WELCOME NEW PATIENT TO:

Form 3 PI

Advanta Total Health

Chart #:_____

_____

Patient Information

Name: _____
Last First MI

Mailing Address: _____City: _____, State:_____ Zip: _____

Phone# (H)_____ (M) _____

Date of Birth: ____/____/____ ☐ Male ☐ Female SS#:_____

Marital Status: ☐ Single ☐ Married ☐ Minor

Employer:_____ Email Address:_____

May we call you at work? ☐ Yes ☐ No Can we leave a voicemail/message? ☐ Yes ☐ No

May we text you to confirm/reschedule appointments? ☐Yes ☐No to inform you of services offered? ☐ Yes ☐ No

How did you hear about us:_____

Emergency contact: Name:_____ Relation:_____

Phone: (H)_____ (W)_____

Accident Information (If not in an Accident, Please skip to Health History Section)

Date of Accident Injury; ___/___/_____Was your accident injury reported? ☐ Yes ☐ No

If yes to whom?_____

What kind of accident were you in? ☐ Auto ☐ Work ☐ Other_____

Attorney: _____ Telephone: _____

Auto Insurance: _____ Claim# for incident: _____

Adjuster Name and telephone: _____

Have you called your insurance in regards to MedPay? _____ If so, what are your limits? _____

HEALTH HISTORY

Who is your main doctor or health care provider: _____

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

- ❑ Neck Pain
- ❑ Mid Back Pain.
- ❑ Low Back Pain.
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Arms Numb
- ❑ Asthma
- ❑ Loss of strength

(Please Circle Areas)

- ❑ Pins/Needles in: Arms,Hands, Fingers Legs, Feet
- ❑ Fatigue
- ❑ Trouble Sleeping Due to Pain
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting

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

Form 3 PI

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

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

Did anybody in your family have any of the following conditions? Please check the box and tell us who it was.

- ❑ Heart Disease _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Arthritis _____
- ❑ Stroke _____
- ❑ Other _____

Do you exercise? ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

At work do you mostly: ☐ Sit ☐ Stand ☐ Do Light Lifting ☐ Do Heavy Labor

What is your daily/weekly intake of the following?

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

PAST, FAMILY & SOCIAL HISTORY (PFSH)

Past History

Allergies: _____

Medications: _____

Illnesses: _____

Operations: _____

Do you have any surgical devices in your body? (i.e. screws, pins, plates, etc?)

If yes, what are they , and where are they located _____

Family History *of Diseases*:

