

**Welcome to**  
**HEALTHQUEST**  
*Your Family Wellness Office*  
**(770) 509-3400**

Thank you for choosing our office for chiropractic care. We are committed to providing you and your family with the highest quality of corrective and wellness chiropractic care available so that everyone can enjoy an active, healthy life. In addition to chiropractic care and spinal decompression, HealthQuest can provide nutrition, exercise, and massage therapy services. We will be working together to help you reach all your health and wellness goals.

If you ever have any questions about your care, please don't hesitate to ask one of our highly-educated team members. All your questions, even the ones you haven't thought of yet, will be answered during your Chiropractic Report.

We look forward to a long, healthy relationship with you and your family.

# HEALTHQUEST CHIROPRACTIC CENTER

## Office Fee Schedule and Financial Policy

Today's charges will include consult, exam, x-rays, and your first adjustment, as well as your Report of Findings on the following visit. This fee does not include care on your return visit. Any further care must be agreed upon by both parties.

<u>Service</u>	<u>Service Fees</u>	<u>Self-Pay</u>
Consultation	N/C	N/C
Extended Consultation	\$80	\$50
Initial Examination	\$150	\$80
Progress Exam	\$80	\$50
X-Rays (per view)	\$50	\$30
Adjustment	\$70	\$50
Electric Stimulation	\$50	\$20
Massage Therapy, 1 hour	\$180	\$70

### Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best service possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your care at the time of service or in advance. You may arrange an Active Life Plan as well. Active Life Plans (ALP) offer individual and family, yearly or monthly options. These Active Life Plans are designed to be the most cost-effective plans. Please inquire and we can discuss the details of these plans with you to help you determine your best options. Please choose one of the two below to be used.

- Health Insurance:** If you have insurance that you would like to use for your care we will be happy to verify it and inform you of your coverage in this office. If utilizing insurance, we will be happy to file your claims for you as a courtesy. Remember, your agreement with your insurance company is between you and them. You will ultimately be responsible for all co-payments and deductibles, or denials for all services rendered to you.
- Self-Pay: (Not available if utilizing insurance.)** This is an option if you have no insurance or your policy or deductible precludes you from using insurance, or if you wish to not use any insurance. As a self-pay patient, you will receive fees, discounted for payment received at time of service, as indicated by the fee schedule above. As a self-pay member, you can pay for your care at the time of each visit, or for greater convenience, monthly and yearly payment options are available as well as packages of adjustments.

There is no qualifying diagnosis provided along with any requested receipts so you are unable to submit these claims to your insurance company for reimbursement. You can, however, be given a receipt for tax purposes or a medical savings account (MSA) or health savings account (HSA) indicating the total amount you have paid for chiropractic care during the year.

If you acquire insurance for a special situation such as an auto accident or a workers compensation injury and choose to utilize that coverage, you will be charged our regular office fees until such claim is settled. We will assist in quick reimbursement on these claims. Once the claim is complete, you can return to self-pay fees again.

I have marked the one that applies to me. I have read and I understand the above policies.

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Patient

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Date

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine and other joints of the body.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

**The Nature of Chiropractic Treatment:** The doctor will use his hands or a mechanical device in order to move your joints. You may or may not feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may or may not feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, or trigger point myotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. 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.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

**Other Treatment Options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of Remaining Untreated:** 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.

**Unusual Risks:** I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

<b>Printed Name</b>	<b>Signature</b>	<b>Date</b>

**WITNESS:**

<b>Printed Name</b>	<b>Signature</b>	<b>Date</b>

**About Your Health**

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

**PATIENT HISTORY**

Name \_\_\_\_\_ Email \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Children \_\_\_\_\_  
Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
Have you ever received chiropractic care? Y N Who & When? \_\_\_\_\_  
Who referred you to this office? \_\_\_\_\_

