

ATLAS FAMILY CHIROPRACTIC
DR. MAGGIE A. SELLERS
Atlas Orthogonist — Specializing in the Cervical Spine

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 used 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.

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 vertebra in the spinal column which causes an 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. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal condition. However, if during the course of a chiropractic spinal examination, 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 another health care provider.

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. However, we may use other procedures to help your body hold the adjustments.

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

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Signature

Date

PATIENT CONSENT / ACKNOWLEDGMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES
F R O M
ATLAS FAMILY CHIROPRACTIC
DR. MAGGIE A. SELLERS, D.C.

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Dr. Maggie A. Sellers, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices. You May Refuse To Sign This.

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.

Printed Patient Name _____ Date _____

Signature _____

IF APPLICABLE:

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____



Atlas Family Chiropractic

Dr. Maggie Sellers, D.C.

Patient Information

Please complete this form in ink. If you have questions, or concerns, please do not hesitate to ask for assistance. We will be happy to help. Thank you for choosing this office for your chiropractic needs. (Please print)

Name (First, Middle Initial, Last) _____

Address _____ City _____ State/Zip _____

Social Security # _____ - _____ - _____ Birth date ____/____/____ Sex: Female Male

Status: Single Married Separated Divorced Widowed Student: FT PT

Home Phone _____ Alt. Phone _____

Employer _____ Occupation _____

In case of emergency contact (include phone number) _____

Referred by _____ e-mail address _____

Is this condition due to an automobile accident: No Yes or work related accident: No Yes
*if "Yes", please request from the receptionist the **Accident Information form***

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State/Zip _____

Insurance Information (please present your insurance card)

Primary Insurance Co. _____

Policy No. _____ Group No. _____

Secondary Insurance Co. _____

Policy No. _____ Group No. _____

If policy holder insured is not the patient, please complete the following:

Policyholder Name _____ Relationship to Patient _____

Address _____

Birth date ____/____/____ SS No. _____ - _____ - _____ Phone No. _____

The patient/responsible party is hereby responsible for charges incurred during the course of treatment.

Atlas Family Chiropractic will, as a service to the patient, file claims with the insurance carrier(s) listed.

Any charges not covered by the carrier will be the responsibility of the patient/responsible party. I hereby

authorize the doctor to release all information necessary to secure payment of benefits from the

insurance carrier(s) listed. I understand finance charges of 18% per annum will be assessed my account

on balances unpaid over 60 days and that I am liable for all legal and collection fees.

I hereby give my permission and consent for treatment.

Patient / Legal Guardian Signature

Date

SYMPTOMS

Describe the symptoms that have brought you here today:

When did the pain begin _____ Rate the severity of pain 1-10 (mild to severe) _____

How often does the pain occur _____

What makes the pain Better / Worse _____

What treatment have you received for your condition:

None Medication Surgery Physical Therapy Other _____

HEALTH HISTORY

Check only those conditions that are applicable:

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Anorexia/Boemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Gout | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt | _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems | |

Last Exam date _____ Last X-ray date _____ Are you pregnant No Yes

List all hospitalizations/surgeries you have had and the dates _____

Please list all medications you are currently taking (prescription and/or over-the-counter)

Name: _____ Dosage _____

Allergies _____

DAILY HABITS

What type of exercise do you perform on a daily basis None Moderate Heavy

What do your daily work habits include (light labor, heavy labor, computer work, sitting, standing, etc.)

What type of nutritional supplements do you take (if any) _____

Thank you for providing this information.
If any of the information changes, please be sure to inform us.