_____

Social History

Smoker Y N Comments _____

Alcohol Y N Comments _____

Illicit Drugs Y N Comments _____

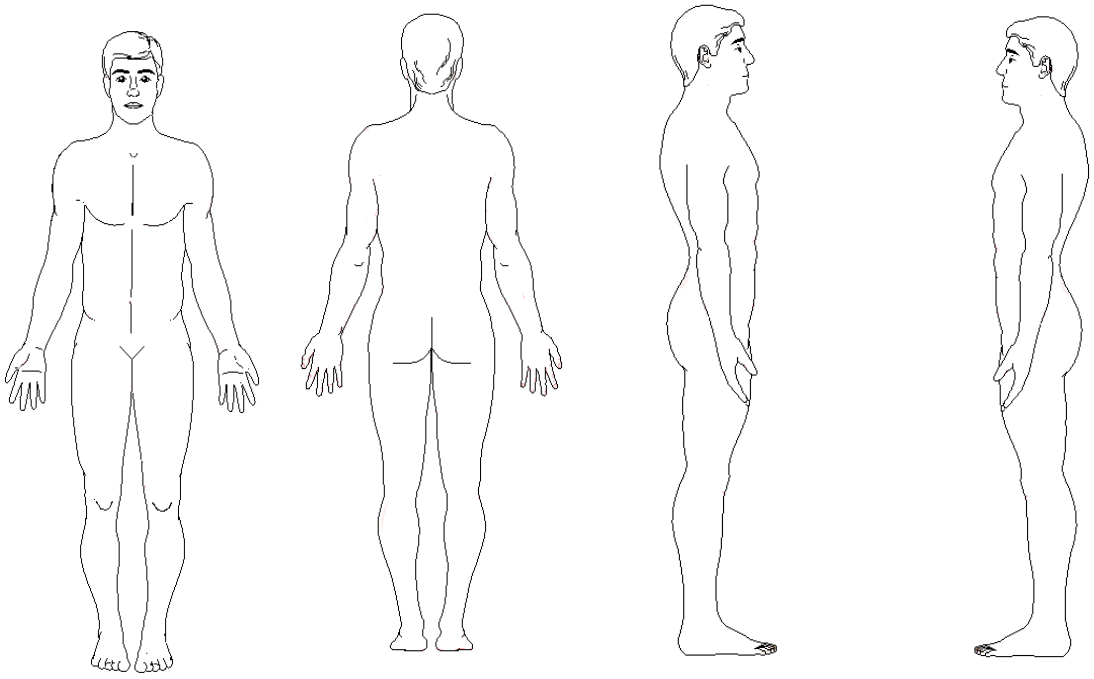
Employment Y N Comments _____

Current Symptom(s)* PLEASE MARK THE DRAWING(S) WITH THE LETTERS UNDER

"KEY" TO SHOW WHERE AND WHAT KIND OF PAIN YOU HAVE. For example: if you have dull pain and numbness in your legs put a "D" and an "N" on the legs of the man below.

KEY:

T = Tight
D = Dull
A = Ache
S = Sharp
N = Numb
B = Burning
ST = Stiff
TG = Tingling
SH = Shooting
TH = Throbbing
O = Other



* PLEASE INDICATE THE SEVERITY OF YOUR CONDITION ON A SCALE OF **0-10**
(0 being no pain, 10 being the worst possible pain) 1._____ currently 2._____ at it's worst

How soon after your injury did you start feeling your pain or other symptoms? ☐ Immediately ☐ a few minutes later
☐ An hour or so later ☐ Days later (how many) _____
Is the pain: ☐ Constant OR ☐ Comes and Goes

Is it getting progressively worse? ☐ No ☐ Yes

Is it worse in the ☐ morning ☐ afternoon ☐ evening ☐ at night.
Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreational Activities
What activities do you enjoy, but do poorly, or not all because of the pain?

_____

Painful movements: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down
What have you done to treat the pain before today?_____

ACCIDENT HISTORY REPORT (If Not in an Accident, Please Skip to Page 6)

Form 3 PI

Date of Accident or Injury:_____/_____/_____ Name of your Attorney if you have one:_____ Phone:_____

SKIP TO PAGE 6 IF YOU WERE NOT INJURED IN AN ACCIDENT OR OTHER TRAUMA
☐☐Car Crash ☐ Workers' Compensation ☐ Other _____

HISTORY - Workers' Compensation (patient's description):

_____
___

☐ Driver ☐ Passenger (front; rear seat) ☐ Pedestrian ☐ Other_____

Location: Street_____ City:_____State:_____

DESCRIPTION OF ACCIDENT (Check or circle appropriate description)

Please Describe Your Accident and <u>Put a Check On Each Line</u> That Applies

I was in the: __driver's seat, __front passenger seat __ back seat on the __left __right.
Make and Model of car I was in _____ Year _____.
The estimate of damage to that car is $____The vehicle was totaled____The vehicle was towed _____ Yes ____ No
Make and Model of the other car(s) involved _____ Year_____
I got a ticket_____. The other driver got a ticket____.
☐ The vehicle I was in was struck in the rear by another vehicle.
☐ The vehicle I was in was struck on the left or right side (circle one).
☐ The vehicle I was in was struck head on by another vehicle.
☐ Another vehicle traveling in the opposite direction suddenly turned in front of my vehicle causing the two vehicles to collide.
☐ Another vehicle made an improper turn and caused the two vehicles to collide.
☐ The vehicle I was in spun around/rolled over (circle one).
☐ Other (Brief Description)_____

_____

☐Air bags inflated and hit me in the (circle one): face, chest, arm, (other) _____.
☐I was wearing a seat belt?

