ATLANTA MEDICAL INSTITUTE
WEIGHT LOSS AND ANTI-AGING SPECIALISTS

Patient Information Form

Name: (Last) _____ (First)_____(MI) _____

Name you prefer to be called: _____

Patient Address for shipping: (No PO Boxes) _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-mail: _____

Birthdate: _____ SS #: _____ Age: _____ Sex: M F

How did you hear about us? (Circle)

Sign Internet Coupon Referral Event Direct Mail TV Attorney: _____

Employment Information:

Patient Employer: _____ Occupation: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

In Case of Emergency:

Name: _____(Relationship)_____ Phone: _____
Patient's Spouse: _____ Phone: _____
Family Physician: _____ Phone: _____

Financial Policy Agreement:

Thank you for selecting Atlanta Medical Institute (AMI) for your health care needs. We are pleased to be of service to you and your family. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, American Express and checks.
By signing this Financial Policy Agreement, I agree: Should this account be referred to an agency or an attorney for collection that I will be responsible for all collection costs, attorney's fees and court costs.

Cancellation Policy

If you have to cancel your appointment, you must notify AMI via telephone or email a minimum of 24 hours before the time of the appointment. If you do not notify AMI of your cancellation, a fee will be billed to the credit card on file.
Third Party Payment Agreement

As a courtesy, we bill your insurance company directly. However, the insurance and or settlement checks may be sent to you and made out in your name. Accordingly, please read and sign the following agreement details:

- I agree to bring these checks to Atlanta Medical Institute (AMI)
- I agree not to tear apart the check from the Explanation of Benefits
- I agree to sign funds over to AMI for services received
- I understand that if I fail to deliver payments or settlement received from the insurance company to AMI within 3 business days of receipt, I will be responsible for the entire amount billed.

I have read, understand and agree to the above written responsibility on my part as your patient.

Patient Signature: _____ Date: _____

Insurance

Who is responsible for this account: _____ Relationship: _____

Insurance Company: _____ Group No.: _____

Additional Insurance Coverage: _____

Subscriber's Name: _____ DOB: _____

SS#: _____ Relationship: _____

Insurance Co. _____ Group No.: _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign all insurance benefits directly to Atlanta Medical Institute (AMI), otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

AMI may use my health care information and may disclose such information to the above-named Insurance company (companies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient/Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

Accident Information

- Is condition due to an accident: ___Yes ___No Date: _____
- Type of accident: ___Auto ___Work ___Home ___Other: _____
- To whom have you made a report of your accident: ___Auto Insurance ___Employer ___Worker Comp. ___Other

Attorney's Name (if applicable): _____

Atlanta Medical Institute Survey

Are You Interested in Improving Your Overall Wellness?

Do you have an interest in? (Please Circle)

- **Hormone replacement therapy:** **Yes / No**
  - Do you want to feel more energized? **Yes / No**
  - Do you want to improve your sex life? **Yes / No**
  - Do you want to sleep better? **Yes / No**
  - Do you want to feel less anxious; less depressed? **Yes / No**

- **Weight Loss:** **Yes / No**
  - How much weight would you like to lose? _____
  - Is there an event in the next 90 days you would like to lose weight by? **Yes / No**
  - Are you ready to commit to a weight loss plan? **Yes / No**

- **Nutrition:**
  - Do you take a multi-vitamin, supplements or fish oil daily? **Yes / No**
  - Are you interested in Freshly Prepared Meals? **Yes / No**

- **Stress Reduction:** **Yes / No**
  - What kind of stress bothers you the most? (Work, family, money, etc.) _____
  - On a scale of 1-10, how much does this stress interfere with you life? _____

- **Detoxification:**
  - Are you interested in cleansing toxins from your system? **Yes / No**
  - Do you experience constipation (slow bowel elimination)? **Yes / No**
  - Do you have joint pain, headaches? **Yes / No**

- **Spinal Health (Chiropractic and Massage):** **Yes / No**
  - Do you have pain in your upper or lower back? **Yes / No**
  - Rate the severity of your pain on a scale from 1-10 _____
  - Do you have insurance that you would like us to verify for future visits? **Yes / No**
  - Have you had a Spinal X-Ray? **Yes / No**

