Atlanta Medical Clinic
1801 Peachtree Street Suite 250 Atlanta, GA 30309 Phone: 404-872-8837 Fax 678-244-2155

PATIENT INFORMATION

Date: _____
First Name: _____Last Name: _____M.I.___
Address: _____
City/State/Zip: _____
Best Contact Number: (Home/Cell/Work) _____
Email: _____SSN#_____
Date of Birth: _____ Age: _____ Sex: _____
Height: _____ Weight: _____

Occupation: _____ Employer: _____
Work Address: _____
City/State/Zip: _____ Work Phone: _____

Marital Status: S M D W # of Children: _____ Driver's License# _____
Spouses Name/Emergency Contact: _____
Contact Number: _____
How did you hear about us?_____

Primary Insurance
Company:_____
Policy/Group# _____
Address:_____
_____

Secondary Insurance
Company: _____
Policy/Group# _____
Address:_____
_____

Where is your pain? _____
Is this condition due to: A) Auto Accident B) Work Injury C) Other_____
Are these symptoms: A) Improving B) Getting Worse C) About the same
Date Symptoms Appeared: _____
Circle any activities that aggravate your condition:
A) Standing B) Walking C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Coughing I) Other _____
Have you had these symptoms before? Yes/No If so when? _____
Have you seen another doctor for this condition? _____
Dr. Name: _____ Date Seen: _____ Diagnosis: _____

PCP Name and Address: _____
Do you have any allergies? _____
Current Medications? _____
Other Medical Conditions:

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PERSONAL/FAMILY HISTORY

NUMBER OF SIBLINGS

PERSONAL	YES	WHEN	NO	FAMILY	YES	SPECIFIC MEMBER	NO
Abdominal Bleeding							
Arthritis							
Asthma/Emphysema							
Back Disorders							
Backache							
Bleeding Disease							
Blood in Stool							
Blood in Urine							
Cancer							
Change in Bowel Habits							
Chest Pain							
Colitis							
Constipation							
Convulsion							
Coughing Blood							
Depression							
Diabetes							
Difficulty Swallowing							
Dizziness							
Double Vision							
Enlarged Heart							
Epilepsy							
Fainting Spells							
Gallstones							
Gall Bladder Disorder							
Glaucoma							
Headaches							
Heart Disease							
Heart Murmur							
Hepatitis							
High Blood Pressure							
Indigestion							
Irregular Heart Beat							
Kidney Infection							
Kidney Stone							
Leg Pain							
Lung Disease							
Lyme Disease							
Nosebleeds							
Nervous Disorder							
Painful Urination							
Paralysis							
Phlebitis							
Rheumatic Fever							
Shortness of Breath							
Stroke							
Swelling of feet							
Swollen/Painful Joints							
Ulcer							
Venereal Disease							

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OFFICE POLICY

Cash

1. All patients are on a cash basis until their respective coverage and deductible have been verified and met, respectively, by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.
3. After 30 days, office policy prohibits cash refunds for non-received care but the remaining balance of services not yet rendered has no expiration.
4. All patients are entitled to a 30 day window of care in which treatment may be terminated and prorated refund for services rendered will be given if the patient is unsatisfied with the services rendered and has been compliant with the doctors prescribed care plan.
5. If the patient commits to care and does not follow the doctors prescribed care plan that 30 day window will be null and void as the patient will be ruled non-compliant.

Insurance

1. If you have insurance, we gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment of the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charged for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets or explanations of benefits from your insurance company, please bring this information into this office as soon as possible. We must have a copy of this to determine proper payment has been made. If you should receive a check from your insurance company for care we have provided, you must bring it to the office upon receipt. If any overpayment exists after all insurance payments have been posted, we will issue an overpayment refund check- it will not come from your insurance company. All insurance payments, regardless of which company issues the check first, are applied to your account as long as any balance is due.
5. Any service's not covered or coverage reductions by your insurance will be the patient's responsibility.

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6. The office will resubmit a claim ONE TIME. We will not enter any dispute with your insurance company. If coverage problems arise, you be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges in a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full is required immediately; regardless of any claims submitted.
8. I appoint this individual: Atlanta Medical Clinic to act as my representative in connection with my claim or asserted right under title Xviii of the Social Security act (the "act") and related provision of title Xi of the act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed the representative indicated below.

If you have any questions concerning this or any other matter, please speak with the office manager or our insurance department prior to seeing the doctor. Thank you!

Patient/Guarantor Acknowledgement

All pre consultations/recommendations are performed by Dr. Dembowski or Dr. Brown. All treatment plans are approved and carried out by our Medical Director.

I have read and understand the Office Policy and agree to abide by these terms

_____ _____
Patient/Guarantor Signature Date

_____ _____
Patient/Guarantor Printed Name SSN

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ SSN#: _____

I request and authorize _____
to release healthcare information to:

Atlanta Medical Clinic
1801 Peachtree Street
Suite 250
Atlanta, GA 30309

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates:
  _____
  _____
- All healthcare information
  Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, suphillis, VDRL, chancroid, lumphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these tests to anyone.

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature _____ Date signed: _____

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HIPPA AUTHORIZATION FORM

Patient Consent to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ understand that as part of my health care Atlanta Medical Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment
A means of communication among the many health professionals who contribute to my care
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third-party payer can verify that services billed were actually provided
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of 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, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Atlanta Medical Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of the Federal Regulations.

I further understand that Atlanta Medical Clinic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Atlanta Medical Clinic change their notice they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures, via fax.

I fully understand and accept/decline the terms of this consent.

