TOTAL HEALTH & INJURY SPECIALIST

Dr. Teresa Jackson
Chiropractor
5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Office: 404-734-9740
records@totalhealthandinjury.com
Fax: 404-845-7834

"Warning: Under Georgia law, there is no liability for an injury or death of an individual entering these premises if such injury or death results from the inherent risks of contracting COVID-19. You are assuming this risk by entering these premises."

COVID-19 QUESTIONNAIRE

1. Have you traveled out of the country in the past 14 days? YES or NO

2. Have you had any contact with anyone with confirm COVID-19 in the past 14 days? YES or NO

3. Have you had any of the symptoms in the past 14 days? YES or NO
   - Fever greater than 100 degrees- YES or NO
   - Difficulty breathing- YES or NO
   - Cough- YES or NO
   - Loss of smell or taste- YES or NO

4. If you answered YES to question 1, 2 and/or 3, please call your primary care provider or Georgia Department of Public Health at (404) 657-2700 for further direction.

PLEASE DO NO ENTER OUR FACILITY IF YOU SAID YES TO ANY OF THE ABOVE QUESTIONS

Print Name: _____

Signature: _____

Date: _____

TOTAL HEALTH & INJURY SPECIALIST

Dr. Teresa Jackson
Chiropractor
5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Office:404-734-9740
Fax: 404-845-7834

OFFICE AND MISSED APPPOINTMENT POLICIES:

It is our wish that each and every one of our patients receive the very best care and service possible. Your Doctor Ordered Treatment Program consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

1. **All patients are setup up on our automated text or email reminder system. To confirm appointments: reply by pressing the #1 and sending it to the text received.**
2. If you become ill, we still want you to come in, because treatments and spinal manipulations will help you recover. **Exception would be a + COVID 19 test** which would require 5-7 days of quarantine. Please bring in your Doctor's note with your positive and negative results to be documented.
3. With the exceptions of unexpected emergencies, we require that **you notify us at least 24 hours in advance with any appointment changes.**
4. **All cancelled or missed appointments must be rescheduled and made up within one week to stay on track with your care plan.**
5. We require that you sign-in at the front desk upon arrival at each visit as we attempt to honor all appointments at their scheduled times. If you arrive late or early, you may have to wait for the next available appointment time.
6. In accordance with CDC regulations, we ask that you wear a mask at all times while in the office.
7. **After 3 weeks of no-show appointments with our office for a single patient, that patient will no longer be able to schedule with Total Health and Injury Specialist. We will close out your file and send all bills and records directly to the law firm. All patients are welcomed to come back and continue treatment with an email from your Attorney/ Law Firm stating so.**
8. There is a **$75 fee for any paperwork required from your job** to be filled out by the doctor**. This must be paid in advance and is not billable to your auto accident case.**
9. I acknowledge that I am receiving services from Total Health and Injury Specialist to treat injuries endured from an auto accident under an attorney lien. I have a law firm representing my case and if they disengage it is my responsibility to find a new attorney and notify Total Health and Injury Specialists of such changes. **If I am unable to have a law firm represent me for my auto accident case, I understand that I am liable to pay for all services rendered by Total Health and Injury Specialist.**

As a courtesy, patients receive an automated text or call reminding them of all their appointments. It is the patient's responsibility to cancel or reschedule any appointments at least 24 hours in advance if they are unable to attend.

I have read, understand, and agree to follow the above policy.

Print Name: _____ **Signature:** _____

Date: _____

TOTAL HEALTH & INJURY SPECIALIST

Dr. Teresa Jackson
Chiropractor
5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Office:404-734-9740
Fax: 404-845-7834

Client Email and Text Message Informed Consent

You may give permission to Total Health and Injury Specialist to communicate with you by email and text message (also known as SMS). This form provides information about the risks of these forms of communication, guidelines for email/text communication, and how we use email/text communication. It will also be used to document your consent for communication by email and text message.

How we will use email and text messaging: We use these forms of communication for non-sensitive and non-urgent issues only. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your email and text messages may be forwarded to another THIS staff member as necessary for appropriate handling. We will not disclose your emails or text messages to researchers or others unless allowed by the state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

Risk of using email and text messages: The use of email and text message has several risks that you should consider. These risks include, but are not limited to, the following: Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients. Senders can easily misaddress an email or text and send the information to an undesired recipient. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy. Employers and on-line services have a right to inspect emails and texts sent through their company systems. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection. Emails and texts can be used as evidence in court. Email and text messaging may not be secure and therefore it is possible that a third party may breach the confidentiality of such communications.