**WHAT BRINGS YOU TO OUR OFFICE?**

**FIRST COMPLAINT:** \_\_\_\_\_  
Date when symptom first appeared \_\_\_\_\_  
Did it begin \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_ Progressive over time  
How did it occur (if applicable) \_\_\_\_\_  
What makes the symptoms worse? \_\_\_\_\_  
What relieves the symptoms? \_\_\_\_\_  
Type of pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burn \_\_\_\_\_ Throb \_\_\_\_\_ Constant \_\_\_\_\_ Intermittent  
Does the pain radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate  
Do you experience numbness or tingling? \_\_\_\_\_ Y \_\_\_\_\_ N  
How often do you experience these symptoms? (\_\_\_\_100% \_\_\_\_75% \_\_\_\_50% \_\_\_\_25% \_\_\_\_10%)  
Severity of pain/complaint (circle 1-10) No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain  
List previous treatments for this condition. Physician/other: \_\_\_\_\_

**OTHER COMPLAINT:** \_\_\_\_\_  
Date when symptom first appeared \_\_\_\_\_  
Did it begin \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_ Progressive over time  
How did it occur (if applicable) \_\_\_\_\_  
What make the symptoms worse? \_\_\_\_\_  
What relieves the symptoms? \_\_\_\_\_  
Type of pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burn \_\_\_\_\_ Throb \_\_\_\_\_ Constant \_\_\_\_\_ Intermittent  
Does the pain radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate  
Do you experience numbness or tingling? \_\_\_\_\_ Y \_\_\_\_\_ N  
How often do you experience these symptoms? (\_\_\_\_100% \_\_\_\_75% \_\_\_\_50% \_\_\_\_25% \_\_\_\_10%)  
Severity of pain/complaint (circle 1-10) No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain  
List previous treatments for this condition. Physician/other: \_\_\_\_\_

**OTHER COMPLAINT:** \_\_\_\_\_  
Date when symptom first appeared \_\_\_\_\_  
Did it begin \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_ Progressive over time  
How did it occur (if applicable) \_\_\_\_\_  
What make the symptoms worse? \_\_\_\_\_  
What relieves the symptoms? \_\_\_\_\_  
Type of pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burn \_\_\_\_\_ Throb \_\_\_\_\_ Constant \_\_\_\_\_ Intermittent  
Does the pain radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate  
Do you experience numbness or tingling? \_\_\_\_\_ Y \_\_\_\_\_ N  
How often do you experience these symptoms? (\_\_\_\_100% \_\_\_\_75% \_\_\_\_50% \_\_\_\_25% \_\_\_\_10%)  
Severity of pain/complaint (circle 1-10) No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain  
List previous treatments for this condition. Physician/other: \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Additional Symptoms:**

- Headaches
- Neck Pain
- Neck Stiff
- Back pain
- Nervousness
- Tension
- Irritability
- Fatigue
- Depression
- Face Flushed
- Sleeping Problems

- Pins & Needles in Legs
- Pins & Needles in Arms
- Numbness in Fingers
- Numbness in Toes
- Shortness of Breath
- Chest Pains
- Dizziness
- Lights Bother Eyes
- Loss of Memory
- Ears Ring/Buzzing
- Fever

- Fainting
- Loss of Smell
- Loss of Taste
- Hands Cold
- Feet Cold
- Diarrhea
- Stomach Upset
- Constipation
- Cold Sw eats
- Loss of Balance
- Allergies

**Please list all past surgeries:**

Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

**Please list all previous accidents/falls/injuries/hospitalizations:**

What \_\_\_\_\_ When \_\_\_\_\_ Injuries \_\_\_\_\_

**Please list any medications you are currently taking (include for how long and any side effects).**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Regarding your **Birth Process**, please list any complications or special circumstances (breech, forceps, vacuum extraction, difficulties, drugs, home birth, etc.).

