ADVANCED INTEGRATIVE MEDICINE

Health Assessment

Name: _____ **Date:** _____

- Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

- Chief complaint (reason you are here):

_____

- Previous treatments for this complaint _____

_____

- Other complaints or problems: _____

_____

_____

- Current medications/drugs being taken: _____

_____

_____

- Nutritional supplements being taken: _____

_____

_____

- Do you smoke, drink coffee or alcohol? (if yes indicate how much)
Cigarettes _____ Coffee _____ Alcohol _____

- List any major illnesses (with approx. dates): _____

_____

- List any surgeries with approx. dates: _____

_____

- Past Accidents or injuries: _____

_____

- Family history of serious illnesses (circle all that apply): Cancer / Diabetes / Heart / Other _____

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

_____

PRINTED Name of Patient or Legal Representative

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

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
TELE: 678-867-7200 • FAX: 770-667-7138

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

5755 NORTH POINT PARKWAY SUITE 72 • ALPHARETTA, GA • 30022
TELE: 678-867-7200 • FAX: 770-667-7138

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

5755 NORTH POINT PARKWAY SUITE 72 • ALPHARETTA, GA • 30022
TELE: 678-867-7200 • FAX: 770-667-7138