

Brown & Whitmarsh Chiropractic

Dr. Kevin & Dr. Gina Brown

Downtown: 513 E. Oglethorpe Ave., Savannah, GA 31401 ~ (912)447-1885

The Village on Skidaway: 15 Lake St., Ste. 224, Savannah, GA 31411 ~ (912)447-1885

Whitmarsh Island 115-A Charlotte Rd., Savannah, GA 31410, ~ (912)897-2688

www.savannahchiropractic.com

Personal and Family Health History

Name: _____ Today's Date: _____
Street: _____ Date of Birth: _____ (Age _____)
City: _____ Social Security #: _____
State: _____ Zip: _____ Occupation: _____
Home Phone: _____ Employer: _____
Work Phone: _____ Marital Status: S M D W Partner
Cell Phone: _____ Name of Spouse/Partner: _____
E-mail: _____ Employer of Spouse/Partner: _____
Emergency Contact: _____ Emergency Contact phone: _____
Favorite Hobbies/Interests: _____ Do you Exercise Regularly? Y N
Previous Surgery: _____

Current Medications Taken: _____

Previous Chiropractic Care? Y N When & Where _____

Reason for Previous Chiropractic Care: _____

Who may we thank for referring you to Brown Chiropractic? _____

Number of Children and Ages

Previous Chiropractic Care?

Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____

Current health complaints/reasons for consulting our office:

1. _____
2. _____
3. _____
4. _____

The above information is true and accurate to the best of my knowledge.

Signature of Patient or Guardian: _____ **Date:** _____

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Terms of Agreement

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goal – To locate, analyze and correct spinal interference to the nerve system. 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.

We do not diagnose conditions of disease other than that which relates to vertebral subluxations (spinal misalignments). However, if during the course of a chiropractic spinal exam, we encounter complaints that warrant medical attention, we will recommend that you seek the services of a provider who specializes in that area. We offer no treatment of conditions other than that which relate to vertebral subluxations. Our primary role is to identify subluxations and our primary method of correcting them is through spinal adjustments.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service (excluding work comp). It is also understood and agreed the amount paid the office for x-rays is for examination only and the x-ray films will remain the legal property of the office. I hereby authorize the doctor to examine and render care. By signing below I agree to all the terms outlined.

Patient or Guardian's Signature X _____ **Date:** _____

FEMALE PATIENTS ONLY - Non-Pregnancy Verification for X-rays

Let it be known by all people by my signature that I am not pregnant. If it later becomes known that I was pregnant during this x-ray examination, that I do not hold Brown Chiropractic and Dr. Kevin Brown liable.

Patient or Guardian's Signature X _____ **Date:** _____

CHILDREN & MINORS ONLY – Consent to Treat a Minor

I hereby authorize the doctor and whomever he may designate as assistants to examine and administer chiropractic care as deemed necessary to my child.

Patient or Guardian's Signature X _____ **Date:** _____

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HEALTH CARE AUTHORIZATION FORM

Every medical and non-medical doctor in the United States is required by law to have patients sign the following authorization form which protects the privacy of your personal health/medical records. This form is for your benefit. If you have any questions, please do not hesitate to ask the office manager.

Patient's Full Name _____

Patients SS# _____ Date of Birth ____/____/____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES BROWN CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to Brown Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.

If Brown Chiropractic contacts me by phone at home, work or on my cell phone, I give permission to the office staff to leave a phone message on my answering machine or voice mail.

I give Brown Chiropractic permission to treat me in an open room where other patients may also be treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I ask to speak with the doctor at any time in private, the doctor will provide a room for these conversations. I understand that I may choose treatment in a private room rather than in the open adjusting suite.

I give permission to Brown Chiropractic to speak to me about treatment or report of findings in front of my spouse or children if I choose to bring them to my appointments.

By signing this form, you are giving Brown Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

Patient or Guardian's Signature X _____ **Date:** _____

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Office Fee Schedule and Financial Policy

We are committed to providing the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. **Everyone is expected to pay for their chiropractic care at the time the service is rendered unless they arrange a Care Plan in advance.** Care plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report.

2009 Fees

Pre-Consultation	Complimentary
Complete Consultation	
Health History & Exam	\$50
Bio-Structural Exam	\$15
Cervical X-Ray (each)	\$35
Lumbar X-Ray (each)	\$45
Radiology Review	\$35
Total First Visit*	\$50 - \$225
Spinal Adjustments	\$38
Senior (Medicare)	\$32.20
Child Adjustments**	\$15/\$38
Intersegmental Traction***	\$10
G5 Massage***	\$10

* **The first visit will include some or all of the following; Complete Consultation, Health History & Exam, Cervical X-Rays, Lumbar X-Rays and a Radiology Review.**

****Discounted child adjustments \$15 when one or more parent is currently under care and the child is 18 years of age or younger. If neither parent is under care, child visits will be the regular price of \$38.**

*** **Intersegmental traction and G5 massage are available at the Whitmarsh office only and are utilized in addition to the adjustment.**

Health Insurance

If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send in your receipts with a copy of your claim form and your insurance company will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.

Adjustment Plans

Adjustment plans are available to provide significant discounts on x-rays, adjustments and re-exams for those who commit to recommended care plans. These plans are based on individual or family needs.

Medicare

The amount of care Medicare allows may be limited, but they will pay for visits related to an accident, injury or exacerbation (on old problem that has recently worsened). You will need to pay for your visits at the time of service unless other arrangements are made. We will in turn file your Medicare and supplemental insurance claims and the checks will be sent directly to you from Medicare and your insurance company.

I have read, understand and agree to the above policies.

signature

date