\_\_\_\_\_

\_\_\_\_\_

**Current Health Behaviors:**

Do you smoke/use tobacco? Y / N \_\_\_\_\_

Alcohol/drug use? Y / N Please explain \_\_\_\_\_

Do you exercise? Y / N What/How often? \_\_\_\_\_

Do you have a healthy/nutritious diet? Y / N Please explain \_\_\_\_\_

\_\_\_\_\_

What supplements do you take? \_\_\_\_\_

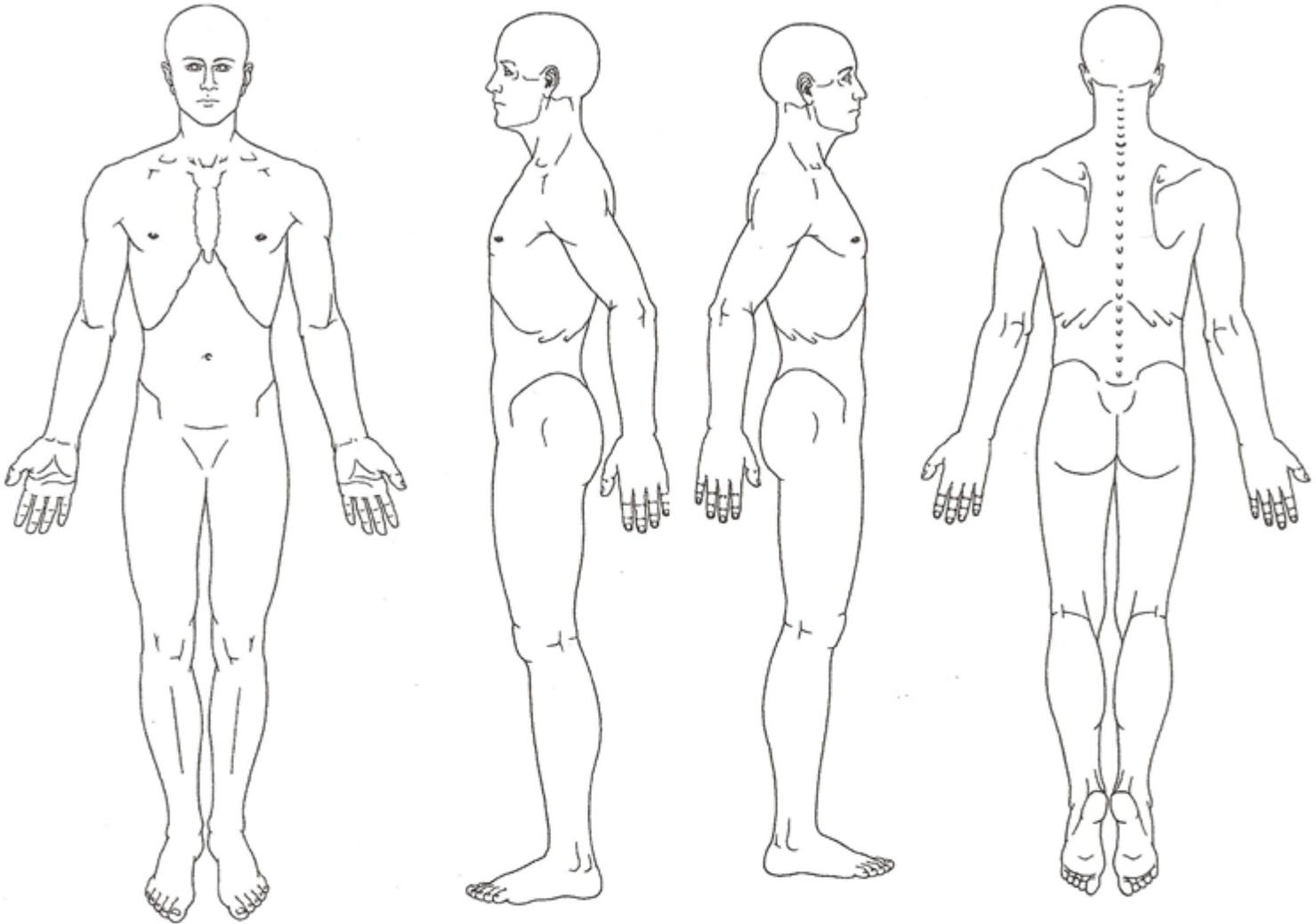
\_\_\_\_\_

**Please do not write below this line**

**DOCTORS NOTES:**

# PATIENT HISTORY

## PAIN LOCATION



**Please mark off the areas of your complaint on the diagram above.  
Please use the following symbols on the pain diagram to accurately  
describe your condition.**

- |            |                                      |
|------------|--------------------------------------|
| <b>PPP</b> | <b>Where you experience Pain</b>     |
| <b>NNN</b> | <b>Where you experience Numbness</b> |
| <b>TTT</b> | <b>Where you experience Tingling</b> |
| <b>BBB</b> | <b>Where you experience Burning</b>  |
| <b>CCC</b> | <b>Where you experience Cramping</b> |

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# HealthQuest Chiropractic Center

## PATIENT AUTHORIZATION

It is the practice of this office to at times provide chiropractic care in an open environment. At times, patients may be within sight of one another and some ongoing details of care are discussed within earshot of other patients, staff, and anyone else who may be present in the office. This environment is used for ongoing care and is not the environment used for taking patient histories, performing consultations or examinations or special appointments or presenting reports of findings. These procedures are completed in a private, confidential room. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an open environment are incidental matters, and in the event that you or someone else would not agree with us we are providing this disclosure.