Select the objects that you struck:

☐ Windshield	☐ Rear window of pick up	☐ Jarred or was thrown about
☐ Headrest	☐ Back of seat	☐ Dazed cannot remember details
☐ Dashboard	☐ Seat broke	
☐ Steering wheel	☐ Doorframe	

Select the parts of your body that struck objects.
☐ Head ☐ Face ☐ Chest ☐ Neck
☐ Back ☐ Shoulder(s)(Rt/Lt) ☐ Arms (Rt/Lt)☐ Elbow(s) (Rt/Lt)
☐ Wrist(s)(Rt/Lt) ☐ Leg(s)(Rt/Lt) ☐ Knee(s) (Rt/Lt) ☐ Ankle(s) (Rt/Lt)
☐ Other_____
☐ I had pain immediately ☐ I had pain a few hours later ☐ My pain began _____ days later.
☐ I was knocked unconscious ☐☐I was Cut or Bleeding (describe)

After the accident I:
☐ Went to the emergency room or urgent care. How did you get there?_____ ☐ Went home and took pain medicine, rested, used ice/stretching to relieve pain.
☐ Went home and later (drove/was driven) to _____Hospital.
☐ Patient doctored him/herself thinking the pain would go away.
Name of Hospital or healthcare office you were treated at:_____

Were you admitted to the hospital? Yes ☐ No ☐

What did they do for you where you were seen the day of the accident?
☐ Examination ☐ Stitches ☐ X-rays ☐ Physiotherapy
☐ Prescription ☐ Cervical collar ☐ Injection ☐ Wounds dressed
☐ Complete bed rest ☐Other _____

Were you seen anywhere else for your injuries since the crash? Yes ☐ No ☐

If yes, where, when and for what _____ Are you still under care? Yes ☐ No ☐

Were you referred to any other physician or sent for any special diagnostic tests or examinations? ☐ No ☐ Yes
(explain)_____
☐ MRI ☐ CT ☐ EMG ☐ NCS ☐ SSEP ☐ Thermography
☐ Other_____

HISTORY

Have you been involved in any previous accidents, injuries neck or back problems of any kind?
Yes ☐ No ☐
dates and details _____

Past surgical history or any condition that could affect present condition:

_____

_____

Was your health good prior to this accident? Yes ☐ No ☐
If No - Explain

_____

DISABILITY

Have you lost any time from work since the accident? Yes ☐ No ☐
If Yes - number of days lost:_____

Are you still off from work? Yes ☐ No ☐
If No - Indicate the date the Patient returned to work:_____

Are you working with any restrictions? Yes ☐ No ☐ What are they?

_____

_____

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

PATIENT SIGNATURE (X)_____DATE_____

PARENT/GUARDIAN SIGNATURE (X)_____DATE_____

Financial Information

Do you have health insurance? ☐ Yes ☐ No Name of Carrier:_____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier:_____

Name of person whose is the policy holder of this insurance:_____ SS#: _____

Relationship to patient (if other than self):_____ DOB: _____ Phone:_____

ID #_____ Group #_____member services phone number _____

Assignment, Consent of Care and Release

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.

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems prior to treatment. It is the responsibility of the patient to make it known to the doctor.

PATIENT SIGNATURE (X)_____ DATE_____

SIGNATURE OF PARENT/GUARDIAN_____ DATE_____

I was given the opportunity to receive and review the office's Patient Notice of Privacy Practices policy.

