Dr. John T. Duke, M.S., D.C.
Duke Health and Wellness
1455 Bells Ferry Rd. Ste 200
Marietta, GA 30066
770-693-0707

PATIENT INFORMATION FORM

Name: _____ Date of Birth _____

Address _____
Street City State Zip

Telephone _____ Email _____

Soc Sec# _____ Marital Status: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

What is your preferred method of communication? Phone Email Mail

Patient's Employer _____ Work #: _____

Are you a student? ___ Yes ___ No If yes, where? _____ PARTTIME FULLTIME

Do you have medical insurance? ___ Yes ___ No

Insurance Name: _____ Policy Holder's Name: _____

Policy Number: _____ Group Number: _____

Policy Holder Date of Birth: _____ Relationship: _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Responsible Party Name: _____ Relationship to Patient: _____

Address _____
Street City State Zip

Patient Signature: _____ **Date:** _____

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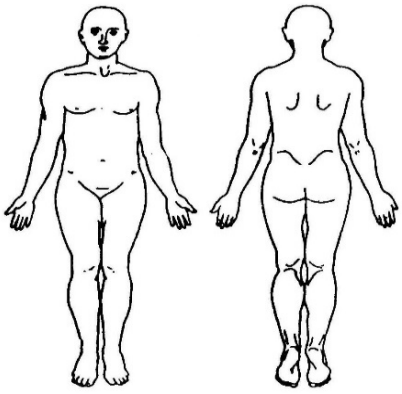
COMPLAINT INFORMATION CONTINUED…

Please indicate your pain.



O-Numbness X-Stabbing B-Burning
A-Aching T-Throbbing

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine
☐ Other _____

Have you received any treatment for this condition? ☐ Yes ☐ No
If Yes, please explain _____

Have you been in an auto collision? ☐ Past year ☐ Past 5 years
☐ Over 5 years ☐ Never

HABITS

☐ Smoking	Packs/Day	_____
☐ Alcohol	Drinks/Day	_____
☐ Coffee	Cups/Day	_____
☐ Soft Drink	Drinks/Day	_____
☐ Water	Glasses/Day	_____
☐ Vitamins	List:	_____

EXERCISE

☐ None
☐ 1-2 days/week
☐ 3-4 days/week
☐ 5+ days/week
Type: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____

Address: _____ City/State/Zip: _____

FAMILY HISTORY

	Stroke	Bad Posture	Heart Trouble	High Blood	Cancer	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Diabetes
Father																
Mother																
Brother																
Sister																
Child																
Child																
Child																

Check all that apply

Current Medications: _____

OTC, Supplements, Vitamins, Medicines: _____

Allergies: _____

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MEDICAL RECORDS REQUEST AND RELEASE

To: _____ Fax # _____

Patient Name: _____ Date of Birth: _____

I hereby authorize you to release records to Duke Health and Wellness any information the diagnosis and records of treatment or examination rendered to me for all care during the period of

_____

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

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PHOTO RELEASE FORM

I hereby grant Duke Health and Wellness permission to use my likeness in a photograph in any and all of its publications, including website entries, without payment or any considerations.

I understand and agree that these materials will become property of the Duke Health and Wellness and will not be returned

I hereby irrevocably authorize the Duke Health and Wellness to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing the Duke Health and Wellness programs or for any other lawful purposes. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensations arising or related to the use of photograph.

I hereby hold harmless and release and forever discharge the Duke Health and Wellness from all claims, demands, and causes of action which I, my heirs, representatives, exacutors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 21 years of age and am competent to contact in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

_____ _____
(Signature) (Date)

_____ _____
(Printed Name) (Date)

If ther person signing is under the age of 21, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____
named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

_____ _____
(Parent/Guardian's Signature) (Date)

_____ _____
Parent/Guardian's Printed Name) (Date)

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PATIENT MISSED APPOINTMENT POLICY

Definitions: Policy- a way of managing affairs so as to achieve some purpose

Appointment- a meeting with someone as a certain time and place

Missed- fail to keep, or be present at

It is the wish of this Office that each and every one of out patients receive the very best care and service possible. Your 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. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because treatment will help you recover.
3. If you are unable to make it due to an emergency, please call us and let us know so we can schedule your appointment.
4. With exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. All cancelled or missed appointments must be rescheduled as made up within the week.
6. We have the right to charge $5.00 for no call/no show appointments.
7. There could also be a $20.00 charge for missing an appointment.

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

Patient's Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Staff Witness: _____

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FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Duke Health and Wellness. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendreed to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered to me will be immediately due and payable.

If I have insurance. I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30-day period, a service fee of 2% will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty-dollar ($50.00) fee added.

