APPLICATION FOR TREATMENT

Cell Phone Number ______________________ **Cell Phone Provider** ____________________

E-Mail Address ______________________

Name: ______________________ Today's Date: ______________________
Address: ______________________ Date of Birth: ______________________
Home Phone Number: ______________________ City: __________ State: _____ Zip: __________
Work Phone Number: ______________________
Check if you are: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated
Name of Husband/Wife: ______________________ Ages of Children: ______________________
Where are you or spouse employed? ______________________
Your days off: ______________________
Who is responsible for your bill? ☐Self ☐Spouse ☐Employer ☐Insurance ☐Other__________
How payment will be made: Type of Insurance
_________ Cash _________ Worker's Comp _________ Health Insurance
_________ Check _________ Credit Card _________ Med-Pay
Name of company and address: ______________________

If you are in pain, please mark the exact location of your pain on the diagram below. Also, please describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example: dull, sharp, constant, off & on, when standing, when sitting, etc.

MAJOR COMPLAINT
(Please describe only the major problem)

How did this condition develop, what caused it, how did it start? ______________________

When was the very first time you were aware of this problem? ______________________
Have you ever had this problem or similar problem before? If yes, please explain: ______________________

Have you ever received any treatment for this condition? If yes, where, when and what were your results?

Has this problem been getting better, worse or staying the same? ______________________
Is there anything you do that makes your condition worse? ______________________

Has this condition affected your life?
A. Home Life ______________________
B. Occupational Life ______________________
C. Recreational Life ______________________
D. Rest and Sleep Life ______________________

Have you ever been in an auto accident? ☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never
Any accidents, falls, etc. that might have caused your problem? ______________________

What surgery has been done? ______________________________

Are you pregnant? ☐Yes ☐No

Drugs you now take: ☐Nerve Pills ☐Pain Killers ☐Muscle Relaxers ☐ "Pep" Pills ☐Tranquilizers ☐Insulin ☐Birth Control Pills ☐Other (please list) ______________________________

Do you experience any of the following: **☐Shortness of breath** **☐Fatigue & Weakness** **☐Chest Pain** **☐Heart Palpations or Murmurs** **☐Swelling** **☐Difficulty Breathing**

Have you ever been diagnosed with any of the following: **☐Aortic, Tricuspid or Mitral Valve Disorder**
☐Mitral Valve Prolapse **☐Myocardial Ischemia/Infarction** **☐Hypertension**
☐Arrhythmias **☐Heart Failure** **☐Coronary Artery Disease**
☐Pulmonary Disease **☐Infectious Endocarditis**

Do you experience: **☐Dizziness** **☐Decreased Hearing** **☐Ringing/Buzzing in Ears**
☐Double/Blurred Vision **☐Sensitivity to light/sound**
☐Frequent Headaches **☐Loss of balance**
☐Numbness/Loss of sensation in legs **☐Trouble walking**
☐Trouble getting out of bed/chair

Patient's Signature ______________ Social Security Number ______________ Date ________

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident: __________ Hour: _____ ☐A.M. ☐P.M. Location: ______________

How did accident occur? ☐Auto Collision ☐On-the-job injury* Other ______________

*If on-the-job injury, are you still employed by the company? ☐Yes ☐No

Please describe the circumstances: ______________________________

List the extent of the injuries as you know them: ______________________________

Did you require post-accident hospitalization? Yes ☐No If yes, name of Hospital ______________

Other prior medical treatment received for injury from the accident:

Date	Name of Doctor	Place of Treatment	Phone Number

Check symptoms you have noticed since accident:

☐Headache ☐Irritability ☐Numbness in Toes ☐Face Flushed ☐Feet Cold
☐Neck Pain ☐Chest Pain ☐Shortness of Breath ☐Buzzing in Ears ☐Hands Cold
☐Neck Stiff ☐Dizziness ☐Fatigue ☐Loss of Balance ☐Stomach Upset
☐Sleeping Problems ☐Head seems too heavy ☐Depression ☐Fainting Spells ☐Constipation
☐Back Pain ☐Pins & Needles in Arms ☐Light bothers eyes ☐Loss of Smell ☐Cold Sweats
☐Nervousness ☐Pins & Needles in Legs ☐Loss of Memory ☐Loss of Taste ☐Fever
☐Tension ☐Numbness in Fingers ☐Ears Ring ☐Diarrhea ☐__________

