Trinity Pain Relief Center, LLC.

CONSENT TO TREAT

I hereby authorize the Doctors at **Trinity Pain Relief Center, LLC.** to treat my case as they deem appropriate through the use of medical care, physical therapy, rehabilitation, manual therapy, chiropractic adjustments of the spine and extremities, nutritional support, trigger point injections, large joint injections and diagnostic testing. I realize the goal of holistic healthcare is to naturally strengthen the patient's body in order for the body to better heal itself and not to treat a particular condition or disease. I also realize this office offers alternatives to holistic care in the form of traditional medical care and that I may elect to receive those services as well. This office will not assume responsibility of treatment of any particular conditions or disease.

It is understood and agreed the amount paid to the clinic for x-rays is for cost of materials and interpretation and the x-ray originals will remain the property of this office for a period of 10 (ten) years, pursuant to Georgia law. The patient will be entitled to a written report of x-ray findings. The patient also agrees that he/she is responsible for all bills incurred at this office.

________________________________ __________________________

Signature Date

NEUROLOGICAL AND VASCULAR QUESTIONAIRE

NAME: ____ DATE: ____________

For any YES answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arm or hands? NO YES
Comment: ____

2. Do have weakness, numbness or burning in your shoulder, arms or hands? NO YES
Comment: ____

3. Do your hands or arms fall asleep regularly? NO YES
Comment: ____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
Comment: ____

5. Do you suffer from a loss of handgrip strength? NO YES
Comment: ____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
Comment: ____

7. Do have weakness, numbness or burning in your buttocks, legs or feet? NO YES
Comment: ____

8. Do your legs or feet fall asleep regularly? NO YES
Comment: ____

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
Comment: ____

10. Do you suffer from cold hands or feet? NO YES
Comment: ____

11. Do you suffer from headaches, dizziness or memory loss? NO YES
Comment: ____

12. Do you have difficulty maintaining your balance? NO YES
Comment: ____

13. Do you suffer from vertigo or blurred vision? NO YES
Comment: ____

14. Do you suffer from reduced hearing capacity? NO YES
Comment: ____

15. Do you suffer from ringing in your ears? NO YES
Comment: ____

16. Do you have bladder or bowel control problems on a regular basis? NO YES
Comment: ____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurer, your health information on this form may be shared with the insurer. Your health information which the insurer sees will be kept confidential by the insurer.

WELCOME

Trinity Pain Relief Center
Patient Information

Date: ____________________

Name: ____
Last First MI

Mailing Address: ____

____

Phone # (H)__________________________ (W) ______________________ (Cell) _________________

Can we call you at work? ❑ Yes ❑ No

Date of Birth: ________________ Sex: ❑ Male ❑ Female SS#: ___________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _________________________________ Employer: ___________________________________

Employer Address: ____ Phone: ______________________

How did you hear about our practice? ____

Emergency contact: Name: ___________________ Relation: ______________ Phone #: ____________________

Phone #: (H) ______________________ (W) ______________________

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other __________

Has it been reported? ❑ Yes ❑ No If yes, to whom? ____________________________________

Financial Information

Name of person responsible for this account: ____

Relationship to patient (if other than self): __________________________ Phone # ___________________________

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _________________________________

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _________________________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) & PHOTO ID

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _______________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) ____ **DATE** ___________________________

Health History

Who is your primary care physician? (doctor and/or practice) ___________________________________Phone_________

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other ________________________________	

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain ___________________________________

Please list any medications you are currently taking: ____

____

Please list any surgeries and/or hospitalizations you have had (type & date): ____

____

____

Please list any allergies (meds, foods, seasonal):____

Please list any supplements you are currently taking (vitamins/herbs/minerals): ____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

❑ Heart Disease ___________________ ❑ Diabetes ___________________

❑ Cancer ___________________ ❑ Arthritis ___________________ ❑ Other ______________________________

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following:

Caffeine ___________ cups/day Alcohol _________ drinks/week Cigarettes _______ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) ____ **DATE** ___________________________

HEAD

- ☐ Headache
- ☐ Entire head
- ☐ Back of head
- ☐ Forehead
- ☐ Temples
- ☐ Migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light headedness
- ☐ Fainting
- ☐ Pain in eyes
- ☐ Light bothers eyes
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK

- ☐ Pain in neck
- ☐ Neck pain without movement
- ☐ Neck feels out of place
- ☐ Stiff neck
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Grating sounds in neck
- ☐ Popping sounds in neck
- ☐ Pinched nerve in neck

SHOULDERS

PAIN IN:

- ☐ Right shoulder
- ☐ Left shoulder
- ☐ Both shoulders
- ☐ Pain across shoulders

CAN'T RAISE ARMS ABOVE:

- ☐ Shoulder level
- ☐ Head
- ☐ Tension in shoulders

MID BACK

- ☐ Mid back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain in mid back
- ☐ Muscle spasms in mid back

CHEST

- ☐ Chest pain
- ☐ Shortness of breath

PAIN AROUND

- ☐ Right rib
- ☐ Left rib
- ☐ Both ribs

WOMEN ONLY

- ☐ Menstrual pain
- ☐ Cramping with menstrual pain
- ☐ Irregularity of menstruation

ARMS & HANDS

PAIN IN:

- ☐ Right upper arm
- ☐ Left upper arm
- ☐ Both upper arms
- ☐ Right forearm
- ☐ Left forearm
- ☐ Both forearm
- ☐ Right wrist
- ☐ Left wrist
- ☐ Both wrists
- ☐ Right hand
- ☐ Left hand
- ☐ Both hands
- ☐ Right fingers
- ☐ Left fingers
- ☐ Both left and right fingers

SENSATION OF PINS & NEEDLES:

- ☐ Right arm
- ☐ Left arm
- ☐ Both arms
- ☐ Right fingers
- ☐ Left fingers
- ☐ All fingers
- ☐ Hands cold

SWOLLEN JOINTS IN:

- ☐ Right fingers
- ☐ Left fingers
- ☐ All fingers

SORE JOINTS IN:

- ☐ Right fingers
- ☐ Left fingers
- ☐ All fingers

LOSS OF GRIP STRENGTH IN:

- ☐ Right hand
- ☐ Left hand
- ☐ Both hands

GENERAL

- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally run down
- ☐ Loss of sleep
- ☐ Loss of weight

LOW BACK

- ☐ Low back pain

LOW BACK PAIN WORSE WHEN:

- ☐ Working
- ☐ Lifting
- ☐ Stooping
- ☐ Standing
- ☐ Sitting
- ☐ Bending
- ☐ Coughing
- ☐ Lying down
- ☐ Low back feels out of place
- ☐ Muscle spasms in lower back

TEMPORMANDIBULAR JOINT

- ☐ Pain in TMJ

HIP, LEG & FEET

PAIN IN:

- ☐ Right Buttocks
- ☐ Left Buttocks
- ☐ Both Buttocks
- ☐ Right Hip Joints
- ☐ Left Hip Joints
- ☐ Both Hip Joints

PAIN DOWN:

- ☐ Right Leg
- ☐ Left Leg
- ☐ Both Legs

PAIN IN

- ☐ Right knee
- ☐ Left knee
- ☐ Right ankle
- ☐ Left ankle
- ☐ Right foot
- ☐ Left foot
- ☐ Leg Cramps

SENSATION OF PINS & NEEDLES IN:

- ☐ Right leg
- ☐ Left leg
- ☐ Both legs

NUMBNESS OF:

- ☐ Right leg
- ☐ Left leg
- ☐ Both legs
- ☐ Right foot
- ☐ Left foot
- ☐ Both feet
- ☐ Right toes
- ☐ Left toes
- ☐ All toes
- ☐ Right foot feels cold
- ☐ Left foot feels cold
- ☐ Both feet feel cold

CRAMPS IN:

- ☐ Right foot
- ☐ Left foot
- ☐ Both feet

SWOLLEN:

- ☐ Right knee
- ☐ Left knee
- ☐ Right ankle
- ☐ Left ankle
- ☐ Right foot
- ☐ Left foot

PAINFUL JOINTS IN:

- ☐ Right toes
- ☐ Left toes
- ☐ All toes

ABDOMEN

- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea

Name ______________________

Date ______________________

DATE:____________________

RECORDS TRANSFER REQUEST

To:____

(Doctor/Hospital)

Phone:___________________________ Fax:___________________________________

Address:____

City:_____________________State:___________________Zip:____________________

I hereby authorize the release of my_______________________ or copies of such and request that they be transferred to:

9434 South Main Street Suite 1100 Jonesboro, GA 30236
(770) 478-1300
FAX: (770) 478-9385

____
Signature

____
Date of birth

____
Print Name

____
Treatment dates (if known)

NOTIFICATION OF NEW POLICY ON CANCELLATION OF APPOINTMENTS

We now require a 24-hour notice for cancelled appointments. If appointments are not cancelled by the notice required, there will be a fee of $30, which must be paid before your next office visit.

This change will allow us to offer open appointment times to other patients who may need them.

We appreciate any help you can give us in this matter. We appreciate your business.

Dr. Genia Fraser Sword & Dr. Stacy Roberts

By signing below, I am stating that I understand and agree to the aforementioned statements and terms.

_______________________ _______________________

Signature Date

TRINTY PAIN RELIEF CENTER

Patient Financial Program

( ) **On-The-Job-Injury:** I was injured at work and this claim is being submitted under my employer's Worker's Compensation Insurance. In the event that this claim should be rejected by that carrier, I understand that I am liable for payment of all treatments and services. Patients Initials ______

( ) **Auto Accident:** I was injured in an auto accident and this claim is being submitted through auto insurance. In the event this claim should be rejected by that carrier, I understand that I am liable for payment of all treatments and services. Patient Initials _____

( ) **Insurance Assignment:** I have insurance and will make assignment to the doctor and/or clinic. Patients Initials _____

DEDUCTIBLE: My deductible is $__________
( ) I have met my deductible for the current year.
( ) I haven't met my deductible for the current year & will pay $_____on______

ESTIMATED PATIENT PORTION: In addition to my deductible, I understand that I am responsible for any amount not covered by my insurance policy(s). I will pay the Estimated portion of my bill on a WEEKLY basis.
Patients Initials _____

REDUCTIONS AND REJECTIONS OF CLAIMS BY MY INSURANCE CARRIER DO NOT IN ANY WAY AFFECT MY OBLIGATION TO PAY THE BILL IN FULL.

( ) Cash Agreement: I will make payment in full for services rendered on my first visit and on a weekly basis thereafter. Patients Initials _____

ALTERNATIVE METHODS OF PAYMENT: VISA, MATERCARD, AMERICAN EXPRESS, DISCOVER

I understand that I will be charged for missed appointments unless I give adequate notice of at least at 24 hour period. Patients Initials _____

NOTICE: One Point give percent (1.5%) interest is charged on all unpaid balances carried over thirty (30) days. Accounts sixty (60%) days past due without written financial arrangements are immediately sent for collection. I agree to pay all reasonable court cost and attorney fees should I default on my account.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care for treatment, any services rendered to me will be immediately due and payable.
I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of medical care or spinal adjustments. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while the patient is at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.
I authorize the Doctors and Staff of Trinity Pain Relief Center, LLC to administer such procedures and treatment as they deem necessary to my (son) (daughter) (ward in my legal custody).

The Clinic, Doctors, and Staff have implied no guarantee of cure.
I have read and agree to abide by the terms set above.

PATIENTS
SIGNATURE____**Date**______________

Guardian's Signature Authorizing Care______________________________________**Date**_____________