- **Aesthetics: (Botox, Fillers, Cosmetic Surgery, Facials)** **Yes / No**
  - Are you concerned about fine lines and wrinkles? **Yes / No**
  - Are you interested in mole removal? **Yes / No**
  - Do you want to improve the look of your jawline? **Yes / No**

- **Are you interested in Additional Testing:** **Yes / No**
  - Food Sensitivity? **Yes/ No**
  - Allergy Testing? **Yes/ No**
  - Adrenal Fatigue? **Yes/ No**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Atlanta Medical Institute (AMI) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to WCOA's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices (NPP) prior to signing this consent. AMI reserves the right to revise its NPP at any time. A revised NPP may be obtained by forwarding a written request to AMI. With my consent, AMI may:

- call my home (or other location) and leave a message on voice mail or in person in reference to any item(s) that assist the practice in carrying out TPO, such as:
  - appointment reminders
  - insurance items
  - calls pertaining to my clinical care (including laboratory results among others)
- mail to my home (or other location) any items that assist the practice in carrying out TPO, such as:
  - appointment reminder cards
  - patient statements as long as they are marked Personal and Confidential
- email to my home (or other location) any items that assist the practice in carrying out TPO, such as:
  - appointment reminder cards and patient statements

By signing this form, I am consenting to AMI's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, AMI may decline to provide treatment to me.

I have been offered and have had the opportunity to review the HIPAA disclosure form: _____

_____
Signature of Patient

_____ Date _____
Patient Name

REQUEST TO RELEASE MEDICAL RECORDS

I request the release of my medical records from Atlanta Medical Institute (AMI) to _____. I release AMI, its managers, physicians, and contractors from any and all claims resulting from this release, as I realize these constitute their permanent records. I authorize each physician, doctor, nurse, clinic, or and other health care provider to provide any and all information or records as to diagnosis, treatment or prognosis concerning my past, present or future physical or mental history or condition for Date: 2016.

I acknowledge and understand that I may revoke this authorization at any time by notifying AMI of my revocation in writing and delivering my revocation by mail or personal delivery. I further understand that, as a result of this Authorization, any of my medical information disclosed by any Authorized Discloser on my behalf may be disclosed and may no longer be protected by the HIPPA Privacy Regulations. I certify I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I request these medical records be forwarded as follows:

Fax: _____ Email: _____

_____ _____ _____

Patient Signature Name (Print) Date

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Informed Consent for Chiropractic Care

When a Patient (PT) seeks Chiropractic Health Care, it is essential that the PT and Chiropractic Health Care Provider (Chiropractor) work for the same objective. It is also important that each PT understand both the objective and the method that will be used to attain the desired results in order to prevent any confusion or disappointment. As a PT, you have the right to be informed about the condition of your health, the recommended care and treatment to be provided and the known benefits, risks and alternatives, so that you can make the decision whether or not to undergo Chiropractic Care.

Chiropractic Medicine is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) and how that relationship my effect the restoration and preservation of health. Health is the state of optimal physical, mental and social wellbeing, not just the absence of disease and infirmity. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and reduced by a Chiropractic adjustment, which is a specific application of force to correct or reduce vertebral subluxation. Adjustments are usually done by hand, but may be performed by handheld instruments. In addition, ancillary procedures, such as physiotherapy or rehabilitation procedures may be included.

If during the course of care we encounter non-Chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another Health Care Provider. Any procedure intended to help, may also do harm. While chiropractic examination and therapeutic procedures are considered remarkably safe and effective, please understand that occasionally there may be adverse reactions. Although the chances of experiencing any of these complications are extremely small, it is the practice of Wellness Centers of America to fully inform and educate all of our guests.

By signing below, I understand that these complications may include, but are not limited to, muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I do not expect he doctor to be able to anticipate or explain all possible risks and complications. I wish to rely on the doctor(s) to exercise judgment during the course of my treatments that he/she feels are in my best interest based upon the facts know at the time of treatment. I understand that there is no guarantee or warranty for a specific cure or result. I understand that at any time, I can request further explanation regarding risks and benefits of care in this facility, alternative courses of care, and the consequences of not having the proposed treatment.

Patient Signature: _____ Date: _____

Consent to Evaluate and Adjust a Minor Child:

I, _____ being he parent or legal guardian of _____
have read and fully understand the Informed Consent and hereby grant permission for my child to receive Chiropractic Care.