Symptoms other than above: ______________________________

Have you lost any days of work? ☐Yes ☐No Dates: ______________

Name of your insurance company involved: ______________________________

Name of insurance company of person/work place responsible for injuries: ______________

Have you been contacted by an insurance adjuster of company representative regarding this claim? ☐Yes ☐No

Do you have an attorney who has advised you in this case? ☐Yes ☐No Name: ______________

Address of attorney: ______________________________ Phone Number: ______________

Knowles Rehabilitation

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic. Manipulation complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin imitation, burns of minor complications.

Probability of risks occurring: The Risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be ancillary procedures is even further reduced by screening procedures. The probability of adverse reaction due to also considered "rare".

Other treatment options which could be considered may include the following:

- Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.
- Medical care: typically, anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

____

Printed Name Signature Date

____

WITNESS:
Printed Name Signature Date

Knowles Rehabilitation
Privacy Practices & Payment Agreement

Patient Name:

I understand that I can request restrictions on how my health information is used or disclosed to carry out treatment or healthcare operations. However, there may be times when Knowles Rehab is not able to honor my requested restrictions. For example, they may need to release my medical information to get paid from an insurance company or to treat me.

I consent to the disclosure of my protected health information for the purpose of medical diagnoses, providing treatment, obtaining payment or to conduct necessary health care operations and authorize direct payment of medical insurance benefits to Knowles Rehab.

I accept that there is no guarantee of protection of my medical records from a court ordered release. In the event of legal proceedings involving patient care, I understand the contents of my file must be made available to legal counsel representing the practice and professional employees.

I agree to pay the amount invoiced in full. In the event Knowles Rehab extends credit to me (i.e. payment plan, attorney lien, insurance checks that patients receive, etc.), I agree that Knowles Rehab may assess interest and service charges on my outstanding balance. I further agree to pay all costs of collection, including costs of collection agency, attorney fees and court costs in the event this balance is turned over to an agency. This agreement will be governed under the law of the State of Georgia. Knowles Rehab has the option of pursuing an action under this agreement in any court of competent jurisdiction in the State of Georgia and I consent to jurisdiction in the State of Georgia.

Signature of Patient ______________________________

Date ______________

Knowles Rehabilitation

Our goal is to provide the best quality chiropractic care, and to do so in a timely manner. In order to accomplish this, we try not to overbook in order to ensure that we have sufficient time to adequately provide the care and attention needed to each of our clients.

We make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments, arriving on time, and notifying us a minimum of 24 hours in advance if you will be unable to keep you appointment.

CANCELLATION OF AN APPOINTMENT

In order to take full advantage of your care program, we strongly recommend that you keep all appointments as scheduled. However, we understand that special circumstances can arise from time to time. If it is necessary to cancel your scheduled appointment, we ask that you notify our office at least 24 hours in advance.

To cancel your appointment, please call 770-985-5223. If you do not reach someone from the office, you may leave a detailed message on the answering machine. Calling as early as possible in the day is also greatly appreciated, as this will give us ample time to offer your appointment to another client who may be waiting to receive care.

LATE ARRIVALS

When we set up an appointment, a specific amount of time is reserved especially for you. If you are running late, please call our office to reschedule. On occasion we are able to work-in late arrivals into the schedule; however this is at the discretion of our front office staff. If you arrive more than 15 minutes late, we may ask you to reschedule in order to meet the needs of those who are on time for their pre-reserved visits. If this happens it will be considered a missed appointment.

MISSED APPOINTMENTS (*NO SHOWS*)

A "no show" is someone who misses an appointment without canceling it in an acceptable manner. When a client does not show up for their appointment, we lose the opportunity to see and help someone else. A missed appointment will be recorded in the patient's file. Due to our 24 hour cancellation policy, if a "no show" arises a fee of $50.00 will be billed to the patient's account with the appropriate provider. "No show" fees are the patient's responsibility and must be paid before your next appointment. The fee cannot be billed to your insurance company.

I have read and understand this policy. I agree to comply and realize that if I do not, I may be charged.

SIGNATURE________________________ DATE______________