DYNAMIC™
SPINE AND SPORTS THERAPY
AT KENNESAW

3400 Blue Springs Rd Suite 100
Kennesaw, GA 30144
T. 678.574.5430
F. 678.501.5175
DynamicSportsTherapy.com

Name_____ Cell Phone_____

Address_____ Home Phone_____

City, State, Zip_____ Work Phone_____

Email Address_____

Date of Birth_____ Age_____ Sex Male ☐ Female ☐

Occupation_____ Employer_____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Social Security #_____

Spouse Name_____ Number of Children_____

Emergency Contact_____ Phone#_____ Relation_____

1. Reason for Today's Visit_____

_____

2. Is this related to an auto accident or work related injury? Yes ☐ No ☐ Incident Date_____

3. How long have you has this symptom/injury?_____ 4. Have you ever had this before? Yes ☐ No ☐

5. What do you think caused this symptom/injury to occur?_____

6. List any and all doctors seen for this injury, dates, and types of treatment received for the above condition(s):

_____

7. List any medications/supplements you are currently taking: _____

_____

8. How many times have you visited a chiropractor in your lifetime? More than 50 times ☐ 25-49 ☐ 24-10 ☐ less than 10 ☐ Never ☐

9. When did you last have an x-ray taken?_____What area of the body?_____ Never ☐

10. How would you rate your posture? Poor- 0 1 2 3 4 5 6 7 8 9 10 -Excellent

11. How would you rate your stress over the last 90 days? Low- 0 1 2 3 4 5 6 7 8 9 10 -High

12. ***FEMALE ONLY***- Is there any chance you are currently pregnant? Yes ☐ No ☐

13. How did you hear about us? ☐ Friend/Family_____ ☐ Online ☐ Insurance Website ☐ Google Maps

☐ Attorney_____ ☐ Event_____ ☐ Sign ☐ Email

☐ Physician Referral_____ ☐ Other_____

**Notice:** Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance. On all insurance, the deductible must be met in the beginning unless prior arrangements are made. I (we) agree to pay for services rendered to the above mentioned patient as the charge is 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 and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me, will be immediately due and payable. I certify that all information provided by me is true and accurate tot the best of my knowledge.

**The above information is true and accurate to the best of my knowledge.**

Patient Signature_____ Date_____

Parent/Guardian_____ Date_____

DYNAMIC™
SPINE AND SPORTS THERAPY
AT KENNESAW

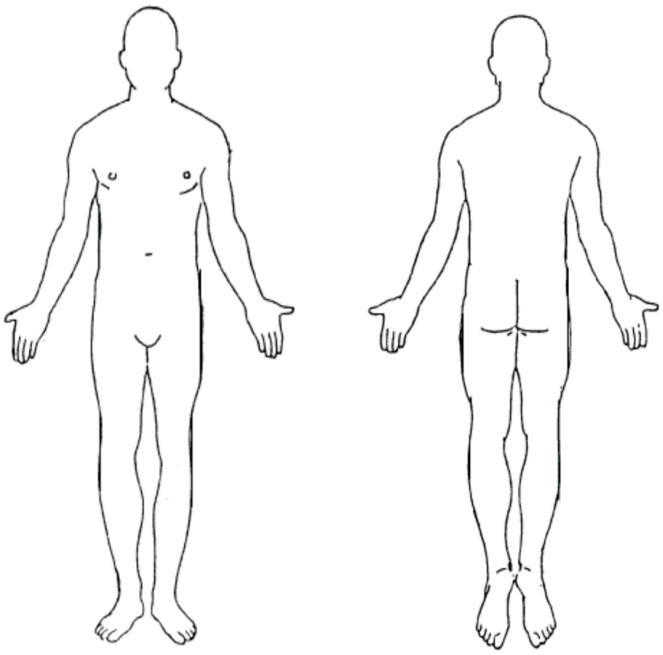
3400 Blue Springs Rd Suite 100
Kennesaw, GA 30144
T. 678.574.5430
F. 678.501.5175
DynamicSportsTherapy.com

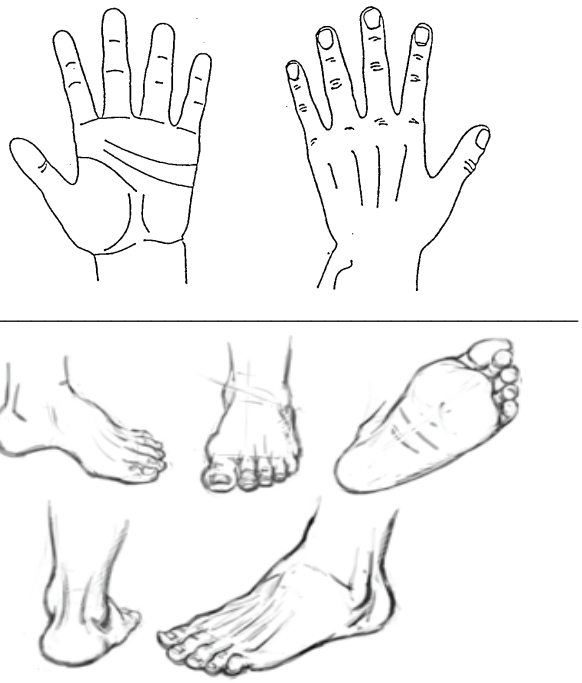
1. Tell us what level of pain you have **NOW** at this moment in time: None- 0 1 2 3 4 5 6 7 8 9 10 -Worst Possible Pain