Conditions for the use of email and text messages: THIS cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:

IN CASE OF A MEDICAL EMERGENCY, DO NOT USE EMAIL OR TEXT, CALL 911. Do not email for urgent problems. If you have an urgent problem during regular business hours, please call our office at 404-734-9740. Urgent messages or needs should be relayed to us by using regular telephone communication. Emails should not be time sensitive. While we try to respond to email messages daily, we cannot guarantee that any email will be read and responded to within any period. If you have not heard back from us within 48 hours, call our office to follow up if we have received your email. You should speak with someone in our office to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations. Email and text messages may be filed electronically into your medical record. Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except as authorized by the law. You should use your best judgement when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages. THIS is not liable for breaches of confidentiality caused by you or any third party. It is your responsibility to follow up with our staff if warranted.

Withdrawal of consent: I understand that I may revoke this consent at any time by advising THIS in writing. My revocation of consent will not affect my ability to obtain future health care, nor will it cause the loss of any benefits to which I am otherwise entitled.

Client Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between THIS staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that THIS may impose to communicate with me by email or text message.

Patient Name:_____

Patient Signature:_____ Date:____/_____/_____

TOTAL HEALTH & INJURY SPECIALIST

Dr. Teresa Jackson
Chiropractor
5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Office:404-734-9740
Fax: 404-845-7834

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination tests, diagnostic x-rays, and physical therapy techniques on me (or on the patient named below for who I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working or associated with, or serving as a back-up doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic. The doctor will use his/her hands or a mechanical device 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.

I understand that, as with any health care procedure, there are certain complications that may rise during a chiropractic adjustment. Those complications include but are not limited to fractures, disc injuries, dislocations, and muscle sprains and strains. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interests. The risks of complications due to chiropractic treatment or ancillary services have been described as "rare".

I understand that the 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. Other treatment options which could be considered may include the following: over-the-counter analgesics, medical care, hospitalization, or surgery. I have had an opportunity to discuss with the Doctor of Chiropractic named above and/or with other office or clinic personnel the nature, purpose and risks of chiropractic adjustments and other procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

Authorizations

I also give Total Health and Injury Specialist LLC permission to treat me in an "open-room environment" whereas the door to the room will remain open. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak to the doctor at any time in private, the doctor will close the door to the room for these conversations. The patient authorizes and grants permission to Total Health and Injury Specialist to use and/or disclose protected health information (i.e., address, phone number, and/or clinical records) in the following ways: Thank You Cards, Appointment Reminders, Newsletters, Office Marketing Material.

Acknowledgement of Notice of Patient Privacy Practices

I have read or been provided with a Notice of Patient Privacy Practices that provides a description of healthcare information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restriction to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Print Name: _____ **Signature:** _____

Date: _____

WELCOME

PATIENT INFORMATION

Date _____

Social Security # _____

Patient Name _____
Last Name

_____
First Name Middle Name

Address _____

City _____

State _____ Zip _____

E-Mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

Spouse's Phone (_____) _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account _____

Relationship to Patient _____

Auto Insurance _____

Policy # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Ins. Company _____

Group # _____

Date of Accident or Injury _____

TOTAL HEALTH & INJURY SPECIALIST

Patient Payment Selection

As a result of the above referenced accident, I choose to bill services related to this accident to:

☐ Auto/MedPay Coverage: 1st party automobile insurance coverage through my auto carrier.

☐ Attorney Lien: I have hired an attorney that will settle my medical bills at the end of my treatment.

☐ Self-Pay: I will pay for my medical services up front at the time of service.

** Any unpaid services are the responsibility of the patient, regardless of the party billed.

Signature _____ Date _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best Time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

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 Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

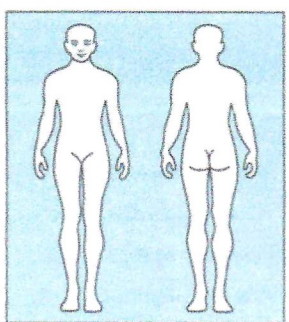
Is this condition getting progressively worst? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movement that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

By my signature on this form, I _____ hereby state that, to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this current time. X _____

Injuries/Surgeries you ever had	Description	Date / Year
Falls		
Head Injuries		
Broken Bones		
Surgeries		
Past Car Accidents		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (_____) _____		

