Georgia Medical Treatment Center

557 Riverstone Pkwy Ste. 140 Canton, Ga. 30114 770.345.2000 office 770.345.4524 fax
www.georgiamtc.com

Please provide your legal name as indicated on your insurance card/s: **Today's Date: _____**

_____
First Last MI Suffix

(Mailing Address) Street: _____

City: _____State:_____Zip:_____

Date of Birth: _____/_____/_____ Sex: □ Male □ Female SS#:_____

Phone: (Home) _____(Cell)_____Email Address: _____

Emergency Contact: Name: _____Relation:_____Phone:_____

Primary Care Physicians Name: _____ Phone Number: _____

Fax Number: _____Physicians Address:_____

How did you hear about us (please use specific name if referred by another patient? _____

Primary Health Insurance (Name): _____

Member ID # (including any letters): _____Group #: _____

Policy Holder Name (first and last):_____DOB: Relation to you: _____

Secondary Health Insurance (Name):_____

Member ID # (including any letters): _____ Group #: _____

Policy Holder Name (first and last):_____DOB: Relation to you: _____

Tertiary Health Insurance (Name):_____

Member ID # (including any letters): _____ Group #: _____

Policy Holder Name (first and last):_____DOB: Relation to you: _____

Name of person responsible for this account? _____
Relationship to patient (if other than self) _____ Phone: _____

Please note if you receive any checks from your insurance company they are meant to pay for your medical services, if you are unsure you owe a bill with us call to avoid collections activity and/or suspension of care.

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PATIENT AGREEMENT:

□ I agree to pay for services rendered to the above mentioned patients as the charges are incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. The injuries/illness sustained and the pain and suffering I have are real and I have not either imagined or exaggerated the extent and nature of my pain and suffering or illness.

□I am of sound mind and to the best of my knowledge all the information I have presented is true. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with_____ and I AUTHORIZE REQUEST AND ASSIGN MY INSURANCE COMPAN Y TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary.

*****If you have a secondary insurance please inform the front desk*****

Financial Policy:

Thank you for selecting our practice for your health care needs. We are honored to be of service to you and/or your family. This is to inform you of our billing requirements and our financial policy. ***Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.***

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.
I have read and understand, understand and agree to all of these statements.

By signing this I agree that the above answers are true to the best of my knowledge. If there are any changes I will notify the office of Georgia Medical Treatment Center and/or staff immediately.

_____ _____

Patient's signature (or guardian) ***Date***

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Please check if you're currently experiencing any of the following conditions currently or in the past 6 months:

□ Light Bothers Eyes	□ Sudden Weight Loss	□Nausea		
□ Back Pain/Stiffness	□Pins/Needles in Legs	□ Depression	□ Loss of Taste	□ Cold Feet
□ Arm/Hand Pain	□ Fatigue	□ Nervousness	□ Loss of Memory	□Chest Pain
□ Leg/Knee Pain	□ Sleeping Difficulties	□ Tension	□ Jaw Problems	□Fever
□ Loss of Smell	□ Cold Sweats	□Constipation	□ Fainting	
□ Dizziness	□ Allergies	□ Stomach Problems	□ Shortness of Breath	
□ Asthma	□ Blurred Vision	□ Night Pain	□ Bowel/Bladder Changes	
□ Pain between Shoulders	□ Numbing/Tingling in Arms/Hands			
□ Neck Pain	□ Numbing/Tingling in the Legs/Feet		□ Ringing in Ears	

□ Other: _____

***Medications helped:** Little Some Much *** Exercise helped**: Little Some Much
* **Physical Therapy helped:** Little Some Much ***Nutrition helped**: Little Some Much
***Chiropractic helped**: Little Some Much ***Stretching helped**: Little Some Much

The reason for this visit is a result of: **(Please Circle)** Work Sport Auto Trauma Chronic

Please Explain What Happened: _____

_____

Please describe the pain and its location: _____

_____

When did this condition begin? _____

Is this condition getting worse? Yes No Constant Comes & Goes

Is this condition interfering with you're: Work Sleep Daily Routine

Have you been treated by a physician for this condition? Yes No

If so, where and how long was treatment? _____

Are you under a doctor's care for any other reasons? If yes, explain: _____

_____

What is your pain level on a scale from 1-10 when you are being active? (1 being no pain 10 being severe pain) _____

What is your current height? _____ What is your current weight? _____

Are you allergic to anything? Please list reactions: _____

Do you have a history of seizures, if so, what kind? _____

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Please check to indicate if you have ever had any of the following:

□ Aids/HIV	□ Cancer	□ Hepatitis	□Osteoporosis	□ Stroke
□ Alcoholism	□ Cataracts	□ Hernia	□ Pacemaker	□ Suicide Attempt
□ Allergy Shots	□ Substance Abuse	□ Herniated Disc	□ Thyroid Problems	□ Parkinson's Disease
□ Anemia	□ Chicken Pox	□ Herpes	□ Pinched Nerve	□ Tonsillitis
□ Anorexia	□ Diabetes	□ High Cholesterol	□ Pneumonia	□ Tuberculosis
□ Appendicitis	□ Emphysema	□ Kidney Disease	□ Polio	□ Tumors/Growths
□ Arthritis	□ Epilepsy	□ Liver Disease	□ Prostate Problems	□ Typhoid Fever
□ Asthma	□ Fractures	□ Measles	□ Prosthesis	□ Ulcers
□ Bleeding Disorders	□ Glaucoma	□ Migraines	□ Psychiatric Care	□ Vaginal Infections
□ Breast Lump	□ Goiter	□ Miscarriage	□ Rheumatoid Arthritis	□ Venereal Disease
□ Bronchitis	□ Gonorrhea	□ Mononucleosis	□ Rheumatic Fever	□ Whooping Cough
□ Bulimia	□ Gout	□ Multiple Sclerosis	□ Scarlet Fever	□ Heart Disease
□ Mumps	□ High blood pressure	□ other: _____		

Please list any additional information we need to know to properly treat and/or diagnosis your medical condition:

Have you had an MRI/CT in the last 3 years? If so what is the name and location of where we can obtain the report?

Please list any supplements that you are taking: _____

Is there a family history of any of the following? (Indicate family member; parents, grandparents, siblings, etc..)

□ Heart Disease _____ □ Diabetes _____

□ Cancer _____ □ Arthritis _____

□ Substance Abuse _____ □ Alcoholism _____

Single Married Divorced Widowed

Children: _____ Yes _____ No If yes, how many_____

Occupation: _____ Full Time Part Time

What is your daily/weekly intake of the following?

Caffeine: _____cups/day Alcohol: _____drinks/week Cigarettes: _____packs/day

STOP! BE SURE YOU HAVE FILLED OUT EVERYTHING COMPLETELY AND LEGIBLY BEFORE MOVING ON.

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SURGICAL PROCEDURES: (Hospital or In-office Procedures)

Date:	Procedure:	Purpose:

MAJOR ILLNESSES AND/OR DIAGNOSISES:

Name:	Start:	End:	Physician:	Treatment Notes:

CURRENT/PAST MEDICATIONS (within the last 12 months)

Name:	Dose:	Frequency:	Starting:	Ending:	Purpose:

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Pharmacy Information: Your Pharmacy ID number is needed for Prior Authorizations, if you need help finding this information ask for assistance.

Name of Pharmacy:_____

Location: _____

Phone Number: _____ Fax Number: _____

What is the name of your prescription drug plan? _____

Policy ID Number:_____ Group Number: _____

Rx Bin Number: _____

PLEASE PROVIDE A COPY OF YOUR PHARMCY CARD TO THE FRONT DESK*

Consent to Treat:

I hereby authorize the Doctors & Staff at Back to Life Medical Group, LLC – DBA- Georgia Medical Treatment Center, to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, x-rays, chiropractic adjustments of the spine, trigger point injections, diagnostic testing, laboratory work, nutritional support, weight loss management, prescription medication and any other procedure/ service.

I _____, understand that I am responsible for all bills incurred in this office that are not covered by insurance.

Patient Signature: _____

Date: _____

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Summary of Notice of Privacy Practices/HIPPA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information or PHI. This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your PHI is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use ad disclosure of your protect health information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

Uses and Disclosure of Health Information: We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

By signing this form, I understand that:

- Protected Health Information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will the cease.
- The practice may condition receipt of treatment upon execution of this consent.

Uses and Disclosure not requiring your authorization: In the following circumstances, we may disclose your health information without your written authorization:

- For purposes of public health and safety
- To government agencies for purposes of their audits, investigations and other oversight activities.
- To government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by law

Patient Rights: As our patient you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request restrictions as to how your health information is being used and disclosed.
- To request that we amend your health information
- To received notice of our privacy practices.
- **To obtain a copy of your Medical Records. We DO require 3 business days to furnish that request.**

If you have a question, concern, or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

_____ _____

Patient Signature Date

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Summary of Notice of Privacy Practices/HIPPA Patient Consent Form Continued

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family? (This includes PHI and/or scheduled appointments) If YES, please name the members allowed:	YES	NO

_____

_____

This consent was signed by: _____
(PRINT NAME CLEARLY)

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this from will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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Are you interested in being evaluated for Food Intolerance? Fill the survey out below.

Please complete the following food and chemical sensitivity questionnaire. Mark each symptom based upon your experiences **over the last 60 days**. Some of these symptoms may have been repeated previously in this paperwork.

