8800 Roswell Road, Suite A235

Sandy Springs, GA 30350

Phone: 770.641.9797

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**PATIENT INTAKE**

Date:

Patient Full **Legal** Name: Preferred: Maiden Name:

Date of Birth: Age: Gender: F / M SSN: Marital Status: Single / Married / Divorced

Street Address:

City: State: Zip: Email:

Cell Phone: Home Phone: Work Phone: Primary: HM / WK / Cell

Employer: SSN:

Employment: ( ) Employed ( ) F / T Student ( ) P/T Student ( ) Retired

Spouse’s Name: Children’s Names and Ages:

In emergency, contact: Phone: Relationship:

How did you hear about us? Radio / Friend / Family / Existing Patient / Internet / Physician / Other:

What brings you in to our office today?

**The Initial Consultation** which includes medical history, anatometer and posture check, pre-films and doctor consultation. All future fees, including first correction, post-films and treatment plan for your care, will be agreed to in writing beforehand. I understand that I am financially responsible for all charges and agree to pay for all services at the time services are rendered or before. I understand the practice's cancellation policy is that appointments need to be cancelled within 24 hours of the originally scheduled time, and those visits shall be rescheduled and services performed within 2 business days of the original appointment date.

**Seniors**

We do not accept medicare patients. If you are a senior, we will provide care to chronic patients only that fall outside medicare guidelines. We do not participate in medicare or any insurance programs.

Please fill out an ABN as a senior as a verification that you are not a medicare patient or candidate.

**Supportive Care Documentation - Insurance**

If you need copies of visit invoices, we will be happy to email not print an invoice for the dates of service. We do not provide a HICFA form. We are a non-insurance office. If you need a report or letter supporting the need for care, the fee is $100.00. Narrative reports are $250.00

**Release of Medical Records/Information and X-rays:** I authorize the release of any and all information/records/x-rays, etc. needed to evaluate my condition. This is to serve as a long-term authorization (i.e. transfer of records to another healthcare provider’s office). I further request that this and any other pertinent information be forwarded to AlternaHealth Solutions (AHS), 8800 Roswell Road, Suite A-235, Sandy Springs, GA 30305.

**Request for Medical Care:** I voluntarily consent to examination, treatment and rendering of chiropractic care by AHS. I grant consent for treatment of me, my spouse or my minor children/dependent listed above. I am aware of the potential benefits and risks of the procedure, common alternative to that procedure, including refusing care and the associated risks.

**Pregnancy Release:** This is to certify to the best of my knowledge, I am not pregnant and AHS has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous. If I am pregnant, I agree to cervical x-ray with the use of filters.

Date of last menstruation: Signature:

**Receipt of Notice of Privacy Practices/Written Acknowledgement Form:** I have had the opportunity to review a copy of AHS Notice of Privacy Practices. I hereby grant permission to AHS to contact me and/or leave a message at either my home or workplace. These numbers are on file and can be used to confirm my appointments, or to conduct other relevant business that is deemed necessary. I further grant AHS to notify me through email with any upcoming office events, newsletters or information regarding my patient experience. I consent AHS owning the copyright to any testimonials I release to the Internet. I also consent to AHS using my name, photograph and my testimonials for media purposes.

**Personal or detailed information will not be disclosed on an answering machine or voice mail.**

Printed Name of Patient/Parent/Guardian

Signature of Patient/Parent/Guardian Date of Signature