TOTAL HEALTH & INJURY SPECIALIST

5304 Panola Industrial Blvd · Suite E
Decatur, GA 30035
Phone (404) 734-9740
Records@totalhealthandinjury.com

Patient Name _____ Date _____

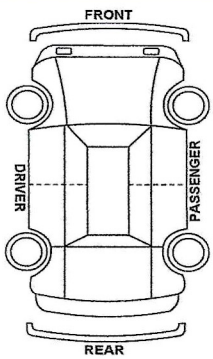
PLEASE ANSWER OR MARK THE APPROPRIATE CIRCLES COMPLETELY TO EACH QUESTION

About your ACCIDENT,

Date of Accident: _____
I am a _____year old ○M / ○F who was involved in a motor vehicle accident
I was the: ○Driver ○Passenger ○Pedestrian
** *If passenger*: ○Front seat or Rear seat on ○Right ○Middle ○Left

The vehicle was struck from: ○Front ○Rear ○Driver side ○Passenger side

On the diagram, please mark the area that the vehicle was struck



Road Conditions ○Wet ○Dry
Were you wearing a seatbelt? ○Yes ○No
Did the airbags deploy? ○Yes ○No
Did your seat break? ○Yes ○No
Did any windows in your car break? ○Yes ○No
Did you get any glass fragments in your body? ○Yes ○No
Where was headrest located before impact? ○Upper Back ○Mid Neck ○Mid Head ○Upper Head

Were you surprised by the impact when the collision occurred? ○Yes ○No

Did you experience pain immediately after the auto collision? ○Yes ○No

Were you looking straight ahead? ○Yes ○No

Was you head turned? ○LEFT ○RIGHT
Did your knee hit the car console? ○Yes ○No
Were you unconscious? ○Yes ○No
Did you suffer any abrasions or contusions? ○Yes ○No
Broken Bones? ○Yes ○No

Did anyone call 911? ○Yes ○No
Did the police arrive? ○Yes ○No Which Police Department? _____
Police Officer's Name? _____ Was anyone cited? _____

Have you made any statements to any insurance company or anyone else? _____
Do you, or anyone else, have photographs of the accident scene, automobiles or your injuries? ○Yes ○No
If so, who?

_____

Did you go to hospital or E.R.? ○Yes ○No

Please name the hospital or E.R

If yes, via Ambulance? ○Yes ○Other _____

Were X-rays or other images taken? ○Yes ○No

Are you taking any pain medications? ○No ○Yes Please List Below

_____

_____

_____

INSURANCE INFORMATION

Driver: _____ Vehicle Owner: _____

Was this a company vehicle? ○Yes ○No Company Name? _____

Driver's Insurance Company: _____ Claim #: _____

What type of vehicle was the other party driving?: ○SEDAN ○SUV ○MINIVAN ○TRUCK ○18-WHEELER ○MOTORCYCLE

What type of vehicle were you in? ○SEDAN ○SUV ○MINIVAN ○ TRUCK ○18-WHEELER ○MOTORCYCLE

What parts of car that you were in were damaged? _____

Cost of repairing your car: $_____

Your driver's or Car's insurance Company (if separate from your own): _____

Adjuster: _____ Phone #: _____ Claim #: _____

About your PAIN,

Where are you hurting?

○ Neck	○ Mid back	○ Low back	○ Rt / Lt Arm	○ Rt / Lt Hand	○ Rt / Lt Shoulder
○ Rt / Lt Hip	○ Rt / Lt Knee	○ Rt / Lt Leg	○ Rt / Lt Ankle	○ Chest	○ Headaches

How would you rate your pain? (0 = no pain at all, 10 = the worst pain ever)

0 1 2 3 4 5 6 7 8 9 10

How often do you have the pain? ○Rarely ○On and off ○Constantly

How would you describe your pain?

○ Dull Ache	○ Stiffness	○ Tension	○ Sharp	○ Burning	○ Weakness
○ Numbness	○ Tingling	○ Throbbing	○ Stabbing	○ Other _____	

What relieves your pain?

○ Nothing	○ Rest	○ Brace	○ Sitting	○ Laying
○ Walking	○ Hot Pack	○ Cold Pack	○ Medication	○ Other _____

What makes your pain worse?

○ Lifting	○ Pushing	○ Pulling	○ Sitting	○ Driving	○ Cough/Sneeze
○ Bending	○ Walking	○ Running	○ Standing	○ Laying	○ Other _____

Sleep Disturbances:

Does the pain wake you up at night? ○Yes ○No

○2-4 hours of sleep due to pain waking you up throughout the night

○4-6 hours of sleep due to pain waking you up throughout the night

What sleep position are you not able to perform due to pain? ○ Back ○ Stomach ○ Side ○ Left or ○ Right

What position do you fall asleep with most ease? ○ Back ○ Stomach ○ Side ○ Left or ○ Right

How many times are you waking up at night due to pain? ○1-2x per night ○4-6x per night ○10x or more per night

How often do you have trouble falling asleep? ○Never ○Sometimes ○Most days ○Everyday

Describe the pain: ○ Stabbing ○ Burning ○ Shooting ○ Electric

Is the loss of sleep affecting your quality of life? ○Yes ○No

○Feel depressed? ○Loss of appetite? ○Feel irritable? ○Feel tired throughout the day?