Furthermore you give authorization to HealthQuest for each of the following:

- permission to post your name on the office's 'welcome board' and 'thanks for referral board' and 'success board', if these are ever used at HealthQuest, where it may be plainly seen;
- use of 'patient files' and placing of files onto counters, adjusting rooms and wall slots, or in office where it may be seen or be in "incidental" contact with other people or their files;
- use of 'sign-in sheet' where you are to sign-in each visit and your name could be seen by others;
- keeping your credit card number and information on file and authorization to charge your card according to the terms agreed upon and applicable under the financial systems and policies in operation at HealthQuest;
- awareness of all employees of HealthQuest including staff, intern assistants, bookkeepers, accountants, coaches, consultants, cleaning crews, or other temporary hired help, being present at various times and having legal or illegal access to office property, including records. (all required and appropriate protective measures are being taken by HealthQuest);
- communicate to you via phone, fax, mail or email regarding your care, appointments, re-evaluations, meetings, workshops/classes, products, in-office promotions or solicitations and business or personal matters.

These authorizations are intended to make your experience with our office more efficient and productive. If you chose not to authorize this information your decision will have no adverse effect on your care from HealthQuest Chiropractic or on your relationship with our staff.

**Your signature indicates your authorization of all of the activity outlined herein.**

This authorization may be revoked at any time. Revocation may be accomplished at any time by advising us (Dr. Christopher A. Rechter, privacy and security officer) in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed, and be aware that revocation is not possible in situations where actions have already been taken relying on this authorization.

A copy of this authorization has been provided to you and a signed copy will be kept on file and serve as your receipt and acknowledgement of your authorization.

\_\_\_\_\_  
Patient (signed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
HealthQuest Representative (signed)

\_\_\_\_\_  
Patient (printed)

\_\_\_\_\_  
HealthQuest Representative (printed)

# HEALTHQUEST CHIROPRACTIC CENTER

## PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at HealthQuest Chiropractic Center, all/any of its staff may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your personal health information, including your clinical records, may be disclosed to all the doctors, interns, staff at HealthQuest.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, email, phone/fax number, and your health care records may be used to contact you regarding appointment reminders, missed appointments, information about your present care or alternatives, any correspondences from the office, or other health-related information that may be of interest to you.

You are by law, hereby granted certain rights as follows:

- the right to amend your protected health information by notifying us, and we are to comply with this within 60 days
- the right to access, inspect, and copy your protected health information (inquire about exceptions)
- the right to request restrictions on certain uses and disclosures for treatment, payment, or health care operations to which we are not required to agree.
- the right to confidential communication by alternative means or location (bearing in mind our open floor plan & atmosphere for which you consent authorization)

If you are not at home to receive an appointment reminder or other message, the message may be left on your answering machine or with someone else. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail, email or fax information to you regarding your health care or about the status of your account or about the office in general or regarding an office newsletter. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

This notice shall serve as valid from the time you first begin care and will continue for anytime thereafter. You may revoke authorization at any time by submitting request in writing to Dr. Christopher A. Rechter at 1000 Johnson Ferry Road, Suite D100, Marietta, GA 30068.

Revocation is not possible in situations where actions have been taken relying on this authorization.

For more information or to file a complaint, contact our security and privacy officer, Dr. Christopher A. Rechter, to whom you have the right to discuss your privacy and security questions or concerns, at 770-509-3400.

You also have the right to lodge a complaint with the Department of Health and Human Services through the Office of the Patient Advocate. A copy of this notice is/has been promptly provided to you and this signed notice will be kept as part of your file and will serve for us as an "acknowledgment of (your) receipt of a privacy notice".

\_\_\_\_\_  
Patient (signed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
HealthQuest Representative (signed)

\_\_\_\_\_  
Patient (printed)

\_\_\_\_\_  
HealthQuest Representative (printed)