_____ _____
Patient's Signature Date

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Informed Consent for Procedure

Patient Name: _____ DOB: _____

You have a pain problem that has not been relieved by routine treatments. A procedure, specifically an injection or operation, is now indicated for further evaluation or treatments of your pain. There is NO GUARANTEE that this procedure will cure your pain, and in rare cases, it becomes worse, even when the procedure is performed in a technically perfect manner. The degree of pain relief varies from person to person, so after your procedure; we will reevaluate your progress, and then determine if further treatment is necessary.

Your physician will explain the details of the procedures listed below. TELL THE PHYSICIANS IF YOU ARE TAKING ANY BLOOD THINNERS SUCH AS COUMADIN, LOVENOX OR HEPARIN. These medications can cause excessive bleeding and a procedure should not be performed.

Alternatives to the procedure include medications, physical therapy, acupuncture, and surgery. Benefits include increased likelihood of correct diagnosis and or decreased or elimination of pain.

Risks include infection, bleeding, allergic reaction, and increased pain; nerve damage involving temporary or permanent pain, numbness, weakness, paralysis or death; air in lung requiring chest tube; tissue bone or eye damage from steroids, Nerve destruction with phenol, Alcohol, or radiofrequency energy used has risks of nerve and tissue damage.

Specific risks pertaining to each specific procedure are as follows (patient to initial line):

- Epidural/Facet joint, Medical Branch Nerve, Sacroiliac Joint, Selective Nerve root or Lumbar Sympathetic Injection/Block/Ablation: Low blood pressure, temporary weak/numb arm or leg, headache requiring epidural blood patch. _____
- Trigger point injection, Peripheral Nerve-Neuroma Block, Occipital Nerve Block, Intercostal Nerve Block/Ablation: air in lung requiring chest tube in hospital, local pain from tissue and/or nerve irritation, dimpling of/depression in skin. _____
- Joint Injections (Hip, Shoulder, Elbow, and Knee): Bleeding infection, allergic reaction, nerve damage, increased pain. _____

The incidence of serious complications listed above requiring treatment is low. Your physician believes the benefits of the procedure outweigh its risks or it would not have been offered to you, and it is your decision and right to accept or decline to have the procedures done.

I have read or had read to me the above information. I understand there are risks involved with spinal procedures, to include rare complications, which may not have been specifically mentioned above. The risks have been explained to my satisfaction and I accept them and consent to any procedure.

I also understand that one of the greatest risks involved with pain management procedures involves various medications taken, allergies and my general medication. I will inform my doctor of any blood thinning medication taken or any changes in other medications, allergies or medical condition prior to any procedure.

_____ _____
Patient's Signature Date

Physician Declaration: I have discussed the contents of this form with the patient and have answered all the patient's questions regarding the operation or procedures.

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Patient Name _____ **Date:** _____

Allergy Survey

Please complete the following allergy survey. Mark each symptom based upon your experiences over the **last 60 days**. Some of these symptoms may have been repeated previously in this paperwork.

Symptom Scoring System:
○○○○=No Symptoms
○○○○= Experience Mild Symptoms
○○○○= Experience Moderate Symptoms
○○○○= Severe Symptoms

Digestive Symptoms
○○○○ Stomach Pains or Cramping
○○○○ Constipation
○○○○ Diarrhea
○○○○ Reflux of Heartburn
○○○○ Bloating
○○○○ Gas
○○○○ Nausea or Vomiting

Weight
○○○○ Inability to Lose Weight
○○○○ Food Cravings
○○○○ Binge Eating
○○○○ Water Retention

Sinus/Respiratory
○○○○ Stuffy of Runny Nose
○○○○ Asthma
○○○○ Chest Congestion
○○○○ Chronic Cough
○○○○ Wheezing
○○○○ Frequent Sneezing

Head/Ears
○○○○ Migraines
○○○○ Headaches
○○○○ Earaches
○○○○ Ear Infections
○○○○ Ringing in Ears

Eyes/Throat
○○○○ Itchy Eyes
○○○○ Watery Eyes
○○○○ Sore Throat
○○○○ Persistent Canker Sores

Emotional/Mental
○○○○ Depression
○○○○ Anxiety
○○○○ Mood Swings
○○○○ Irritability
○○○○ Poor Concentration

Energy
○○○○ Fatigue
○○○○ Hyperactivity
○○○○ Lethargy
○○○○ Restlessness
○○○○ Insomnia

Skin Disorders
○○○○ Eczema
○○○○ Dermatitis
○○○○ Excessive Sweating
○○○○ Rashes
○○○○ Hives

Other Symptoms
○○○○ Joint Pain
○○○○ Arthritis
○○○○ Irregular Heartbeat
○○○○ Chest Pains
○○○○ Muscle Aches

List allergy medication/treatment tried:
_____
_____
_____
_____

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Are You at Risk for Peripheral Arterial Disease (PAD)?

Your answers to these questions will help you know.

DO YOU HAVE:

Cardiovascular (heart) problems such as high blood pressure, heart attack, stroke?	○ Yes ○ No
Diabetes?	○ Yes ○ No
A family history of diabetes or cardiovascular problems (immediate family such as parent, sister, brother)?	○ Yes ○ No
Aching, cramping or pain in your legs when you walk or exercise, but then the pain goes away when you rest?	○ Yes ○ No
Pain in your toes or feet at night?	○ Yes ○ No
Any ulcers or sores on your feet or legs that are slow in healing?	○ Yes ○ No
An inactive lifestyle?	○ Yes ○ No
Do you smoke?	○ Yes ○ No
Have you ever smoked?	○ Yes ○ No

The higher your score, the more important it is for you to see your doctor. You and your doctor may wish to discuss your responses to this questionnaire.

==> ☐ / 9

Name:_____Date:_____