TOTAL HEALTH & INJURY SPECIALIST

Dr. Teresa Jackson
Chiropractor
5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Office: 404-734-9740
records@totalhealthandinjury.com
Fax: 404-845-7834

Patient Name: _____ Date: _____/_____/_____

Loss of Enjoyment/ Duties Under Duress Summary

Place a check in front of the day-to-day living or work duties that are painful or difficult for you to perform as a result of the injuries you sustained. Then check mark the appropriate box designating reason for difficulty.

Job Description: _____

N/A Work	Reason for the Difficulty/Limitation
____ Lifting	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Bending	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Sitting	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Walking	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Standing	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Reading	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Writing	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Child Care	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Using telephone	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Computer Duties/Typing	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform

____ Have Not Been Able to Work Since Date: _____/_____/_____

N/A Studies/School	Reason for the Difficulty/Limitation
____ Lifting	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Bending	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Sitting	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Walking	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Studying	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____ Computer Duties/Typing	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform

N/A Sports — **Reason for the Difficulty/Limitations**

Name Sport: _____ ☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform

Pre-Accident Level of Participation: ☐ Socially ☐ Competitively ☐ Professional

Activities which you have performed despite pain, due to financial, family or personal needs (Duties Under Duress):
•Work •Education •Domestic (Activities within the Home) •Household (Duties outside the Home)

_____

_____

_____

N/A	Domestic Duties (Activities within the Home)	Reason for the Difficulty/Limitation
____	Eating	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Bending	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Ironing	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Laundry	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Dusting	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Cleaning	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Dressing	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Vacuuming	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Watching TV	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Preparing Meals	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Sexual Relations	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Shampooing Hair	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Bathing/Showering	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Washing Dishes	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Taking Care of Kids	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform

- # of Children: _____ Ages_____

N/A	Household Duties (Activities outside the Home)	Reason for the Difficulty/Limitation
____	Traveling	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Shopping	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Gardening	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Driving Car	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Dinning Out	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Social Events	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Car Washing	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Tree Trimming	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Mowing Lawn	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Transportation	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Taking out Trash	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	Trimming Bushes	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform
____	House Maintenance	☐Increased Pain ☐Restricted Movement ☐Weakness ☐Cannot Perform

Patient Signature: _____ Date: _____/_____/_____

TOTAL HEALTH & INJURY SPECIALIST

5304 Panola Industrial Blvd · Suite E
Decatur, GA 30035
Phone (404) 734-9740
Fax (404) 845-7834
Records@totalhealthandinjury.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **SS#:** _____
DOB: _____ **Home Phone:** _____

I authorize _____ to release copies of the following medical records of for the dates of service _____, as follows:

- ___ **History of Physical**
- ___ **Operation Report(s)**
- ___ **Consultation Summary**
- ___ **Discharge Summary**
- ___ **Other, Specify:**
- ___ **Radiology Report(s)**
- ___ **Laboratory Report(s)**
- ___ **Pathology Report(s)**
- ___ **Complete Medical Record**

I want this information faxed to Total Health & Injury Specialist for the purpose of review.

I understand and acknowledge that the records I have requested to be released pursuant to this authorization may contain psychiatric, drug, alcohol abuse and/or infectious disease information, which is protected under the laws of the State of Georgia and Federal Regulation (42 CFR Part 2). I hereby release Total Health & Injury Specialist, LLC from all legal liability that may arise from the release of any information from my alcohol, drug abuse or infectious diseases (HIV and AIDS) Information protected under State and Federal Laws. The authorization, except for action already taken, may be revoked by me at any time. This authorization is valid for 90 days unless otherwise specified.

Patient Signature _____ Date _____

_____
Doctor's Signature Date _____

***If the patient is unable to sign, his/her legally qualified representative may authorize the release of medical information.**

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO TOTAL HEALTH AND INJURY SPECIALIST FROM INSURANCE CARRIER

DOA: _____ DOB: _____

Patient: _____

Ins. Company: _____

Insured SS #: _____

Claim #: _____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Total Health and Injury Specialist
5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Office: 404-734-9740
records@totalhealthandinjury.com
Fax: 404- 845-7834

As payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to TOTAL HEALTH AND INJURY SPECIALIST and mail it as follows:

Total Health and Injury Specialist
5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Office: 404-734-9740
records@totalhealthandinjury.com
Fax: 404- 845-7834

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or and attorney involved in this case.

