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

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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REVIEW OF SYSTEMS (ROS):

GENERAL
- Fever
- Chills
- Weakness
- Night Sweats
- Weight Gain
- Weight Loss
- Loss of Appetite

CARDIOVASCULAR
- Chest Pain
- Angina
- Murmur
- Irregular Heart Beat
- Palpitations
- Extremity Swelling
- Varicose Veins
- Pain with Walking
- Cold Hands or Feet

GENITOURINARY
- Frequent Urination
- Difficulty Controlling Urination
- Blood in Urine
- Pain with Urination
- Passage of Stones

ENDOCRINE
- Heat/Cold intolerance
- Thyroid Disease
- Decreased Energy

HEAD
- Headache
- Trauma
- Dizziness
- Vertigo

RESPIRATORY
- Shortness of Breath
- Wheezing/Asthma
- Sputum Production
- Night Sweats
- Cough
- Coughing up Blood
- COPD/Emphysema
- Bronchitis

SKIN
- Rash
- Pruritis
- Moles
- Cancer
- Dryness

BLOOD/LYMPH
- Anemia
- Blood Thinner
- Easy Bruising
- Easy Bleeding
- Lymph Node Swelling
- Lymph Node Pain

EYES
- Double Vision
- Blurred Vision
- Cataracts
- Discharge
- Glaucoma

GASTROINTESTINAL
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Ulcer
- Blood in Stool
- Abdominal Pain
- Rectal pain
- Hernia
- Hemorrhoids
- Change in Appetite

MUSCULOSKELETAL
- Muscle Pain
- Muscle Spasm
- Muscle Atrophy
- Back Pain/Stiffness
- Neck Pain/Stiffness
- Joint Pain
- Joint Stiffness
- Weakness
- Fractures

ALLERGY/IMMUNOLOGIC
- Sinusitis
- Seasonal Allergies

ENT
- Loss of Hearing
- Discharge
- Loss of Smell
- Congestion
- Dentures
- Sores
- Gingival Bleeding
- Hoarseness
- Sore Throat
- Difficulty Swallowing
- Jaw Pain

GYNECOLOGIC
- Self-Exam
- Masses/Lumps
- Pain
- Nipple Discharge

PSYCHIATRIC
- Anxiety
- Depression
- Hallucinations
- Sleep Disturbance

NEUROLOGIC
- Loss of Consciousness
- Fainting
- Numbness
- Weakness
- Tingling
- Seizures

FAMILY HISTORY: (Please list all that apply to **blood relatives;** If deceased, please indicate cause and age of death)

____ High Blood Pressure ____ Diabetes ____ Depression/Anxiety

____ Heart Disease ____ Cancer

Other significant family diseases:____

______________________________ ______________________________
Signature of Patient or legal Representative Patient or Legal Representative (Please Print)

______________________________ ____________________
Allison Comrie MD Date

______________________________ ____________________
Julie Abrahamson PA-C Date

Advanced Integrative Medicine

Initial Evaluation Questionnaire
Allison Comrie MD

Name ______________________________ **Age**______ **DOB**_________ **Gender**______

CHIEF COMPLAINT: ____

PAST MEDICAL HISTORY: (Please check if you have or have had any of the following)

____ High Blood Pressure
____ Irregular Heartbeat
____ Stroke
____ Back Pain/Neck Pain
____ Blood Clots
____ Arthritis
____ Herniated Disc
____ Spinal Stenosis
____ Diabetes
____ Cancer
____ Ulcer/Reflux Disease
____ Degenerative Disc Disease
____ Peripheral Vascular Disease
____ Heart Failure/ Heart Attack

Other significant medical history:_______ NA

Do you have a pacemaker? Yes No

Do you have a defibrillator? Yes No

Do you have any surgical devices in your body? (e.g. pins, plates, screws, etc?) If yes, please specify and record location____

PAST SURGICAL HISTORY: Yes No

If yes, please list and their dates:

____

____

____

MEDICATIONS:____

____

____

ALLERGIES (to medications):____

SOCIAL HISTORY:

Smoking: Y N

Alcohol: Y N

Vocation____

Hobbies and Other Activities: ____

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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