Dr. Cynthia Seebacher
(o) 404-838-8985
(f) 404-850-8645

Fusion Chiropractic & Functional Healthcare

2820 Lassiter Road, Ste A-150
Marietta, GA 30062
Fusion-Chiro.com

Name: _____ DOB:_____ Today's Date: _____

Address:_____ City, State: _____Zip_____

Phone: cell/home/office_____ cell/home/office_____

Email: _____ Would you prefer appointment reminders as text or email?

Who may we thank for referring you? _____

Have you ever received chiropractic care? No Yes with whom? _____

Have you ever received therapeutic massage? No Yes with whom?_____

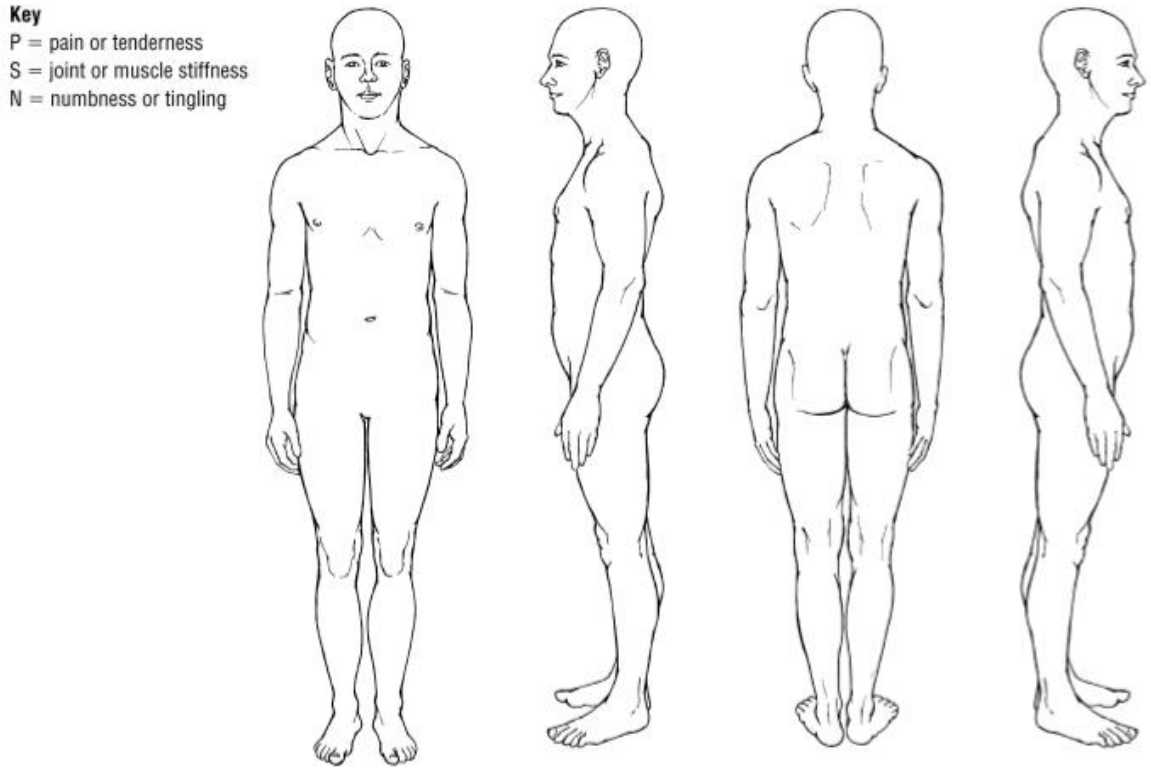
Reason for visit:_____

When did this first start?_____

Have you ever experienced this pain before? No Yes When?_____

Have you seen any other healthcare provider for this? _____

Please circle the area(s) of concern:



(for Doctor's Notes)

Short Leg **L**____ **R**____ *-D TrP* **L R** *+D leg lag* **L R** *PRI* **L R** *BCS* *1st Rib* **L R**
Legs Balanced after adjustment **Y N** *Sacral Extension Restriction* **L R** *Ant. Pubis* **L R**

CO C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 SAR SAP SAL

Cervical F ___/50 E ___/60 LLF ___/45 RLF ___/45 LR ___/180 RR ___/8
Lumbar F ___/60 E___/25 LLF ___/25 RLF ___/25 LR ___/30 RR ___/30
Hip F ___/100 E___/30 AB ___/40 AD___20 IR ___/40 ER ___/50

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For each area of complaint, please answer the following questions.

