Lanier Chiropractic and Rehabilitation Information

4530 Nelson Brogdon Blvd., Suite B, Sugar Hill, GA 30024
770-271-8949

Thank you for choosing Lanier Chiropractic and Rehabilitation!

It is our desire to help you achieve and maintain the healthiest lifestyle possible. Please feel free to ask us about any and all issues concerning your care.

Our office is open: **Monday through Thursday 9:00 AM to 7 PM**
Closed on Friday
Saturday 9 AM to 1 PM
Available for Emergencies

Our initial office visit involves a thorough head to toe exam. The doctor will evaluate you on chiropractic, orthopedic and neurological levels. We do not take x-rays in this office. If upon examination the doctor feels an x-ray is warranted, we will make arrangements for you to receive those. Please bring with you any recently taken x-rays for the doctor to review. After your exam, the doctor will explain what you need, and how chiropractic care can benefit you. Your first adjustment will be given on the first visit unless your condition indicates otherwise. Doctor Seebach uses a "hands-on" approach and will explain every step to you during your treatment. Other modalities are available for your care if needed. These include Ultrasound, Laser, and Interferential treatment, to name a few. Dr Seebach is also versed in many different techniques to specifically treat your condition.

A financial policy is a necessary part of any business. It is our desire to operate as efficiently as possible. Our fees are competitive and we offer insurance filing of claims.

For accounts without insurance, we expect payment in full at the time of treatment. We also offer wellness memberships that may be beneficial for you.

If you have insurance, all deductibles and co-payment amounts are due at each visit. If your insurance cannot be verified prior to your visit, we require full payment on your first visit. We are happy to help you with your insurance claims. However, we ask that you remember that you are ultimately responsible for understanding your own policy. We will call to verify your insurance coverage and co-pay amounts as a courtesy to you, but we cannot be responsible for the information given to us by your insurance provider. Please refer to your insurance booklet to verify your coverage limits. Knowing the specifics of your policy will help you make informed health care decisions. Please be aware that if a service is denied we are obligated to bill you for that service. All payments are due upon request.

Any amount not paid to us within 60 days by an insurance company will automatically be billed to you for prompt payment. If an insurance payment is received after you have paid, we will gladly apply it toward any additional treatment or refund your money if your account has a zero balance. A finance charge and late fee will be added monthly once the account becomes past due.

We accept cash, personal checks, Visa, MasterCard, and American Express. There will be a $25 charge for any check returned for insufficient funds.

Please let us know if you have any concerns, questions, or comments and our staff will gladly assist you.

WELCOME

Please check with our staff if you have any questions

Name (Last, First, MI) _____ Mr. Mrs. Ms. Dr. Sr. Jr.

I prefer to be called _____ ☐ Male ☐ Female Birthdate _____/_____/_____ Age_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address _____ City _____ State _____ Zip_____

Email : _____

Home Phone _____ Cell _____

For Appointment Reminder Calls and Emergency Cancellation Calls: Contact Phone #_____

Employer: _____ Work # _____ Occupation _____

Employer's Address: _____ City, _____State_____ Zip _____

Other Family Members seen by us: _____

How did you hear about us: _____

Spouse's Name: _____ Birthdate _____/____/_____

Employer _____ Work Phone _____ Occupation _____

Employer's Address _____ City, State, Zip _____

Name of Insurance Company: _____

Name of Policy Holder:_____
(Person who has the insurance through work)

Policy Holder's Date of Birth _____/_____/_____

I affirm that the information I have given is correct to the best of my knowledge. I agree to inform this office of any changes in my medical status. My signature affirms I have been given a copy of, have read, and/or understand the office policy for Lanier Chiropractic and Rehabilitation.

_____
Signature

_____
Date

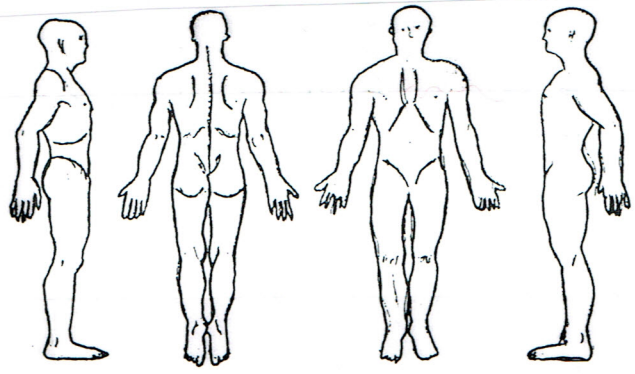
STOP!! PLEASE GIVE THE FRONT DESK THIS COMPLETED SHEET BEFORE CONTINUING WITH PAPERWORK

EXPLANATION OF CONDITION

Patient Name _____ **Date:** _____

Please mark areas of injury or discomfort using the key below.

KEY:
Numbness - - - -
Pins & Needles ooooo
Burning ^^^^
Aching xxxxx
Stabbing 0000



Your Chief Complaint is _____

_____

When did your problem begin? _____

Describe how your condition occurred in detail: _____

_____

Rate your pain: (Circle one) 0 No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Are you worse in the morning? ____Yes ___No

Are you worse at the end of the day? ____Yes ___No

What position(s) aggravates your condition (please circle all that apply)

Sitting **Standing** **Driving** **Walking** **Sleeping** **Sit to Stand**

Did you do anything to relieve this problem? ___Yes ___No

If yes, please explain: _____

Did you use ice? ____Yes ____No **Did you use heat?** ____Yes ___No

Have you seen any other doctors for this condition? __Yes ___No

If so, who? _____

Have you ever experienced this condition in the past? ___Yes ___No

If yes, explain_____

How much water do you drink each day? Glasses/Bottles _____

FAMILY HISTORY

YOUR NAME _____

Physician's Name: _____ **Phone #** _____ **Date of last visit** _____

Address: _____ **City, State** _____ **Zip** _____

Please list any medications you are currently taking: _____

_____

Please list any family (genetic) health problems: (like cancer, diabetes and heart disease)

Mother _____ **Father** _____

Siblings: _____ **Grandparents** _____

MEDICAL HISTORY

Your current physical health is: __Good ___Fair ___Poor

Have you been to a Chiropractor before? ___Yes ___No
If yes, when and for what purpose _____

Name of Chiropractor _____

Do you take vitamins or minerals? ___Yes ___No
If so, please list: _____

Do you think you need to take vitamins/minerals? ___Yes ___No

Are you taking any laxatives and/or sleeping pills? ___Yes ___No
If so, how many, how often? _____

Are you under a lot of stress on a daily basis? ___Yes ___No

How long has it been since you really felt good? _____

During the day I (please circle) sit, stand, walk, desk work, Phone work, computer work, drive, mechanical work, heavy lifting.

Do you read in bed? ___Yes ___No

Is your mattress comfortable? ___Yes ___No

Are you right or left handed? ___Right ____Left

Do you smoke or use tobacco in any other form? ___Yes ___No

Have you ever been involved in a bicycle, bus, train motorcycle or car accident? ___Yes ___No
Please explain _____
_____
_____

Were you ever knocked unconscious? ___Yes ___No

Have you broken any bones? ___Yes ___No
Please explain _____
_____

Have you had any impacts, falls or jolts that you feel may have injured you? ___Yes ___No
Please explain:_____
_____

Have you had any surgeries? ___Yes ___No
Please list: _____

_____

FOR WOMEN:

Are you taking birth control pills? ____Yes ____No
Age Periods stopped and why _____
_____

Are you pregnant? ____Unsure ____Yes ____No
Are you nursing? ____Yes ____No

DO YOU HAVE OR HAVE YOU EXPERIENCED THE FOLLOWING? PLEASE CHECK ALL THAT APPLY

__Abnormal Bleeding
__Alcohol Abuse
__Allergies
__Arthritis
__Anemia
__Artificial Bones
__Artificial Joints
__Artificial Valves
__Asthma
__Blood Transfusion
__Cancer
__Chemotherapy
__Chicken Pox
__Colitis
__Congenital Heart Defect
__Depression
__Diabetes
__Difficulty Breathing
__Drug Abuse
__Emphysema
__Epilepsy
__Fainting Spells
__Fatigue
__Fever Blisters
__Glaucoma
__Gout
__Hay Fever
__Headaches
__Heart Disease/Problems
__Hemophilia
__Hepatitis
__Herpes
__High Blood Pressure
__HIV+/AIDS
__Hospitalized
__Kidney Problems
__Kidney Stones
__Leukemia
__Liver Disease/Problems
__Low Blood Pressure
__Lupus
__Migraine
__Mitral Valve Prolapse
__Obesity
__Pacemaker
__Persistent Cough
__Psychiatric Problems
__Radiation Treatment
__Rheumatic Fever
__Rheumatism
__Scarlet Fever
__Sciatica
__Scoliosis
__Seizures
__Shingles
__Sickle Cell Disease
__Sinus Problems
__Stroke
__Suicidal Thoughts
__Thyroid Problems
__Tonsillitis
__Tuberculosis (TB)
__Ulcers
__Venereal Disease
__Other _____

LANIER CHIROPRACTIC & REHABILITATION
4530 Nelson Brogdon Blvd
Buford, GA 30518
770-271-8949

OFFICE POLICY

- Our primary concern is providing quality chiropractic care to our patients. Dr. Seebach is currently participating in many managed care plans in an effort to accommodate our patients. It is impossible for our office staff to be aware of the specific requirements of each and every plan. There may be limitations by your plan on number of visits, referrals, etc. You must inform our staff of guidelines set by your insurance company. If you do not inform us of special guidelines and restrictions of your plan, and we subsequently bill your insurance for a specific procedure not covered by your insurance company – ***payment of these services will become your responsibility.***
- I understand and agree that I will be responsible for any balances not covered

by my insurance company. I understand and agree that I will be assessed a finance charge and a monthly $10.00 late fee once the account becomes past due unless a specific payment plan has been arranged.

- Any NSF/returned checks will be assessed a $25.00 fee

I have read and understand the above office policy and agree to accept responsibility as described.

_____ _____

Patient Signature **Date**

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my Insurance Companies, including all doctors' notes and record of services rendered.
- I understand that I am Responsible for my bill. If my insurance does not pay the full amount, I agree to pay the balance upon request. I agree to pay all co-pays at each visit.
- I authorize my doctor to act as my agent in helping me to obtain payment from my Insurance companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- I understand that if my insurance company requires pre-certification before my visit here, it is my responsibility to obtain this information. I understand that if this has not been done prior to my first visit here, I will be financially responsible for all services rendered.

Name (PLEASE PRINT) _____

_____ _____

Signature Date

LANIER CHIROPRACTIC & REHABILITATION

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Buford GA 30518

I hereby acknowledge that I have been made aware that Lanier Chiropractic & Rehabilitation has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient, I acknowledge the following:

- Lanier Chiropractic has a privacy policy in effect.
- Lanier Chiropractic has made this policy available for review by placing a copy on this clipboard.
- I am entitled to a copy of the Privacy Policy if I desire a copy for my personal files.

Upon your review of our privacy policy, please sign at the bottom acknowledging that you have been advised of the policy implemented by Lanier Chiropractic and Rehabilitation and have read and understand the form. If you desire a copy of the Privacy Policy, please request one at this time.

____ No, I do not wish to obtain a copy of the policy but I am aware one exists.

____ Yes, I do want a copy of the Privacy Policy.

_____ _____

Patient Signature Date