Advanced Health Solutions
Georgia Spine and Disc

APPLICATION FOR CARE

Name: _____ **Date of Appointment:** _____

Thank you for allowing us to help you. Whom may we thank for referring you to this office? _____

PERSONAL DEMOGRAPHICS

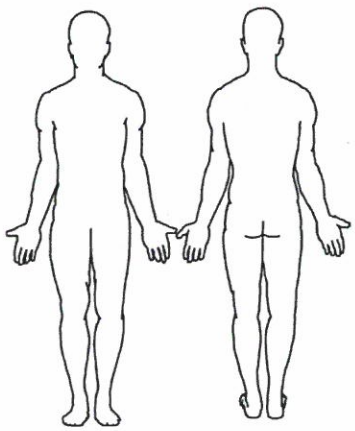
Birth Date: ____-____-____ Age: _____ ❑ Male ❑ Female
Address: _____ City: _____ State: ____ Zip: _____
Social Security No: _____ Email Address: _____
Cell Phone: _____ Work Phone: _____
May we leave you a voicemail and/or text message? ❑ Yes ❑ No
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Do you have Insurance: ❑ Yes ❑ No
Type of Insurance: ❑ BC/BS ❑ Aetna ❑ Cigna ❑ UHC ❑ Coventry ❑ Humana ❑ Medicare
Pharmacy Name: _____ Phone No: _____
Employer: _____ Occupation: _____
Emergency Contact: _____ Phone: _____ Relationship: _____

CHIEF COMPLAINT & HPI

Please identify the condition(s) that brought you to this office: First: _____
Second: _____ Third: _____ Fourth: _____
Rate your pain for each complaint, on a scale of 1 to 10 with 10 being the worst pain and zero being no pain. Rate your complaints above by circling the number:

Primary or chief complaint:	0	1	2	3	4	5	6	7	8	9	10
Second Complaint:	0	1	2	3	4	5	6	7	8	9	10
Third Complaint:	0	1	2	3	4	5	6	7	8	9	10
Fourth Complaint:	0	1	2	3	4	5	6	7	8	9	10

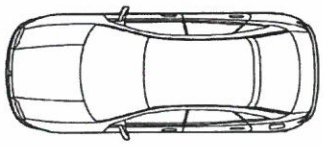
When did the problem(s) begin? _____
When is the problem at its worst? ❑ AM ❑ PM ❑ Mid-Day ❑ Late PM
Frequency of Main Problem/Pain? ❑ Constant ❑ Frequent ❑ Intermittent
How did the pain start? _____
Have you seen any doctor(s) for this condition? ❑ No ❑ Yes If yes, when? _____
By whom? _____
How long were you under care? _____ What were the results? _____



***PLEASE MARK the areas on the Diagram** with the following letters to describe your symptoms:

T= Tingling N = Numbness S = Sharp/ Stabbing R = Radiating
B = Burning D = Dull A = Aching

What relieves your symptoms? _____
What makes them feel worse? _____
Is your problem the result of ANY type of accident? ❑ No ❑ Yes
If yes, what kind of accident? ❑ MVA ❑ WC ❑ PI Date: _____



Mark X on the diagram.

Notes: _____

Patient's Name: _____ **Date:** _____

ACCIDENT HISTORY: _____

_____

_____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of life:

ACTIVITIES:	EFFECT:			
Carrying Groceries	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sit to Stand	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Climbing Stairs	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Extended Computer Use	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Household Chores	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Lifting Children	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Reading/Concentration	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Bathing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Shaving	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sexual Activities	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sleep	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Static Sitting	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Static Standing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Yardwork	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sweeping/Vacuuming	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Dishes	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Laundry	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Other_____	No Effect	Painful (can do)	Painful (limits)	Unable to Perform

MEDICATIONS

Please list the dose and frequency of ALL medications you are currently taking (including Aspirin, Allergy Medication, Birth Control Pills, Vitamins, etc.):

_____

_____

MEDICAL HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes

If yes, how many times? _____ When was the last episode? _____

Please list any medical condition that you think you have or have been diagnosed with:

_____

ALLERGIES

Please list any allergies or intolerance to medications, iodine, or other materials:

_____

SURGICAL HISTORY

Please list any operations you had in the past 10 years:

_____

HOSPITALIZATION

Please list any reason for hospitalization in the past 5 years:

_____

Patient's Name: _____ **Date:** _____

FAMILY HISTORY:

Member	Age	Diabetes	Hypertension	Heart Dx	Stroke	Cancer	Other
Father							
Mother							
Grandfather							
Grandmother							

SOCIAL HISTORY

Do you smoke? If yes, how much and how often? _____

Do you drink alcohol? If yes, how much per day? _____

Do you use drugs? If yes, what kind of drugs and how much do you use per day? _____

REVIEW OF SYSTEMS (ROS)

Do you have a history of any of the following? Check any that apply:

- ❑ Diabetes: _____
- ❑ Heart Disease: _____
- ❑ High Blood Pressure: _____
- ❑ Stroke: _____
- ❑ Cancer: _____
- ❑ Skin Diseases (i.e., Psoriasis, etc.) _____
- ❑ Lung Disease: _____
- ❑ Stomach Problems: _____
- ❑ GI Problems: _____
- ❑ Eye Disease: _____
- ❑ Nose or Throat Problems: _____
- ❑ Psychiatric Problems (i.e., Depression, etc.): _____
- ❑ Circulatory Problems: _____
- ❑ Infectious Disease Problems (i.e., AIDS, Pneumonia, Tuberculosis, etc.): _____
- ❑ Neurological Problems (i.e., Multiple Sclerosis, Diabetic Neuropathy, etc.): _____
- ❑ Kidney or Bladder Problems: _____
- ❑ Joint Problems (i.e., Arthritis, Bursitis, etc.): _____

NEUROLOGICAL / VASCULAR HISTORY

Do you suffer from shoulder, arms or hands pain, tingling/numbness or weakness? ❑ Yes ❑ No If yes, how often?

_____

Do you suffer from cold hands or feet? ❑ Yes ❑ No

_____

Do you suffer from loss of hand grip strength? ❑ Yes ❑ No

_____

Do you suffer from tingling, numbness or weakness in your legs or feet? ❑ Yes ❑ No

_____

Do you suffer from frequent headaches? ❑ Yes ❑ No

_____

Have you had an MRI? ❑ Yes ❑ No

If yes, who ordered it? When was it done? What part of the body was it ordered on?

_____

Have you used any splints or braces prescribed by an MD? ❑ Yes ❑ No

If yes, when? Who ordered it? What kind?

_____

Patient signature: _____ Today's Date: ____/____/____

Quality of Life Questionnaire

Date: _____

Patient's Name: _____ DOB: _____

Patient's Phone Number: _____ Email: _____

1. Have you ever been diagnosed with Allergies? YES ❑ NO ❑ _____

2. Are you currently taking or have you within the last year taken or have been prescribed any over-the-counter or prescription strength medications for allergies, hay fever, or nasal Congestion? YES ❑ NO ❑ _____

If YES, please list all that apply:

_____

_____

3. Have you ever been diagnosed with asthma? YES ❑ NO ❑ _____

4. Is your doctor currently treating your asthma with medications? YES ❑ NO ❑ _____

If YES, please list all that apply:

_____

_____

5. Please note that in the case of seasonal allergies, you may not be experiencing the following symptoms now, but may experience them regularly during a different season of the year.

Please check all that apply:

❑ Stuffy Nose	❑ Sore Throat	❑ Bad Breath
❑ Runny Nose	❑ Cough	❑ Snoring
❑ Nasal Congestion	❑ Post Nasal Drip	❑ Mouth Breathing
❑ Itchy Eyes	❑ Headaches	❑ Nose Bleeding
❑ Watery Eyes	❑ Trouble Sleeping	❑ Sinus Pain
❑ Itchy Throat	❑ Fatigue	❑ Loss of Taste/Smell

Patient Name: _____ **Date:** _____

ADVANCED HEALTH SOLUTIONS PRIVACY NOTICE

Your privacy and personal information is one of our highest priorities. This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign your name indicating your understanding of these policies.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. For payment purposes - to obtain payment from your insurance company or any other collateral source.
3. For workers' compensation purposes-to process a claim or aid in investigation.
4. Emergency-in the event of a medical emergency we may notify a family member.
5. For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. To government agencies or law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
7. For military, national security, prisoner and government benefit purposes.
8. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
9. Telephone calls or emails and appointment reminders -we may call your home and leave messages and send texts regarding a missed appointment or apprise you of changes in practice hours or upcoming events.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records but you can request copies be made for you.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Donna Hodgdon at (770) 380-4443. If she is unavailable, you may make an appointment with our receptionist to see her within 72 Hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS Office of Civil Rights at 200 Independence Ave. SW, Room 509F HHH Building, Washington, DC 20201.

I_____have received a copy of Advanced Health Solutions privacy notice and I understand the practices duty to protect my health information and have conveyed my understanding of these rights and duties to the doctors. I further understand that this office reserves the right to amend this notice of privacy practice at any time and will make the new provision effective for all information that it maintains past and present. I am aware that a more comprehensive version of this notice is available to me upon request.

Signature of Patient or Personal Representative: _____ Date: _____

Witness Signature: _____

FINANCIAL AND ADMINISTRATIVE POLICIES

Welcome to our office. We are pleased to have you as a patient and committed to meeting your health care needs. It is our goal to provide you with the best possible health care and to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of services you rendered from our office Advanced Health Solutions (DBA Georgia Spine and Disc) and its affiliate Woodpark Family Chiropractic. Please contact your insurance company to confirm coverage and benefits. We can never guarantee coverage for any service provided by our office. You are responsible for any services that the insurance does not cover, such as but not limited to well visits, procedures, injections and immunizations, balance left after all insurance payments and contracted adjustments.