Pregnancy Release:

This is to certify that, to the best of my knowledge, I am not pregnant and the above Chiropractor and Associates have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Last Menstrual Cycle: _____

_____ __ _____ _____

PT Signature DOB Date

Massage

I understand the Massage I receive is provided for the basic purpose of relaxation and the relief of muscle tension. If I experience any pain or discomfort during the session, I will immediately inform the massage therapist so that the pressure/stroke may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical or chiropractic examination, diagnosis or treatment. Because massage should not be performed under

certain medical conditions, I affirm that I have stated all of my known conditions and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical/health status.

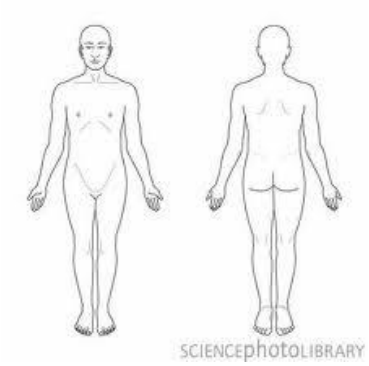
I assume all legal responsibility for my health and well-being. I release the massage therapist from any and all present and future responsibility. I understand that the massage therapist reserves the right to terminate my session and further sessions if deemed necessary.

Patient Signature: _____ Date: _____

If Minor: Parent/Guardian Signature: _____ Date: _____

Patient Condition

- Reason for visit:_____
- When did symptoms appear:_____
- Is this condition getting progressively worse: ___Yes ___No ___Unknown
- Rate the severity of your pain on a scale from 1 (least) to 10 (most): ___
- Mark an X on the picture where you have pain, numbness and tingling.



- Type of pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting ___Burning ___Tingling ___Cramps ___Stiffness ___Swelling ___Other
- How often do you have this pain: _____
- Does it interfere with: ___Work ___Sleep ___Recreation ___Daily Routine
- Activities that are painful to perform: ___Sitting ___Standing ___Walking ___Bending ___Lying Down
- What treatment have you already received: ___Medication ___Surgery ___Physical Therapy ___Chiropractic Services ___Other: _____
- Name/Address of other Doctor(s) who have treated condition: _____

_____

- Check all that apply:

AIDS/HIV			Epilepsy			Mononucleosis			Thyroid Problems		
Alcoholism			Fractures			Multiple Sclerosis			Tonsillitis		
Allergy Shots			Glaucoma			Mumps			Tuberculosis		
Anemia			Goiter			Osteoporosis			Tumors, Growths		
Anorexia			Gonorrhea			Pacemaker			Typhoid Fever		
Appendicitis			Gout			Parkinson's Disease			Ulcers		
Arthritis			Heart Disease			Pinched Nerve			Vaginal Infections		
Asthma			Hepatitis			Pneumonia			Venereal Disease		
Bleeding Disorder			Hernia			Polio			Whooping Cough		
Breast Lump			Herniated Disk			Prostate Problem			Other:		
Bronchitis			Herpes			Prosthesis					
Bulimia			High Cholesterol			Psychiatric Care					
Cancer			Kidney Disease			Rheumatoid Arthritis					
Cataracts			Liver Disease			Rheumatic Fever					
Chemical Dependency			Measles			Scarlet Fever					
Diabetes			Migraine Headaches			Stroke					
Emphysema			Miscarriages			Suicide Attempt					

- Are you pregnant: ___No ___Yes Due Date: _____

  Exercise: ___None ___Moderate ___Daily ___Heavy

- Work Activity: ___Sitting ___Standing ___Light Labor ___Heavy Labor

- Habits:

	Smoking			**Alcohol**			**Coffee/Caffeine**			**High Stress**
	Packs/Day			Drinks/Week			Cups/Day			Reason:

- Injuries/Surgeries:

	Description	**Date**
Falls	1. 2.	
Head Injuries		
Broken Bones	1. 2.	
Dislocations		
Surgeries	1. 2.	

- List:

Medications	**Allergies**	**Vitamins/Mineral/Herbs**
1.	1.	
2.	2.	
3.	3.	
Pharmacy Name:		
Pharmacy Number:		