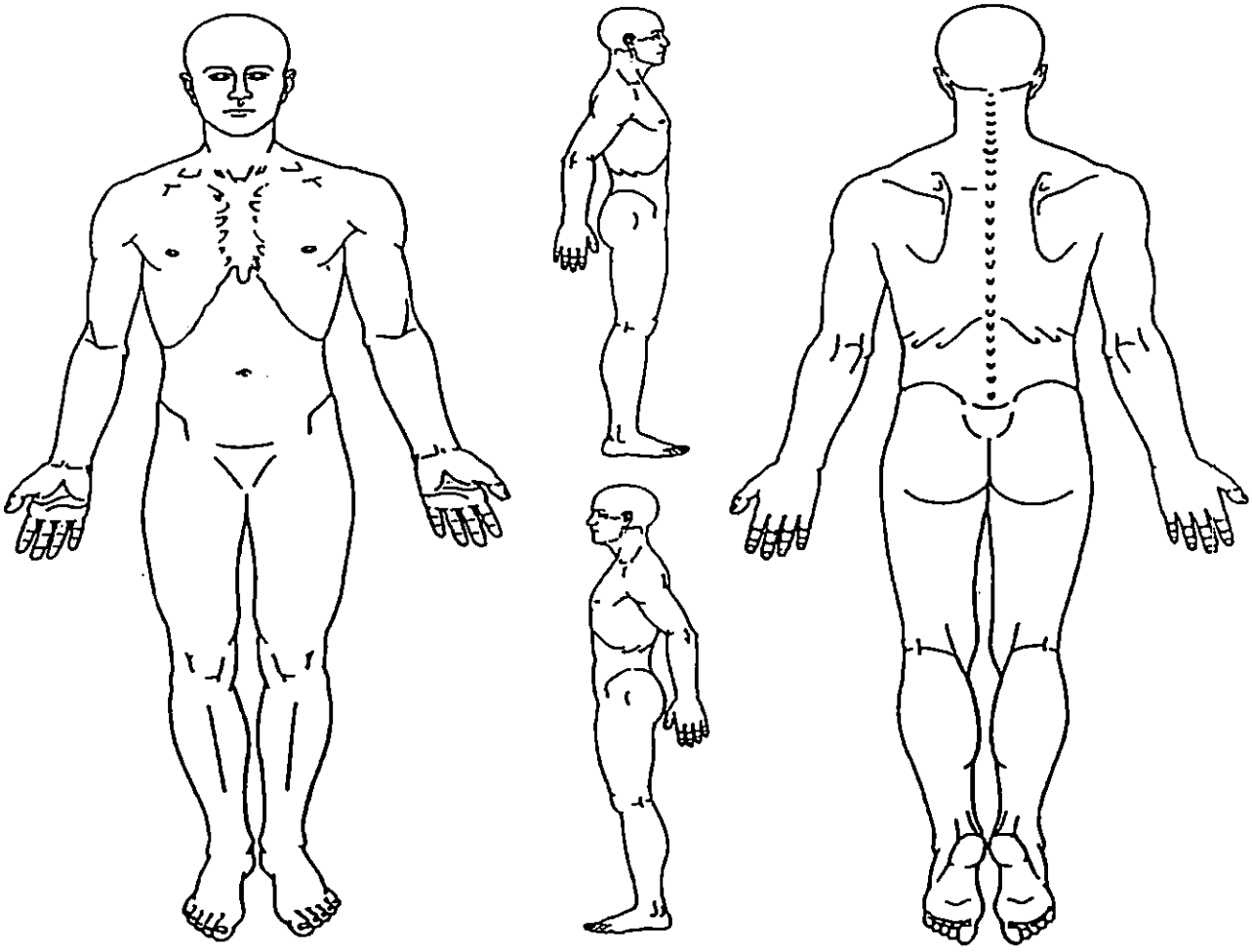
Age: _____ Date of Birth: _____ Occupation: _____

How long have you had neck pain? _____ Years _____ Months _____ Weeks

Is this your first episode of neck pain? _____ Yes _____ No

Use the letters below to indicate the type and location of your sensations right now.
Please remember to complete both sides of this form.

KEY: A= Ache B= Burning N= Numbness
P= Pins & Needles S= Stabbing O= Other



ADVANCED INTEGRATIVE™ MEDICINE

Advanced Integrative Medicine

Patient Health Questionnaire

Patient Name _____ Date _____ ID # _____

If you have ever had a symptom in the past listed below, please check that symptom in the past column. If you are presently troubled by a particular symptom check the symptom in the present column. This is a history of various systems of your body and knowledge of these conditions may influence the type of treatment, therapy, or referral you may receive.