Primary area of complaint: _____
Describe the pain: Aching Burning Dull Sharp Stabbing Throbbing Stiff Weakness
Intensity of Pain: 1 2 3 4 5 6 7 8 9 10
Is there any Numbness or Tingling? Where? _____
Frequency of Pain: Constant Frequent Intermittent Occasional
Does the pain stay local to one area or does it travel to other areas of the body?_____
Anything that makes it feel better? Cold Heat Increase Activity Lying Down OTC meds
Posture Changes Prescribed Meds Rest Stretching Support Brace Chiropractic
Massage Nothing relieves the pain
Anything that makes it feel worse? Activity: heavy, moderate, light Bending Lifting Prolonged Activity
Prolonged Standing Stress Temperature Changes Twisting Sit to Stand Stand to Sit
Changing Positions Change Position in Bed Driving Getting Dressed Getting In/Out of Car
Lying Down Poor Posture Sitting at Desk Walking

Secondary area of complaint: _____
Describe the pain: Aching Burning Dull Sharp Stabbing Throbbing Stiff Weakness
Intensity of Pain: 1 2 3 4 5 6 7 8 9 10
Is there any Numbness or Tingling? Where? _____
Frequency of Pain: Constant Frequent Intermittent Occasional
Does the pain stay local to one area or does it travel to other areas of the body?_____
Anything that makes it feel better? Cold Heat Increase Activity Lying Down OTC meds
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Massage Nothing relieves the pain
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Prolonged Standing Stress Temperature Changes Twisting Sit to Stand Stand to Sit
Changing Positions Change Position in Bed Driving Getting Dressed Getting In/Out of Car
Lying Down Poor Posture Sitting at Desk Walking

Next area of complaint: _____
Describe the pain: Aching Burning Dull Sharp Stabbing Throbbing Stiff Weakness
Intensity of Pain: 1 2 3 4 5 6 7 8 9 10
Is there any Numbness or Tingling? Where? _____
Frequency of Pain: Constant Frequent Intermittent Occasional
Does the pain stay local to one area or does it travel to other areas of the body?_____
Anything that makes it feel better? Cold Heat Increase Activity Lying Down OTC meds
Posture Changes Prescribed Meds Rest Stretching Support Brace Chiropractic
Massage Nothing relieves the pain
Anything that makes it feel worse? Activity: heavy, moderate, light Bending Lifting Prolonged Activity
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Anything that makes it feel worse? Activity: heavy, moderate, light Bending Lifting Prolonged Activity Prolonged Standing Stress Temperature Changes Twisting Sit to Stand Stand to Sit Changing Positions Change Position in Bed Driving Getting Dressed Getting In/Out of Car Lying Down Poor Posture Sitting at Desk Walking

Do you have any scars? No Yes Where?_____

Have you had any recent visits to the hospital or urgent care? No Yes Why?_____

Please list any surgeries:

When:_____ What kind of surgery?_____

When:_____ What kind of surgery?_____

When:_____ What kind of surgery?_____

Please list any medications and supplements:

Name:_____ Taken for what?_____

Name:_____ Taken for what?_____

Name:_____ Taken for what?_____

Name:_____ Taken for what?_____

Name:_____ Taken for what?_____

Do you smoke? No Yes Have you ever smoked? No Yes When did you stop?_____

How many packs per day?_____ How many years have you smoked?_____

Do you drink alcoholic beverages? No Yes How often? _____

Do you drink carbonated beverages? No Yes How much and how often?_____

What is your daily water intake?_____

Please list any allergies you have: _____

Have you had any recent immunizations? _____

Do you exercise? No Yes What kind and how often? _____

Recreational activities: _____

Occupation: _____ How long? _____

Any other areas of concern today?_____

_____

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Name_____DOB_____

General

Have	Had		Have	Had		Have	Had	
		Recent weight gain			Recent weight loss			Fatigue
		Loss of sleep			Loss of appetite			Fever

Integumentary (Skin)

		Skin problems			Skin rashes			Psoriasis
		Eczema			Skin Cancer			Slow bleeding
		Discoloration			Change in moles			Scars
		Bruise easily			Itching			Sores

Neurological

		Lightheaded/dizzy			Fainting			Disorientation
		Weakness			Memory Loss			Concussion
		Loss of consciousness			Numbness			Difficulty speaking
		Headaches			Difficulty walking			Tingling
		Tremors			Parkinson's Disease			Epilepsy/Seizures
		Alzheimer's Disease			Disc Problem			Other _____