PATIENT SIGNATURE (X)_____ DATE_____

MEDICAL RECORDS REQUEST

Form 3 PI

Please list the name of the health care provider who referred you to us or any other health care providers who have your personal Health information. To:_____

(primary care physician)

_____ (significant other)

_____ (other care takers)

I, _____ hereby request that my recent medical records be released to:

Advanta Total Health
1720 Powers Ferry Road, Suite 100
Marietta GA 30067
Phone: 770-955-2225 Fax: 770-953-6658

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at any time. This consent will automatically expire without my expressed revocation 90 days from the date on this form.

PATIENT NAME:_____DATE OF BIRTH:___/___/___

ADDRESS:_____

PATIENT/GUARDIAN SIGNATURE:_____

AUTHORIZATION FOR CARE
ASSIGNMENT OF INSURANCE BENEFITS

Form 3 PI

This is an agreement between the undersigned patient and Advanta Total Health LLC (hereinafter referred to as Advanta).

Initial the Following:

_____ **I hereby authorize Advanta to treat my condition, as the clinician deems appropriate including the use of diagnostic testing and prescribed treatment modalities.** Original x-rays taken at Advanta will remain the property of Advanta, being on file where they may be seen at any time while a patient of this office. Should I require copies of the films, I also agree to pay for the cost of duplication. Advanta will not be held responsible for any pre-existing medically diagnosed conditions.

_____ **I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself**. Furthermore, I understand that Advanta 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 Advanta 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 that my fees for professional services rendered to me by Advanta will be immediately due and payable. Balances over 90 days will be transferred to an outside collection firm.

_____ **I understand that I am responsible to pay all collection and/or attorney fees for any debts including a 35% collection fee and court costs involved in collecting said balances.**

_____ ***I agree to accept responsibility for whatever is not covered or accepted by the insurance company; this will include any part of my deductible, which has not been met, co-pays or disallowed services.***

_____ **I authorize and direct my insurance company, and/or my attorney, *to pay directly to Advanta* such sums as may be due and owing Advanta for services rendered me**, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I understand that if my treatment is the result of a personal injury, that Advanta may have to provide additional documentation, depositions, and testimony. Because of this, I agree to pay Advanta the full amount of all services at their usual and customary fees notwithstanding any agreements Advanta may have with any other insurance companies/Health Maintenance Organizations, Preferred Provider Organizations, Point of Service carriers or healthcare entities or carriers of any kind. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks received for payment of my doctor bill.

_____ **I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.** I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collections efforts, including but not limited to all reasonable court costs and all attorney fees. I grant Advanta my permission to contact me in regards to my appointments and leave messages on my home, cell, or office.

_____ **I understand that, if I am accepted for care by Advanta, I will be responsible for attending all my appointments.** AND that, if necessary, I will call Advanta to reschedule my appointment a minimum of 24 hours in advance. If I fail to do this, I further understand Advanta may charge me a $50 missed appointment charge.

_____ _____
Patient Name (Printed) Person Authorizing Care if other than Patient

_____ _____/_____/_____
Signature Date

_____ _____/_____/_____
Witness Date

Form 3 PI

FOR PERSONAL INJURY CASES ONLY
AUTHORIZATION FOR CARE
ASSIGNMENT OF INSURANCE BENEFITS AND ATTORNEY LEIN

This is an agreement between the undersigned patient and Advanta Total Health (hereinafter referred to as Advanta).

_____ **I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself**. Furthermore, I understand that Advanta 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 Advanta 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 that my fees for professional services rendered to me by Advanta will be immediately due and payable. *I agree to accept responsibility for whatever is not covered or accepted by the insurance company; this will include any part of my deductible which has not been met, co-pays or disallowed services.*

_____ **I authorize and direct my insurance company, and/or my attorney, *to pay directly to Advanta* such sums as may be due and owing Advanta for services rendered me**, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I understand that if my treatment is the result of a personal injury, that Advanta may have to provide additional documentation, depositions, and testimony. Because of this, I agree to pay Advanta the full amount of all services at their usual and customary fees notwithstanding any agreements Advanta may have with any other insurance companies/Health Maintenance Organizations, Preferred Provider Organizations, Point of Service carriers or healthcare entities or carriers of any kind. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks received for payment of my doctor bill.