2. All co-payments and deductibles are collected at the time of service.

3. If you miss your appointment without notification, you will be charged a fee as below:

    1. Massage Appointment canceled less than 24 hours notice for appointments $25.00
    2. Medical Doctor Appointment canceled $25.00
    3. Returned payment for Non-Sufficient Funds $30.00
    4. If patient account(s) is unpaid 90 days, +7% interest charge will be applied monthly to the balance. If sent to collection agency, there will be a $100 administrative fee added.

REFILL REQUEST and NURSE CALLS

Please allow 3 business days for your refill request to be filled. Although we will try to return patient telephone requests within 48 hrs., we ask that you kindly give our staff 72 hrs. to return any requests. Please have the pharmacy fax the request to us at (770) 926-9284. Most medications refills may require a follow-up visit with the physician. Pain medication will not be called in after hours. An appointment with the physician will be required to replace lost or misplaced prescriptions.

COMPLETION OF ALL FORMS

Please allow our office 7-10 business days to complete your request. The forms may be completed earlier than that. There might be a fee associated with completing these forms and you will be notified before it is done.

1. FMLA, disability, life insurance forms
2. Travel letters
3. School forms
4. Sports Physical forms
5. Other miscellaneous administrative forms required by third parties other than your health insurance company

PLEASE UNDERSTAND: We file insurance claims as a courtesy to our patients. You have a contract with your insurance company of choice. We are not responsible for how your insurance company handles its claims or for the benefits they pay. We do not guarantee what your insurance company will or will not do with each claim. This is performed as a courtesy to you.

I have read and understand the financial policy stated above and agree to accept responsibility as described.

PATIENT NAME: _____ DATE: _____

Signature of Patient or Personal Representative: _____

If Personal Representative, give relationship to patient: _____

PATIENT CONSENT FORM

During the course of my care and treatment, I understand that various types of tests, diagnostics or treatment procedures may be necessary. These procedures may be performed by physicians, chiropractors, nurses, technicians, physician assistants or other healthcare professionals at Advanced Health Solutions.

While routinely performed without incident, there may be material risks associated with each of these procedures. I understand that it is not possible to list every risk for every procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the procedures. I also understand that various healthcare professionals may have differing opinions as to what constitutes material risks and alternative procedures.

The procedures may include, but are not limited to, the following:

(1) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. *The material risks associated with these types of procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death.* Apart from using modified procedure and/or refusal of treatment, no practical alternative exists.

(2) **Administration of medications** whether orally, rectally, topically or through my eye, ear or nose. *The material risks associated with these types of procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death.* Apart from varying the method of administration and/or refusal of treatment, no practical alternative exists.

(3) **Drawing blood, bodily fluids or tissue samples** such as that done for laboratory testing and analysis. *The material risks associated with this type of procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function.* Apart from long-term observation and/or refusal of treatment, no practical alternative exists.

(4) **Chiropractic care**, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, *yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.*

I understand that:

- The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any procedures;
- The healthcare professional participating in my care will rely on my documented medical history, as well as other information obtained from me, family or others having knowledge about me, in determining whether to perform or recommend the procedures therefore, I agree to provide accurate and complete information about my medical history and conditions; and
- By signing this form:
- I consent to healthcare professionals performing procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgement, **including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and
- I acknowledge that I have been informed in general terms of the nature and purpose of the procedures; the material risks of the procedures; and practical alternatives to the procedures.

If I have any questions or concerns regarding these procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign additional informed consent documents.

PATIENT NAME: _____ **DATE:** _____

Signature of Patient or Personal Representative: _____

If personal Representative, give relationship to patient: _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Advanced Health Solutions (DBA Georgia spine and disc) and Woodpark Family Chiropractic, Dr. Khaled Abouhaif, Dr. Thomas Federico and Scott Boschetto as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy (ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____day of _____, 20 ___.

X_____(SEAL)
(Patient signature)

_____
(Please print patient name)

X_____(SEAL)
(signature of Guardian if applicable)

Revised March 23, 2020

Advanced Health Solutions

Dr.Thomas Federico,M.D
Dr. Kal Abouhaif, D.C.
Scott A Boschetto,PT,ATC,MS

Authorization to Release Medical Information / HIPPA

Patient: _____ Birth Date: _____

SSN: _____ Telephone: _____

Released from: _____

Release to: _____ Advanced Health Solution *Georgia Spine and Disc* or _____ Myself
Or authorized person (name) _____

Specific type of information to be disclosed:

- Complete Medical Record _____
- MRI Report of Cervical _____ Lumbar _____ Others _____
- Other: _____ Time Period: _____

-I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.
-I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.
-I understand that the Practice will not condition my treatment, payment, enrollment, in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the request use or disclosure. Furthermore, if the practice will receive payment for obtaining this information, I understand I will be notified of the same.
-I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state laws.
-Without express written revocation, this consent expires after one year.

_____ _____
Signature of Patient Printed Patient Name

_____ _____
Relationship to Patient Witness Signature

Date_____

Advanced Health Solutions
Georgia Spine and Disc

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