This office cannot promise that an insurance company will pay. If the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this clinic to release any information pertinant to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this clinic of any consequences thereof.

Although our office will call to verify your insurance coverage, it is yoru responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information provided in this three-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Duke Health and Wellness responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____ Date: _____

Patient Name (print): _____ D.O.B.: _____

Signature of Parent/Guardian: _____ Date: _____

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although Chiropractic care is one of the safest forms of healthcare, it is assocaited with some minor risks and it is my responsibility to be informed about those risks by asking the doctor of a staff member prior to treatment.

Chiropractic is a system of health care delivery and therefore, as with any healthcare delivery system, we cannot promise a care for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.

I hereby authorize the doctors and staff affiliated with Duke Health and Wellness to treat my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

CONSENT OF TREATMENT OF A MINOR CHILD

I hereby authorize Dr. John Duke and whomever he may designate as assistance to administer chiropractic care as deemed necessary to my minor child, _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Staff: _____ Date: _____

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Assignment of Health Plan Benefits and Rights as well as an Appointment as an ERISA*/PPACA** Representative Designation

I understand and agree that, regardless of whatever health insurance or medical benefits I have, I am ultimately responsible to pay **Duke Health and Wellness** the balance due on my account for any professional medical and chiropractic services rendered and for any ancillary supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to **Duke Health and Wellness** for medical/healthcare services rendered and for any ancillary supplies, tests, and medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, or to pursue any other remidies necessary in connection with same.

I hereby assign directly to **Duke Health and Wellness** all rights to payments, benefits, and all other legal rights under, pursuant to, any health plan, ERISA plan, PPACA plan, or insurance contract rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy. This assignment includes, but not limited to, a designation that **Duke Health and Wellness** can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to **Duke Health and Wellness** as a result of services rendered by **Duke Health and Wellness** and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. This assignment as designation remains in effect unless revoked in writing and a photocopy or scan is to be considered as a valid and enforceable as the original.

Signed this _____ day of _____ 20____

_____
Patient's Signature

_____
Signature of Guardian (if applicable)

_____
Staff Signature

*ERISA - Employee Retirement Income Security Act

**PPACA - Patient Protection and Affordable Care Act

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HIPPA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used of discloesd for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations; you have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice or Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the practice does not have to agree to the restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice my condition receipt of treatment upon the execution of this consent.

This consent was signed by: _____ D.O.B. _____
(Printed name of Patient or Representative)

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ D.O.B. _____

Signature: _____ Date: _____

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APPLICATION FOR TREATMENT

Please check the type of care desired: □ Temporary Relief □ Lasting Correction Date: _____

□ Check here if you want the Doctor to recommend the best type of care for you.

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone:

Check if you are: □ Married □ Single □ Widowed □ Divorced □ Separated

Name of Husband or Wife: _____ Ages of Children: _____

Where are your husband/wife employed? _____

Your days off: _____ Referred to our office by: _____

Who is responsible for your bill? □ Self □ Spouse □ Employer □ Insurance □ Other _____

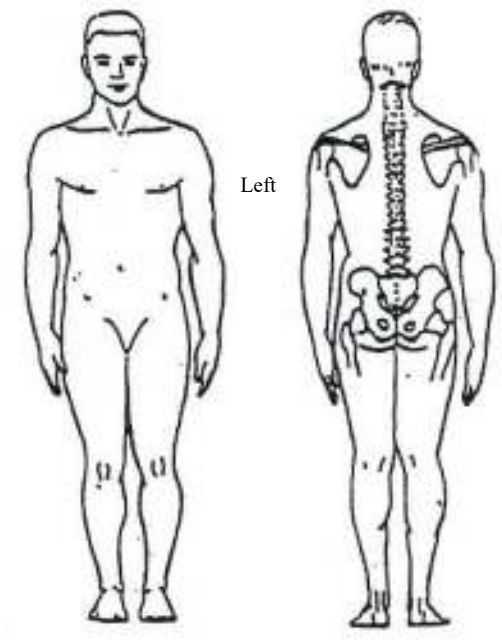
How Payment will be made:
____ Cash
____ Check

Type of Insurance:
____ Workman's Comp.
____ Credit Card
____ Health Insurance
____ Automobile Insurance Policy

Name of Company and Address: _____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type & frequency of your pain, as well as any activity which brings on or aggravates the pain.

Right Left Right



MAJOR COMPLAINT
(Please describe only your major problem)

How did this condition develop?
(What caused it? How did it start?)

When was the first time you were aware of this problem? _____

Have you ever had this problem or a similar problem before? If yes, please explain: _____

Have you ever received any treatment for this condition? If yes, where and when, and what were the results? _____

Has this problem been getting better, worse, or staying the same? _____