_____ _____

Print Date

_____ _____

SIGNATURE Witness

TOTAL HEALTH & INJURY SPECIALIST

5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Phone (404) 734-9740
Fax (404) 845-7834
Records@totalhealthandinjury.com

NOTICE OF MEDICAL PROVIDER LIEN

I do hereby authorize Total Health & Injury Specialist, LLC (hereinafter ***THIS)*** to furnish you, my attorney, with full report of their examination and tests of myself regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said ***THIS*** such sums as may be due and owing it for medical services rendered me both by reason of any other bills that are due its office to withhold such sums from settlement, judgment or verdict as may be necessary to adequately protect said ***THIS*** , and I further hereby give a lien on my case to said ***THIS*** against any and all proceeds of my settlement, judgments or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney, I hereby instruct that in the event another is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to the said ***THIS*** for all medical bills submitted by it for services rendered me and that this agreement is made solely for said ***THIS*** additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

If the undersigned is discharged from representation of patient/client, withdraws from the representation of patient/client or closes patient's/ client's file, then the undersigned agrees to notify Total Health and Injury Specialist in writing in writing within forty-eight (48) hours of such discharge, withdrawal or closing.

Settlement: *THIS* will not consent to a reduction until it receives a written break down of the reduction(s) taken by the patient/client's attorney and other medical providers, including the percentage of the reduction(s) taken. Reduction agreements are only valid for 30 days. After 30 days a resubmission of the request is required.

I have been advised that if my attorney does not wish to cooperate in ***THIS's*** interest, that ***THIS*** will not await payment but may declare the entire balance due and payable.

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms the above and agrees to withhold such sums from any settlement, judgment or direct, as may be necessary to adequately protect ***THIS*** above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

PATIENT SIGNATURE DATE

ATTORNEY's SIGNATURE DATE

ASSIGNMENT OF BENEFITS

I hereby direct and authorize, without equivocation, my insurance company, or attorney, to make payment directly to Total Health & Injury Specialist for any and all benefits due as a result of my treatment.

By signing this document 1 hereby releases to ***THIS*** the right and privileges and those causes of action not in violation of O.CG.A. 44-12-24 against any insurance carrier of other proper party which may be responsible for payment toward any claims incurred. This assignment of benefits shall expressly exclude any assignment of the patient's personal injury claim.

This authorization will supersede and have precedence over any foregoing agreement including Power of Attorney. I am also aware that I am personally responsible for chargers and/or any amount not recovered by ***THIS*** through any insurance payment or settlement distribution.

Georgia State Statute §33-24-54 requires insurance carriers, including medpay carriers, to honor assignment of benefits, upon receipt of written assignment, and to mail the payment directly to Total Health and Injury Specialist. Please consider this an official, written notice of assignment.

PATIENT SIGNATURE DATE

Total Health and Injury Specialist

5304 Panola Industrial Blvd, Suite E
Decatur, GA, 30035

Telephone: 404-734-9740
Fax: 404-845-7834

HEALTH CARE AUTHORIZATION FORM

Patient's Name:_____

Patient's SS#:_____

Date of Birth:_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES (TOTAL HEALTH AND INJURY SEPCIALIST) TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

(Please Check all Boxes)

- I give permission to (Total Health and Injury Specialist) to use my address, phone number and clinical records to contact me with appointment reminders, missed appointments notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.
- If (Total Health and Injury Specialist) contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give (Total Health and Injury Specialist) permission to disclose protected health information in the presence of anyone accompanying me into a treatment room or consultation room by my request.
- By signing this form, you are giving (Total Health and Injury Specialist) permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The authorization shall be in effect for as long as the patient is a patient at this clinic.

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 AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of (Total Health and Injury Specialist). The written notice must contain the following information: Your name, SS#, and date of birth; a clear statement of your intent to revoke AUTHORIZATION; THE DATE OF YOUR REQUEST; AND YOUR SIGNATURE. The revocation is not effective until it is received by the Privacy Official. The AUTHORIZATION is requested by (Total Health and Injury Specialist) 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, (Total Health and Injury Specialist) will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

Print Name Patient _____

Signature of Patient _____

Date _____

Signature of Personal Representative_____

Description of Representative's Authority to Act for Patient _____

TOTAL HEALTH & INJURY SPECIALIST