_____ **I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.** I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collections efforts, including but not limited to all reasonable court costs and all attorney fees. I grant Advanta my permission to contact me in regards to my appointments and leave messages on my home, cell, or office.

_____ _____
Patient Name Person Authorizing Care if other than Patient

_____ _____/_____/_____
Signature Date

_____ _____/_____/_____
Witness Date

I,_____, being attorney of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Advanta.

_____ _____/_____/_____
Attorney's Name (Please Print) Date

_____
Attorney's Address

_____ _____
Attorney's Signature Attorney's Phone Number

Form 3 PI

ADVANTA TOTAL HEALTH

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Patient Name: _____ Date of Birth: _____

I, _____, have had the opportunity to review a copy of Advanta Total Health's Notice of Privacy Practices.

_____ _____
Signature of Patient/Parent/Guardian Date

_____
Relationship to Patient

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____ _____
Date Initials

I hereby grant permission to Advanta Total Health 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 an appointment, to notify me that test results are available, to notify me that a form or prescription if ready for pick-up, or to conduct any other relevant business that is deemed necessary.

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

_____
Signature of Patient/Parent/Guardian

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____ _____
Date Initials

DO NOT FILL THIS FORM OUT

Form 3 PI

This is only for a Collision Repair Center that does the estimate.costs to fix your car.. It is very important to capture vital information to get your vehicle properly repaired.

Owner of Car:_____ Year_____Make_____Model_____

1. Frame time cost:_____ Are OEM parts used? Yes_____ No_____.
You may do an alternative estimate for non OEM parts. $_____

2. Did the rear bumper absorbers move more than one inch? Yes_____No._____ If so, how many inches? Yes_____ How many inches?_____ No_____. Was photo taken?Yes_____No._____

3. Did rear bumper absorbers not move at all Yes____ No____ Is there rust or other buildup visible on the absorber armature?Yes____No_____ Was 35mm photograph taken? Yes_____No._____

4. Was this a submarine style accident? In other words, was there undercarriage damage but little visible damage to the unibody of the vehicle? Yes____ No____ Photograph taken? Yes_____No._____

5. Are more than two hours of frame repair time required? Yes_____ No_____ (Please document this with a certified frame inspection. Often times this is overlooked when the insurance carrier completes the estimate. They are taught to write only what can be seen.)

6. Does the damage travel beyond the rear wheel well? Yes_____No._____ (This should be documented by a 35mm photograph taken along the side of the vehicle. Often times this is overlooked when the insurance carrier completes the estimate. They are taught to write only what can be seen.) Yes_____ No_____ 35mm available?_____

8. Is this is a unibody vehicle? Yes_____ No_____

9. Did the vehicle have an attached item; which would eliminate the effectiveness of the unibody and/or low impact bumper. (This is often seen when the vehicle has a trailer hitch directly mounted onto the frame of the vehicle. Also, watch for items such as bicycle carriers, wheelchair lifts or other such devices, which would eliminate the functionality of the low impact bumper or unibody structure.) Yes_____ No_____What kind of item_____.

10. Were ALL seatbelts and seatbelt locking mechanisms checked for replacement? Yes_____ No_____.
Which ones need replacement?_____.

11. Were the driver or passenger seat mounts damaged? Or were any of the seats knocked off their mounts? Yes_____ No_____ If so, which one?____

12. Were any head rests damaged? Yes__No__Which one?_____

Estimate of Repair $_____ Name of Person Doing Estimate_____

Name of Collision Repair Center;_____ Phone:_____/_____/_____