Past	Present	Conditions
____	____	Abdominal Pain
____	____	Abnormal Weight Gain/Loss
____	____	Angina
____	____	Anorexia
____	____	Aortic Aneurysm
____	____	Arthritis
____	____	Asthma
____	____	Bladder Infections
____	____	Blood Disorder
____	____	Breast Soreness/Lump
____	____	Cancer, explain
____	____	Chest Pains
____	____	Chronic Cough
____	____	Chronic Sinusitis
____	____	Colitis
____	____	Constipation/Irregular bowel habits
____	____	Convulsions
____	____	Diabetes
____	____	Depression
____	____	Dermatitis/Eczema/Rash
____	____	Difficulty in Swallowing
____	____	Dizziness
____	____	Emphysema (Chronic Lung Disorders)
____	____	Endometriosis
____	____	Epilepsy
____	____	Excessive Thirst
____	____	Fainting
____	____	Frequent Urination
____	____	General Fatigue
____	____	Hand Pain (R___ L___)
____	____	Headache
____	____	Heart Attack (date_____)
____	____	Heartburn/Indigestion
____	____	Hepatitis
____	____	High Blood Pressure
____	____	Irritable Colon

Past	Present	Conditions
____	____	Loss of Bladder Control
____	____	Low Back Pain
____	____	Mid Back Pain
____	____	Muscular Incoordination
____	____	Neck Pain
____	____	Pain in Ankle or Foot
____	____	Pain in Lower Leg or Knee
____	____	Pain in Upper Arm or Elbow
____	____	Pain in Upper Leg or Hip
____	____	Painful Urination
____	____	PMS
____	____	Profuse Menstrual Flow
____	____	Prostate Problems
____	____	Rapid Heart Beat
____	____	Rheumatoid Arthritis
____	____	Scoliosis
____	____	Shoulder Pain
____	____	Stroke (date_____)
____	____	Swelling, Stiffness of Joint(s)
____	____	Tinnitus (Ear Noises)
____	____	Tumor, Explained _____)
____	____	Ulcer
____	____	Visual Disturbances
____	____	Jaw Pain
____	____	Wrist Pain

FAMILY HISTORY:

If any of your immediate family members have/had the following, please mark the appropriate line.

	MOTHER	FATHER	BROTHER(S)	SISTER(S)
Cancer	____	____	____	____
Retinal Detachment	____	____	____	____
Chronic Back Problems	____	____	____	____
Kidney Failure	____	____	____	____
Cardiovascular Disease	____	____	____	____
Diabetes	____	____	____	____
High Blood Pressure	____	____	____	____
Rheumatoid Arthritis/Lupus	____	____	____	____

Have you ever had surgery or been hospitalized? ___No ___Yes _____

What medications are you currently taking? _____

Do you use tobacco? ___No ___Yes Do you drink alcohol? ___No ___Yes

Do you have or have you had an alcohol, drug, or any other kind of addiction or dependence? ___No ___Yes

In the past 90 days have you had:

Weight gain or loss of 10 or more pounds:	No	Yes
Any loss of appetite:	No	Yes
Fevers, Chills, or Night Sweats:	No	Yes

Doctor's Notes _____

x _____

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ADVANCED INTEGRATIVE™ MEDICINE

WELCOME TO ADVANCED INTEGRATIVE MEDICINE

PERSONAL

Patient Name: _____

Address: _____

City/State/Zip: _____

Social Security #: _____

Gender: F / M

Marital Status: _____

Age: _____

Spouse's Name: _____

Patient's Birthdate: ___/___/___

Home Phone: _____

Work Phone: _____

Ext: _____

Cell: _____

Email: _____

Emergency Contact: _____

Phone: _____ Relation: _____

May we ask how you were referred?

GUARANTOR

Policy Holder: _____

Address: _____

City/State/Zip: _____

Social Security #: _____

Gender: F / M Birthdate: _____/_____/_____

Home Phone: _____

Employer: _____

Address: _____

City/State/Zip: _____

Work Phone:

_____YES , I have completed/filed the necessary benefits form.

Insurance Co: _____

Call Benefits @ ( ) -

Contact: _____ Ext:

Group Name: _____ Group #

ID/Claim #: _____

Patient is: self spouse child 3rd party

other: _____

CASE

Were you in an Auto Accident? Injury Date:

Were you in a Work related Injury? Injury Date:

Will you be utilizing medical benefits?

NO Insurance	Insurance	_____Fund	Auto/Accident Ins
Medicaid/Medical	Medicare	Government	Work Comp Ins

Attorney Name

Attorney Phone Number

Paralegal You Spoke With

Paralegal Email Address

Do You Have Med Pay? Yes No

If Yes: Claim Number

Adjuster Phone Number

Adjuster Name

Do you have pictures of your accident? Yes No

If Yes: Please email to aimedicine@bellsouth.net

Daily Activity/Occupation:

___ YES, I will pay my portion at the time of service.

___ YES, this office has my permission to copy my driver's license or photo ID for the sole purpose of identification and verification.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I authorize the release of any medical information necessary to process and pay this claim. I authorize payment directly to Advance Integrated Medicine of the "Health Benefits," "Medical Reimbursement" from a Third Party Payor and/or "Government Benefits" otherwise payable to me.

I understand this office only accepts assignment when insurance pays directly.

I fully understand when the insurance company verifies my benefits, it is not a guarantee or authorization to pay on claims submitted. I agree to pay my portion, plus any balance insurance does not reimburse for, at each visit. I agree to pay/settle any denied/unpaid claims. I submitted by this office are my responsibility and require my participation to understand all claims settle regardless of my insurance company or assignment of benefits.

_____

PRINT

Patient/Guarantor -PRINT name

x _____ / /

Patient/Guarantor - SIGNATURE Date

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