1801 Peachtree St. 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: ___

May we contact you via text and/or email?: YES:_____ NO:_____ TEXT ONLY: _____ EMAIL ONLY_____

Occupation: _____________________________ Employer Name: _____________________________

Work Address:____

City/State/Zip: ____

Work Phone: ________________________

Marital Status: S M D W # of Children: ___________ Driver's License# ________________________

Spouses Name/Emergency Contact: ____

Contact Phone Number: _____________________________

How did you hear about us? _____________________________________

Primary Insurance

Name: _______________________________

Policy #: _____________________________

Address _____________________________

____

Secondary Insurance

Name: _______________________________

Policy #: ______________________________

Address: ______________________________

____

<u>What is your primary complaint?</u>: ____

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? If so when? Date: ______________________________

Dr. Name: _____________________________ Diagnosis: _______________________________________

PCP Name and Address: ____

Do you have any allergies? ____

List Current Medications? ____

Other Medical Conditions: ____

Atlanta Medical Clinic

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Family Medical History

Personal	YES	WHEN	NO	FAMILY	YES	SPECIFIC FAMILY MEMBER	NO
Abdominal Bleeding							
Arthritis							
Asthma/Emphysema							
Back Disorders							
Backache/pain							
Bleeding Disease							
Blood in Stool							
Blood in Urine							
Cancer							
Change in Bowel Habits							
Chest Pain							
Colitis							
Constipation							
Convulsion/Seizures							
Depression							
Diabetes							
Difficulty Swallowing							
Dizziness							
Double Vision							
Enlarged Heart							
Epilepsy							
Fainting Spells							
Gallstones							
Gall Bladder Disorder							
Glaucoma							
Headaches							
Heart Disease							
Heart Murmur							
Hepatitis A, B, or C							
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/Edema							
Swollen/Painful Joints							
Ulcer							
Venereal Disease							

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Cash Paying Patients:

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 doctor's prescribed care plan.
5. If the patient commits to a care plan and does not follow the doctor's prescribed care plan, that 30-day window will be null and void as the patient will be ruled non- compliant.

Patient Insurance Policy

1. If you have insurance, we gladly accept assignments with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept the assignment of the initial treatment plan only. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance, but charges will be due upon post insurance processing.
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 charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the 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 the 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 if any balance is due.
5. Any services not covered or coverage reductions by your insurance will be deemed the patient/guardian/caregivers' responsibility post insurance processing. Payment will be requested immediately once billed
6. The office will resubmit a claim ONE TIME. We will not enter any dispute with your insurance company. If coverage problems arise, you are expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on 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 payable 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 in 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-consultation/recommendations are performed by Dr. Dembowski.

All treatment plans are approved and carried out by our Medical Director.

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

_______________________________________ ______________________

Patient/Guarantor Signature Date:

_______________________________________ ______________________

Patient Guarantor Printed Name Social Security Number

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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
Tax ID#: 27-1900264
1801 Peachtree Street, Suite 250
Atlanta, GA 30309-1881
Telephone#: (404) 872-8837   Fax#: (678) 244-2155

This request and authorization apply 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 papillomavirus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, 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 treatments, payments, or other 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 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 organization's 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 signature	Date

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Patient Informed Consent for Procedures

Patient name: ____ Date:________________________

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 each line)**:

1. 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 the skin. ____________ (Patient Initials)
2. Joint Injections (Hip, Shoulder, Elbow, and Knee): Bleeding infection, allergic reaction, nerve damage, increased pain. _____________ (Patient Initials)

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 general medication. I will inform my doctor of any blood-thinning medication taken or any changes in other medications, allergies, or medical conditions prior to any procedure.

____   ________________________

Patient 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 No Show Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Atlanta Medical Clinic will provide a call reminder and a text message notice within 24 hours of in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment.

As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us **at least 24 hours' notice.**

If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a **$25.00 "no show" service charge to your account**. This "no show charge" is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of Atlanta Medical Clinic and agree to provide a credit card number, which may be charged **$25.00 for any no-show of a scheduled appointment.**

I understand that I must cancel or reschedule an appointment at least 24 hours in advance in order to avoid a potential no-show charge to the credit card provided.

Patient printed name: ____

Patient signature: ____

Date: ____

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Are you at risk for Peripheral Arterial Disease (PAD)?

Your answers to the following questions will help you and us know.

Do you have:

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

TOTAL NUMBER OF YES:___________

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

Patient name: _____________________________ DOB: ___/____/____
Today's date: _____/_____/_____

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Venous Insufficiency Questionnaire

	NO	YES
Do you experience any pain, aching, pressure, burning, or heaviness in your legs or ankles?		
Do you experience cramping or tightening in your legs/calves?		
Does your leg discomfort get worse when you are standing or sitting?		
Do you experience swelling in your legs or ankles?		
Are your legs restless?		
Do you have Varicose or Spider Veins that bother you or cause discomfort?		
Do you experience any ulcers, wounds, or sores on your feet, ankles, or legs that are slow to heal?		
Do you experience patches of discoloration/darkness of the skin on your legs, ankles, feet, or toes? (Skin changing colors, especially around your ankles)		
Have you experienced a thickening of the skin on your legs, ankles, or feet?		
Have you been diagnosed with an Enlarged Heart, Congestive Heart Failure (CHF), Atrial Fibrillation, and/or abnormal heart rate?		

TOTAL NUMBER OF YES:___________

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

Patient name: ______________________________ DOB: ___/____/____
Today's date: _____/_____/_____

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Initial Patient Questionnaire

Patient name: ______________________________________ Date of Birth: _____________

1. What is the cause of your pain? (accident, slip & fall, etc.) ___________________
2. What is your current pain level on a scale from 1 to 10? _____________________
3. What makes your pain worse? ____
4. What helps ease your pain? ____
5. Is the pain constant or does it come and go? ______________________________
6. Can you describe your pain? (dull, achy, sharp, burning, stiff, etc.):
   ____
7. Does the pain radiate (arm, leg, hand, foot) or stay in one area?
   ____
8. What type of treatments have you already tried? How much relief have you gotten? ____
   ____
9. Do you currently take any medications? Please provide a list of medications:

10. Have you had any past surgeries? If so please list:
    ____
    ____
    ____
11. Do you have any allergies, specifically drug allergies?
    ____
    ____
12. Who/Where is your preferred Pharmacy:
    a. Name: ____
    b. Address: ____
    c. Telephone: __________________________ Fax#: ______________________