Symptom Scoring System:
● ◦ ◦ ◦ =No Symptoms
◦ ● ◦ ◦ =Mild Symptoms
◦ ◦ ● ◦ =Moderate Symptoms
◦ ◦ ◦ ● =Severe Symptoms

Digestive Symptoms:
◦ ◦ ◦ ◦ Stomach Pains or Cramping
◦ ◦ ◦ ◦ Constipation
◦ ◦ ◦ ◦ Diarrhea
◦ ◦ ◦ ◦ Reflux of heartburn
◦ ◦ ◦ ◦ Bloating
◦ ◦ ◦ ◦ Gas
◦ ◦ ◦ ◦ Nausea or Vomiting

Weight:
◦ ◦ ◦ ◦ Inability to lose weight
◦ ◦ ◦ ◦ Food Cravings
◦ ◦ ◦ ◦ Water Retention
◦ ◦ ◦ ◦ Binge Eating

Sinus/Respiratory:
◦ ◦ ◦ ◦ Stuffy or runny nose
◦ ◦ ◦ ◦ Asthma
◦ ◦ ◦ ◦ Chest congestion
◦ ◦ ◦ ◦ Wheezing
◦ ◦ ◦ ◦ Frequent sneezing

Head/Ears:
◦ ◦ ◦ ◦ Migraines
◦ ◦ ◦ ◦ Headaches
◦ ◦ ◦ ◦ Earaches
◦ ◦ ◦ ◦ Ear Infections
◦ ◦ ◦ ◦ Ringing in ears

Eyes/Throat:
◦ ◦ ◦ ◦ Itchy eyes
◦ ◦ ◦ ◦ Watery eyes
◦ ◦ ◦ ◦ Sore throat
◦ ◦ ◦ ◦ Persistent canker sores

Emotional/Mental:
◦ ◦ ◦ ◦ Depression
◦ ◦ ◦ ◦ Anxiety
◦ ◦ ◦ ◦ Mood Swings
◦ ◦ ◦ ◦ Irritability
◦ ◦ ◦ ◦ Poor Concentration

Energy:
◦ ◦ ◦ ◦ Fatigue
◦ ◦ ◦ ◦ Hyperactivity
◦ ◦ ◦ ◦ Lethargy
◦ ◦ ◦ ◦ Restless
◦ ◦ ◦ ◦ Insomnia

Skin Disorders
◦ ◦ ◦ ◦ Eczema
◦ ◦ ◦ ◦ Dermatitis
◦ ◦ ◦ ◦ Excessive sweating
◦ ◦ ◦ ◦ Rashes
◦ ◦ ◦ ◦ Hives

Other Symptoms:
◦ ◦ ◦ ◦ Joint Pain
◦ ◦ ◦ ◦ Arthritis
◦ ◦ ◦ ◦ Irregular Heartbeat
◦ ◦ ◦ ◦ Chest Pains
◦ ◦ ◦ ◦ Muscle Aches

Please List any symptoms not mentioned above: _____
_____

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Practice Rules and Regulations:

1. I agree to follow the dosing schedule and treatment recommendations prescribed to me by my doctor.
2. I will NEVER share, sell, or exchange my medications with anyone for any reason
3. I understand that I am solely responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. **I know that this office does not replace LOST OR STOLEN prescriptions or controlled medications.**
4. I understand that I should not drive or operate heavy machinery while I am taking medications that my cause drowsiness or impaired cognitive function.
5. I agree to notify a staff member if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to the office for disposal.
6. I agree that if I receive controlled substance prescriptions from this office, I am not allowed to accept controlled substance prescriptions from any other physician without my doctor's consent.
7. I agree to use only one pharmacy for my pain-related medications. In the event, that circumstances require the use of another pharmacy, I will notify a staff member of this immediately and provide them with all pertinent contact information.
8. I understand that medication refill prescriptions involving narcotic pain medicine require a SCHDULED appointment with my PRIMARY DOCTOR IN THE OFFICE. **Narcotic pain medication refills will not be called into a pharmacy. Narcotic dosages will not be increased by phone.**
9. I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointment. I understand that if I am more than 15 minutes late to my scheduled appointment time, may have to reschedule for a different time and day. Additionally, if I am late or "no show" on a consistent basis this office reserves the right to dismiss me as a non-compliant patient.
10. The office phone triage hours are 9:00am to 4:00pm, Monday through Thursday and Friday 9:00am-12:30pm.
11. I know that I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for prescription compliance check (pill count).
12. I understand that the prescriber may write narcotic medication and prescriptions on a 30-day basis. In order to receive another narcotic medication prescription I must schedule another office visit within 30 days of the date on my current prescription so my doctor can properly evaluate my progress.
13. **I understand that abusive behavior or harassment toward any staff member WILL NOT be tolerated. Management will determine what actions can be considered harassment on a case-by-case basis and, if warned, I can be dismissed from the practice.**
14. I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from the practice.
15. I understand that this office reserves the right to PERFORM A URINE DRUG SCREEN AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED SUBSTANCES. If the results that the urine drug screen does not reflect medicine prescribed by my doctor, or test positive for illegal drugs, I understand that I can be dismissed immediately from the practice.
16. I know I am responsible for any payments on the DAY OF MY TREATMENT unless arrangements are made with management prior to my appointment.

By signing this agreement, you concur with all rules set in place, and that you have read in full, understood and accepted these terms. Non-compliance with this agreement will be terms for dismissal from the practice. You accept these terms by signing below and this agreement is bond from the date below moving forward.

_____ _____

Print Name Clearly Signature of Patient or legal representative

Date: _____