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: _____

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OFFICE AND NO SHOW 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 payments are expected at the time of service.**

2. **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.**

3. 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.

4. With the exceptions of unexpected emergencies, we require that **you notify us at least 24 hours in advance with any appointment changes.**

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. If you are seeking maximum health benefits from chiropractic care in our office, we recommend that you follow the doctor's treatment plan.

- **Effective January 1, 2023, there will be a NO SHOW or NO NOTICE WITHIN 24 HOURS OF SCHEDULED APPOINTMENT FEE OF $25 AND MUST BE PAID AT THE NEXT DATE OF SERVICE IN ADDITION TO ANY SERVICES PROVIDED ON THAT DATE.**

Appointment Reminders by Text Message or Email!

As a courtesy, patients receive an automated text or email 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: _____

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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: _____

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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:____/_____/_____

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? _____

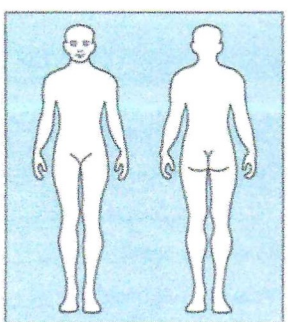
Is this condition getting progressively worst? ☐ Yes ☐ No ☐ Unknown

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 (_____) _____		

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Patient Name: _____ Date of Birth: _____/_____/_____

Good Faith Estimate for Health Care Items and Service

An itemized list of items or services that are "reasonably expected" to be furnished:
Date of First Visit: _____ This estimate covers dates thru: **January 1st, 2023**.

DIAGNOSIS CODE(S): _____

	CPT:	COST:	x # Visits:
Exam CPT Code and estimated cost:	99203	$125	
Re-evaluation(s) CPT codes and estimated cost: (If patient has not been treated in the past 6 months or if a new injury has occurred)	99212	$95	
Adjustment plus Massage Chair:	98941	$55	
Adjustment plus Massage Chair & 1 Area of Myofascial Release:	97140 & 98941	$65	
Adjustment plus Massage Chair & 1 Region of Myofascial Release: (i.e. 1. Full Back, 2. Chest and Biceps, 3. Hamstrings and Calf, 4. Quadriceps and IT Band)	97140 & 98941	$75	
Adjustment plus Massage Chair & 2 Regions selected from above of Myofascial Release: (i.e., Full Back and Chest or Front and Back of Legs)	97140 & 98941	$95	
Adjustment plus Massage Chair & Full Upper and Lower body Regions	97140 & 98941	$115	
	ADDITIONAL SERVICES	**AND OR FEES**	
Therapies: • **E-Stim:** • **Ice/Heat:** • **Photonic Laser Stimulation:**	 97014 97010 97032	 $25 $10 $45	
Kinesio Taping (per area):	97112	$25	
Other Charges: • **Chirothin Weight Loss Program** • **Credit Card Processing Fee** • **No Show or Notice within 24 hours of scheduled appointment (EFFECTIVE JAN 1, 2023) must be paid at next date of service**		 $699 $3 $25	

TOTAL ESTIMATED CHARGES* (Per Visit): $_____
*This is an estimated cost only covering date stated. More (or less) visits may be needed.
Print: _____
Signature: _____ Date: _____/_____/_____

If your condition requires other (outside) testing, such as an MRI or Lab you will receive a separate estimate and billing directly from them. If we anticipate any outside scheduling it would be:
List of items from other providers that will require separate scheduling if applicable:

• **MRI:** AHI or Elite Radiology • **Orthopedic Physician**: Per patient preference or Doctor will recommend patient follow-up with their PCP for the referral.

Please Note:

• Disclaimer: there may be other services requires that must be scheduled separately during the course of treatment and are not included in the Good Faith Estimate (GFE)

• Disclaimer: this is only an estimate and actual services, and charges may differ

• Disclaimer: GFE is not contract, and the patient is not required to obtain services from this provider

• You have the right to receive a "Good Faith Estimate" explaining how much your medical health care will cost.

• Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services.

• You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services.

• You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

• If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

• For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

• Complaints about your medical billing – You can submit a complaint about a medical billing experience you had, whether you're insured or uninsured.
http://www.cms.gov/nosurprises/consumers/complains-about-medical-billing

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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