**Today’s Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Insurance Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Insurance Co:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Last 4 of SS#\_\_\_\_\_\_\_ Policy#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_Zip:\_\_\_\_\_\_ Provider Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you the Subscriber? Yes No (circle one)

Hm/Wk Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Ins. Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Single Married Divorced Widow Minor (circle one) In case of emergency, please contact:*

Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nature of Injury: Choose one Automobile Slip&Fall Work Related Other\_\_\_\_\_\_\_\_\_

Date of loss: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_City & County of Occurrence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cited? Y or N

Police Report#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Were you the Driver or Passenger?*

Were you treated at a hospital, clinic , or your PCP after the accident? Yes/No Date of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/Clinic/PCP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you contacted the **at fault party’s** insurance company? Yes / No

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext\_\_\_\_\_\_

Have you contacted **your** insurance company? Yes / No

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext\_\_\_\_\_\_

Major Area of Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your pain: Mild Moderate Severe

How often does the pain occur? Constantly Frequently Occasionally Intermittently

What aggravates or relieves your complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current/Previous Medical History**

Do you have or have you had any of the following diseases, medical conditions, or procedures? **Circle**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Heart Attack | Stroke | Artificial Valves | Pacemaker | Heart Murmur |
| Congenital Heart Defect | Mitral Valve Prolapse | Alcohol/ Drug Abuse | Venereal Disease | Hepatitis |
| Allergies | Shingles | Cancer | Glaucoma | Anemia |
| Diabetes | High Blood Pressure | Low Blood Pressure | Psychiatric Problems | Rheumatic Disease |
| Kidney Problems | Connective Tissue Disorder | Ulcers/Colitis | Seizure/Epilepsy | Sinus Problems |
| Asthma | Emphysema | Tuberculosis | Chemotherapy | Arthritis |
| Osteoporosis | Artificial Bones/Joints | AIDS/HIV | Headaches | Multiple Sclerosis |

Please list any injuries/surgeries you have had (including falls, head injuries, broken bones, dislocations, surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are taking including prescription, OTC, birth control, vitamins, supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list anything you may be allergic to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes/No Packs/Day:\_\_\_\_\_\_\_\_\_ Do you drink alcohol? Yes/No Drinks/week\_\_\_\_\_\_\_\_\_\_

Do you drink coffee/caffeine drinks? Yes/ No Cups/day\_\_\_\_\_\_ High stress level? Yes/No Why?\_\_\_\_\_\_\_

Do you exercise? None Moderate Daily Heavy

Have you ever been treated by a chiropractic doctor before? Yes/No When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last: Physical Exam:\_\_\_\_\_\_\_\_\_\_\_\_Spinal Exam:\_\_\_\_\_\_\_\_\_\_\_\_Spinal X-Ray:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest X-Ray: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MRI, CTScan, Bone Scan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**X-Ray Consent**

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patient’s consent for such test to be performed.

**Please choose ONE Option**

\_\_\_\_\_\_\_I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests.

\_\_\_\_\_\_\_I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose not to have any x-rays at this time and release my doctor of all liabilities.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALES ONLY:**

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus and I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for x-ray exam. With those factors in mind, I am advising my doctor that:

I am pregnant: Yes No Don’t Know I have begun menopause: Yes No

My menstrual period is late: Yes No I have had a tubal ligation: Yes No

I have irregular menstrual periods Yes No My last menstrual period began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have had a hysterectomy: Yes No

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent to Chiropractic Treatment**

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s). Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. Following are the known risks:

**Temporary soreness or increased symptoms or pain.** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

**Dizziness, nausea, flushing.** These symptoms are relatively rare.

**Fractures.** It is important to notify your chiropractor, if you have been diagnosed with a bone disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk or fracture.

**Disc herniation or prolapse.** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

**Stroke.** According to most recent research, there is no evidence or excessive risk of stroke associated with chiropractic care.

Other risks associated with chiropractic treatment, include rare burns from physiotherapy devices that produce heat. I understand that the practice of chiropractic is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing of this document. I have made my decision voluntarily and freely.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please release records for the following patient. Contact the office should you have questions or concerns.

Thank You!

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN# (last 4 digits)\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Do Not Write Below This Area\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

ALL RECORDS & REPORTS ON or ABOUT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I-20 W: Positive Reinforcement Wellness- 4485 Fulton Industrial Blvd Ste D, Atlanta, GA 30336

I-20 E: Lambert Chiropractic 2978 Miller Road, Lithonia, GA 30038

Downtown Atlanta: Peachtree Center Rehab- 241 Peachtree St, Ste B Atlanta, GA 30303

75S: Priority Healthcare- 521 Forest Parkway #100, Forest Park, GA 30297

470-222-5101

[dr.miawalker@gmail.com](mailto:dr.miawalker@gmail.com)

**IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY**

I hereby authorize and direct you, my insurance carrier and/or attorney to pay directly to Mitchell Street Chiropractic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident Workers Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect Mitchell Street Chiropractic and Dr. Mia Walker, DC.

I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Mitchell Street Chiropractic. This is to act as an assignment of my rights and benefits to the extent of the office’s services provided.

I understand that I remain personally responsible for the total amounts due to the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if Mitchell Street Chiropractic must take action to collect any outstanding balance on this account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and attorney fees.

I authorize my Attorney to sign this lien to pay the outstanding balance at settlement.

**Patient signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign this Assignment, Lien and Authorization and fax to Mitchell Street Chiropractic.

**Attorney Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_