2. Indicate the area(s) showing the type of discomfort you currently have using the provided markings:

Aching ✶ Dull Pain ///// Stabbing ○ Tingling X Numbness △ Pins & Needles ◊ Burning ☐

R Front L L Rear R





1. List all of the surgeries you have had in the past:_____

2. Have you ever been involved in an auto accident? Yes ☐ No ☐ If so when did this occur?_____

3. Has a Doctor ever told you have heart problems? Yes ☐ No ☐ If so what problems?_____

4. Do you often have pains in your chest or heart? Yes ☐ No ☐ If so when was the most recent episode?_____

***If you checked yes above, was medical clearance granted to return to regular exercise and other activities?*** Yes ☐ No ☐

5. Do you often feel faint or have dizzy spells? Yes ☐ No ☐ 6. Have you ever had a stroke or heart attack? Yes ☐ No ☐

If you said ***yes*** above please explain_____

Any other concerns we should know about your health?_____

7. Please check any box next to the medical conditions which apply to you:

| | | | | | |
|---|---|---|---|---|---|
| ☐Cancer | ☐ Depression | ☐ Headache | ☐ Pulmonary Disorder | ☐ Turberculosis | ☐ Metal Implants |
| ☐Asthma | ☐ Anxiety | ☐ High Blood Pressure | ☐ Fracture/Dislocations | ☐ HIV | ☐ Osteoporosis |
| ☐Diabetes | ☐ ADHD | ☐ Thyroid Disorder | ☐ Cardiac Pacemaker | ☐Open Wound | ☐ Concussion |

☐Allergy_____ ☐ Other_____

**The above information is true and accurate to the best of my knowledge.**

Patient Signature_____ Date_____

Parent/Guardian_____ Date_____

DYNAMIC™
SPINE AND SPORTS THERAPY
AT KENNESAW

3400 Blue Springs Rd Suite 100
Kennesaw, GA 30144
T. 678.574.5430
F. 678.501.5175
DynamicSportsTherapy.com

# Health Care Authorization Form

Patient's Name: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **Dynamic Spine and Sports Therapy LLC** TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMAITON (PHI) IN COMPLIANCE WITH HIPAA AND ACCORDANCE WITH THE FOLLOWING:

## SPECIFIC AUTHORIZATIONS

**Initial** _____*
I give permission to **Dynamic Spine and Sports Therapy LLC** to use and disclose any information needed for completion of my claims for payment from third-party payers including, but not limited to insurance companies, health maintenance organizations, preferred provider organizations, and their representatives.

**Initial** _____*
I hereby give permission to **Dynamic Spine and Sports Therapy LLC** to treat me and give my permission to initiate care. This permission will be given as long as I am a patient with **Dynamic Spine and Sports Therapy LLC**, and will refer and pertain to all providers working for **Dynamic Spine and Sports Therapy LLC**.

**Initial** _____*
If **Dynamic Spine and Sports Therapy LLC** contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

**Initial** _____*
I give permission to **Dynamic Spine and Sports Therapy LLC** to disclose protected health information in the presence of anyone accompanying me into a treatment room or consultation room by my request.

**Initial** _____*
I give permission to **Dynamic Spine and Sports Therapy LLC** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.

## EXPIRATION

The AUTHORIZATION shall be in effect for as long as the patient is a patient at **Dynamic Spine and Sports Therapy LLC**.

## APPOINTMENTS

I understand that I am solely responsible for all appointments made by me at Dynamic Spine and Sports Therapy LLC and a failure to provide an 24 hour cancellation notice will result in a fee.

## RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization in writing at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorizationby mailing or hand delivering a written notice to the Privacy Official of **Dynamic Spine and Sports Therapy LLC**. The written notice must contain the following information: your name, SS#, date of birth, a clear statement of your intent to revoke this authorization, the date of your request and your signature. The revocation is not effective until it is received by the Privacy Official. This authorization is requested by **Dynamic Spine and Sports Therapy LLC** for its own use/disclosure of PHI. *(Minimum necessary standards apply.)* You have the right to refuse to sign this authorization. If you refuse to sign this authorization, **Dynamic Spine and Sports Therapy LLC** will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

DYNAMIC™
SPINE AND SPORTS THERAPY
AT KENNESAW

3400 Blue Springs Rd Suite 100
Kennesaw, GA 30144
T. 678.574.5430
F. 678.501.5175
DynamicSportsTherapy.com

# ASSIGNMENT OF BENEFITS

To Whom It May Concern:

I hereby direct and authorize without equivocation, my insurance company or attorney to **make payments directly to Dynamic Spine and Sports Therapy LLC** for any and all benefits due as a result of my treatment.

By signing this document, I hereby release to **Dynamic Spine and Sports Therapy LLC** the rights, privileges and those causes of action not in violation of O.C.G.A. 44-12-24 against any insurance carrier or other proper party which may be responsible for payment toward any claims incurred. This assignment of benefits shall expressly exclude any assignment of my personal injury claim.

This authorization will supersede and have precedence over any foregoing agreement. I am also aware that I am personally responsible for charges and/or any amount not recovered by **Dynamic Spine and Sports Therapy LLC** through any insurance payment or settlement distribution.

Signature of Patient: _____Date: _____

Signature of Parent or Guardian: _____Date:_____

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL