TOTAL HEALTH & INJURY SPECIALIST

Dr. Teresa Jackson
Chiropractor
5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Office: 404-734-9740
records@totalhealthandinjury.com
Fax: 404-845-7834

"Warning: Under Georgia law, there is no liability for an injury or death of an individual entering these premises if such injury or death results from the inherent risks of contracting COVID-19. You are assuming this risk by entering these premises."

COVID-19 QUESTIONNAIRE

1. Have you traveled out of the country in the past 14 days? YES or NO

2. Have you had any contact with anyone with confirm COVID-19 in the past 14 days? YES or NO

3. Have you had any of the symptoms in the past 14 days? YES or NO
   - Fever greater than 100 degrees- YES or NO
   - Difficulty breathing- YES or NO
   - Cough- YES or NO
   - Loss of smell or taste- YES or NO

4. If you answered YES to question 1, 2 and/or 3, please call your primary care provider or Georgia Department of Public Health at (404) 657-2700 for further direction.

PLEASE DO NO ENTER OUR FACILITY IF YOU SAID YES TO ANY OF THE ABOVE QUESTIONS

Print Name: _____

Signature: _____

Date: _____

WELCOME

PATIENT INFORMATION

Date _____

Social Security # _____

Patient Name _____
Last Name

_____
First Name Middle Name

Address _____

City _____

State _____ Zip _____

E-Mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

Spouse's Phone (_____) _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account _____

Relationship to Patient _____

Auto Insurance _____

Policy # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Ins. Company _____

Group # _____

Date of Accident or Injury _____

TOTAL HEALTH & INJURY SPECIALIST

Patient Payment Selection

As a result of the above referenced accident, I choose to bill services related to this accident to:

☐ Auto/MedPay Coverage: 1st party automobile insurance coverage through my auto carrier.

☐ Attorney Lien: I have hired an attorney that will settle my medical bills at the end of my treatment.

☐ Self-Pay: I will pay for my medical services up front at the time of service.

** Any unpaid services are the responsibility of the patient, regardless of the party billed.

Signature _____ Date _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best Time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

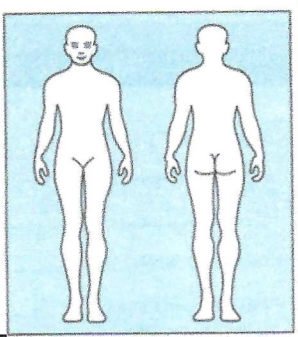
Is this condition getting progressively worst? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movement that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits

☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

By my signature on this form, I _____ hereby state that, to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this current time. X_____

Injuries/Surgeries you ever had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (_____) _____		

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Client Email and Text Message Informed Consent

You may give permission to Total Health and Injury Specialist to communicate with you by email and text message (also known as SMS). This form provides information about the risks of these forms of communication, guidelines for email/text communication, and how we use email/text communication. It will also be used to document your consent for communication by email and text message.

1. **How we will use email and text messaging:** We use these forms of communication for non-sensitive and non-urgent issues only. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your email and text messages may be forwarded to another THIS staff member as necessary for appropriate handling. We will not disclose your emails or text messages to researchers or others unless allowed by the state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

2. **Risk of using email and text messages:** The use of email and text message has several risks that you should consider. These risks include, but are not limited to, the following:
    - **a.** Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
    - **b.** Senders can easily misaddress an email or text and send the information to an undesired recipient.
    - **c.** Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
    - **d.** Employers and on-line services have a right to inspect emails and texts sent through their company systems.
    - **e.** Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
    - **f.** Emails and texts can be used as evidence in court.
    - **g.** Email and text messaging may not be secure and therefore it is possible that a third party may breach the confidentiality of such communications.

3. **Conditions for the use of email and text messages:** THIS cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:
    a. **IN CASE OF A MEDICAL EMERGENCY, DO NOT USE EMAIL OR TEXT, CALL 911.** Do not email for urgent problems. If you have an urgent problem during regular business hours, please call our office at 404-734-9740. Urgent messages or needs should be relayed to us by using regular telephone communication.
    b. Emails should not be time sensitive. While we try to respond to email messages daily, we cannot guarantee that any particular email will be read and responded to within any particular period of time. If you have not heard back from us within 48 hours, call our office to follow up if we have received your email.
    c. You should speak with someone in our office to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.
    d. Email and text messages may be filed electronically into your medical record.
    e. Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except as authorized by the law.
    f. You should use your best judgement when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
    g. THIS is not liable for breaches of confidentiality caused by you or any third party.
    h. It is your responsibility to follow up with our staff if warranted.

4. **Withdrawal of consent:** I understand that I may revoke this consent at any time by advising THIS in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

5. **Client Acknowledgement and Agreement:** I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between THIS staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that THIS may impose to communicate with me by email or text message.

Patient Name:_____

Patient Signature:_____ Date:_____

TOTAL HEALTH & INJURY SPECIALIST

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Phone (404) 734-9740
Records@totalhealthandinjury.com

Patient Name _____ **Date** _____

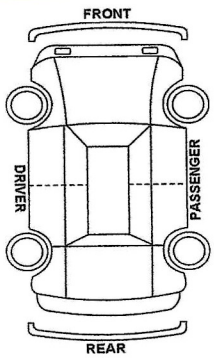
PLEASE ANSWER OR MARK THE APPROPRIATE CIRCLES COMPLETELY TO EACH QUESTION

About your ACCIDENT,

Date of Accident: _____
I am a _____year old ○M / ○F who was involved in a motor vehicle accident
I was the: ○Driver ○Passenger ○Pedestrian
** *If passenger*: ○Front seat or Rear seat on ○Right ○Middle ○Left

The vehicle was struck from: ○Front ○Rear ○Driver side ○Passenger side

On the diagram, please mark the area that the vehicle was struck



Road Conditions ○Wet ○Dry

Were you wearing a seatbelt? ○Yes ○No

Did the airbags deploy? ○Yes ○No

Were you surprised by the impact when the collision occurred? ○Yes ○No

Did you experience pain immediately after the auto collision? ○Yes ○No

Were you looking straight ahead? ○Yes ○No

Was your head turned? ○Yes ○No

○LEFT ○RIGHT

Did your Knee hit the car console? ○Yes ○No

Were you unconscious? ○Yes ○No

Did you suffer any abrasions or contusions? ○Yes ○No

Broken bones? ○Yes ○No

Did you go to hospital or E.R.? ○Yes ○No

Please name the hospital or E.R.

_____

If yes, via Ambulance? ○Yes ○Other _____

Were X-rays or other images taken? ○Yes ○No

Are you taking any pain medications? ○No ○Yes Please List Below

_____

_____

_____

About your PAIN,

Where are you hurting?

○ Neck	○ Mid back	○ Low back	○ Rt / Lt Arm	○ Rt / Lt Hand	○ Rt / Lt Shoulder
○ Rt / Lt Hip	○ Rt / Lt Knee	○ Rt / Lt Leg	○ Rt / Lt Ankle	○ Chest	○ Headaches

How would you rate your pain? (0 = no pain at all, 10 = the worst pain ever)

0 1 2 3 4 5 6 7 8 9 10

How often do you have the pain? ○Rarely ○On and off ○Constantly

How would you describe your pain?

○ Dull Ache	○ Stiffness	○ Tension	○ Sharp	○ Burning	○ Weakness
○ Numbness	○ Tingling	○ Throbbing	○ Stabbing	○ Other _____	

What relieves your pain?

○ Nothing	○ Rest	○ Brace	○ Sitting	○ Laying
○ Walking	○ Hot Pack	○ Cold Pack	○ Medication	○ Other _____

What makes your pain worse?

○ Lifting	○ Pushing	○ Pulling	○ Sitting	○ Driving	○ Cough/Sneeze
○ Bending	○ Walking	○ Running	○ Standing	○ Laying	○ Other _____

Sleep Disturbances:

○Does the pain wake you up at night? ○Yes ○No

○2-4 hours of sleep due to pain waking you up throughout the night?

○4-6 hours of sleep due to pain waking you up throughout the night?

○What sleep position are you not able to perform due to pain?

○ Back ○ Stomach ○ Side ○ Left or ○ Right

○What position do you fall asleep with most ease

○ Back ○ Stomach ○ Side ○ Left or ○ Right

○How many times are you waking up at night due to pain

○1-2x per night ○4-6x per night ○10x or more per night

○How often do you have trouble falling asleep

○Never ○Sometimes ○Most days ○Everyday

Describe the pain:

○Stabbing
○Burning
○Shooting
○Electric

Is the loss of sleep affecting your quality of life? ○Yes ○No

○Feel depressed?

○Loss of appetite?

○Feel irritable?

○Feel tired throughout the day?

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Patient Name: _____ **Date:** ____/____/20____

Loss of Enjoyment/Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day-to-day living or work duties that are painful or difficult for you to perform as a result of the injuries you sustained. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities, which require that you reduce the time you are capable of performing them.

Please Print Clearly in Black Ink

Job description: _____

N/A	Work	Reason for the Difficulty/Limitation			
____	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
____	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
____	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
____	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
____	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
____	Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A	Studies/School	Reason for the Difficulty/Limitation			
____	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
____	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
____	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
____	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
____	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
____	Studying	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
____	Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A	Domestic Duties	Reason for the Difficulty/Limitation			
____	Vacuuming	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
____	Taking Care of Kids	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
____	Cleaning	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
____	Preparing Meals	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
____	Other: _____	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform

N/A	Household Duties	Reason for the Difficulty/Limitation			
____	Yardwork	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
____	Transportation	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
____	Shopping	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
____	Taking Out Trash	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
____	Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A Sports
Name Sport: _____
Pre-Accident Level of Participation:

Reason for the Difficulty/Limitation
☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Socially ☐ Competitively ☐ Professional

Patient Signature: _____ **Date:** ____/____/20____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **SS#:** _____
DOB: _____ **Home Phone:** _____

I authorize _____ to release copies of the following medical records of for the dates of service _____, as follows:

- ___ **History of Physical**
- ___ **Operation Report(s)**
- ___ **Consultation Summary**
- ___ **Discharge Summary**
- ___ **Other, Specify:**
- ___ **Radiology Report(s)**
- ___ **Laboratory Report(s)**
- ___ **Pathology Report(s)**
- ___ **Complete Medical Record**

I want this information faxed to Total Health & Injury Specialist for the purpose of review.

I understand and acknowledge that the records I have requested to be released pursuant to this authorization may contain psychiatric, drug, alcohol abuse and/or infectious disease information, which is protected under the laws of the State of Georgia and Federal Regulation (42 CFR Part 2). I hereby release Total Health & Injury Specialist, LLC from all legal liability that may arise from the release of any information from my alcohol, drug abuse or infectious diseases (HIV and AIDS) Information protected under State and Federal Laws. The authorization, except for action already taken, may be revoked by me at any time. This authorization is valid for 90 days unless otherwise specified.

Patient Signature _____ Date _____

_____
Doctor's Signature Date _____

***If the patient is unable to sign, his/her legally qualified representative may authorize the release of medical information.**

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO TOTAL HEALTH AND INJURY SPECIALIST FROM PATIENT'S INSURANCE CARRIER

DOA: _____ DOB: _____

Patient: _____

Ins. Company: _____

Insured SS #: _____

Claim #: _____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Total Health and Injury Specialist
5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Office: 404-734-9740
records@totalhealthandinjury.com
Fax: 404- 845-7834

As payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to TOTAL HEALTH AND INJURY SPECIALIST and mail it as follows:

Total Health and Injury Specialist
5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Office: 404-734-9740
records@totalhealthandinjury.com
Fax: 404- 845-7834

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or and attorney involved in this case.

_____ _____

Print Date

_____ _____

Insured/SIGNATURE Witness

Total Health and Injury Specialist

5304 Panola Industrial Blvd, Suite E
Decatur, GA, 30035

Telephone: 404-734-9740
Fax: 404-845-7834

HEALTH CARE AUTHORIZATION FORM

Patient's Name:_____

Patient's SS#:_____

Date of Birth:_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES (TOTAL HEALTH AND INJURY SEPCIALIST) TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

(Please Check all Boxes)

- I give permission to (Total Health and Injury Specialist) to use my address, phone number and clinical records to contact me with appointment reminders, missed appointments notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.
- If (Total Health and Injury Specialist) contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give (Total Health and Injury Specialist) permission to disclose protected health information in the presence of anyone accompanying me into a treatment room or consultation room by my request.
- By signing this form, you are giving (Total Health and Injury Specialist) permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The authorization shall be in effect for as long as the patient is a patient at this clinic.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of (Total Health and Injury Specialist). The written notice must contain the following information: Your name, SS#, and date of birth; a clear statement of your intent to revoke AUTHORIZATION; THE DATE OF YOUR REQUEST; AND YOUR SIGNATURE. The revocation is not effective until it is received by the Privacy Official. The AUTHORIZATION is requested by (Total Health and Injury Specialist) for its own use/ disclosure of PHI. (Minimum necessary standards apply). You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, (Total Health and Injury Specialist) will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

Print Name Patient _____

Signature of Patient _____

Date _____

Signature of Personal Representative_____

Description of Representative's Authority to Act for Patient _____

TOTAL HEALTH & INJURY SPECIALIST

TOTAL HEALTH AND INJURY SPECIALIST
Dr. Teresa Jackson, D.C.
5304 Panola Industrial Blvd Suite E, Decatur, GA 30035
404-734-9740

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination tests, diagnostic x-rays, and physical therapy techniques on me (or on the patient named below for who I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working or associated with, or serving as a back-up doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic. The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

I understand that, as with any health care procedure, there are certain complications that may rise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, and muscle sprains and strains. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interests. The risks of complications due to chiropractic treatment or ancillary services have been described as "rare".

I understand that the delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. Other treatment options which could be considered may include the following: over-the-counter analgesics, medical care, hospitalization or surgery. I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature, purpose and risks of chiropractic adjustments and other procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____	_____
Print Patient's name	Print name of Patient's Representative
_____	_____
Signature of Patient or Representative	Relationship/authority of Patient Representative
_____	_____
Date	Translated or Read by Signature

_____
Witness to patient's signature

TOTAL HEALTH & INJURY SPECIALIST

5304 Panola Industrial Blvd Suite E
Decatur, GA 30035
Phone (404) 734-9740
Fax (404) 845-7834
Records@totalhealthandinjury.com

NOTICE OF MEDICAL PROVIDER LIEN

I do hereby authorize Total Health & Injury Specialist, LLC (hereinafter ***THIS)*** to furnish you, my attorney, with full report of their examination and tests of myself regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said ***THIS*** such sums as may be due and owing it for medical services rendered me both by reason of any other bills that are due its office to withhold such sums from settlement, judgment or verdict as may be necessary to adequately protect said ***THIS*** , and I further hereby give a lien on my case to said ***THIS*** against any and all proceeds of my settlement, judgments or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney, I hereby instruct that in the event another is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to the said ***THIS*** for all medical bills submitted by it for services rendered me and that this agreement is made solely for said ***THIS*** additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I have been advised that if my attorney does not wish to cooperate in ***THIS's*** interest, that ***THIS*** will not await payment but may declare the entire balance due and payable.

PATIENT SIGNATURE DATE

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms the above and agrees to withhold such sums from any settlement, judgment or direct, as may be necessary to adequately protect ***THIS*** above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

ATTORNEY's SIGNATURE DATE

ASSIGNMENT OF BENEFITS

I hereby direct and authorize, without equivocation, my insurance company, or attorney, to make payment directly to Total Health & Injury Specialist for any and all benefits due as a result of my treatment.

By signing this document 1 hereby releases to ***THIS*** the right and privileges and those causes of action not in violation of O.CG.A. 44-12-24 against any insurance carrier of other proper party which may be responsible for payment toward any claims incurred. This assignment of benefits shall expressly exclude any assignment of the patient's personal injury claim.

This authorization will supersede and have precedence over any foregoing agreement. I am also aware that I am personally responsible for chargers and/or any amount not recovered by ***THIS*** through any insurance payment or settlement distribution.

PATIENT SIGNATURE DATE