Eyes, Ears, Nose & Throat

		Vision problems			Glaucoma			Ear pain
		Sore Throat			Blurred Vision			Double vision
		Hoarseness			Mouth Sores			Nos e bleeds
		Ear noises			Dental Problems			Other _____

Cardiovascular

		Pain over the heart			Pressure over the chest			High blood pressure
		Heart attack			Pain down the arm			Pain in the jaw
		Low blood pressure			Profuse sweating			Irregular heartbeat
		Cardiomegaly			High triglycerides			High Cholesterol
		Nausea			Murmurs			Ankle swelling
		Vomitting			Feeling anxiety			Other_____

Hematologic (blood)

		Anemia			Bleeding disorder			Sickle Cell Anemia
		Lymphoma			Other_____			

Gastrointestinal

Have	Had		Have	Had		Have	Had	
		Gallbladder problem			Pain over stomach			Constipation
		Diarrhea			Blood in the stool			Liver trouble
		Burning in the stomach			Mucus in the stool			Hepatitis
		Ulcers			Hiatal Hernia			Pancreatitis
		Distress from greasy foods			Heartburn			Colon Cancer

Genitourinary

		Painful urination			Frequent urination			Kidney infection
		Blood in urine			Incontinence			Sexual difficulty
		Pain during sex			Loss of libido			Other _____

Musculoskeletal

		Arthritis			Osteoarthritis			Rheumatoid Arthritis
		Head injury			Neck injury			Back injury
		Osteoporosis			Scoliosis			Bone spurs
		Muscle spasm			Spinal trauma			Muscular Dystrophy
		Lupus			Broken Bones			Birth trauma
		Scheurmann's Disease			Spina Bifida			Compression fractures
		Joint pain			Spondylolisthesis			Other _____

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Allergy/Immunological

Have	Had		Have	Had		Have	Had	
_____	_____	**Catch colds easily**	_____	_____	**Frequent Sinus trouble**	_____	_____	**Frequent Influenza**
_____	_____	**Fever**	_____	_____	**HIV**	_____	_____	**AIDS**
_____	_____	**Allergies**	_____	_____	**Hay fever**	_____	_____	**Other**
Women Only								
_____	_____	**Irregular periods**	_____	_____	**Nipple discharge**	_____	_____	**Hot flashes**
_____	_____	**Premenstrual depression**				_____	_____	**Menstrual cramps**
_____	_____	**Lumps in breasts**	_____	_____	**Vaginal discharge**	_____	_____	**Ovary Removal**
_____	_____	**Abnormal PAP smear**	_____	_____	**Hysterectomy**	_____	_____	**Other**_____
Men Only								
_____	_____	**Burning on urination**	_____	_____	**Nightly urination**	_____	_____	**Prostate trouble**
_____	_____	**Difficulty starting urine**	_____	_____	**Dripping after urination**	_____	_____	**Prostate cancer**

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Financial Policy

Our care plan instructions are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Regardless of your coverage, care plan instructions will be based on the the chiropractic care you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE We offer a cash discount to be paid at time of service. We are happy to accept your check, cash or credit card.

GROUP OR INDIVIDUAL INSURANCE *Your insurance is an agreement between you and your insurance company, not between your insurance company and our office*. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:
1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to three months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

INSURANCE FORMS/PAYMENT If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

_____ ***If you are running late, please be courteous by calling or texting to let us know.***

_____ ***We ask that you please reschedule or cancel at least 24 hours before the beginning of your appointment or you will be charged a cancellation fee of 100% of the cost of your service.***

_____ ***Any cancelled and/or missed appointments will be charged full price of service and will result in pre-payment of services thereafter. For your convenience, you may leave a credit card on file. This fee is not covered by insurance companies.***

For your convenience, you may also schedule online at Fusion-Chiro.com.

_____ _____
Patient's signature (or guardian if patient is a minor) Date

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature: _____ Date:_____

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"ON THE JOB" INJURY (Worker's Compensation) If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

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1. Pay cash for your care and we will submit reports whenever necessary.
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I have read and understand the payment policy of Fusion Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Fusion Chiropractic and my insurance company. I request that Fusion Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Fusion Chiropractic that fees will be due and payable immediately.

Chronic cancellations or missed appointments without 24-hours notice will be subject to a non-refundable fee that is not covered by your insurance plan. The usual and customary fee is $25. You may be required to pre-pay for future appointments. Please call or text if you believe you will be late. For your convenience, you may also schedule online at Fusion-Chiro.com.

_____ _____

Patient's signature (or guardian if patient is a minor) Date