Dr. Deborah M. Brown, D.C. CHIROPRACTOR

FAMILY HEALTHCARE CLINIC, INC
2768 Five Forks Trickum Rd.
Lawrenceville, GA 30044
www.drdeborahbrown.com

TELEPHONE 770-978-4419
FAX 770-978-2017

August 25, 2011

Dear ,

Of all the chiropractic offices in our area, thank you for selecting ours. You're joining a growing number of residents who are choosing safe, conservative, chiropractic care.

I was twelve years old when first introduced to Chiropractic. My father injured his low back while working. His boss immediately suggested seeing a Chiropractor, but my father, a skeptic at the time said they are "Quacks" and I'll just give it some time, it'll get better. Three months later, and to the point of exhaustion from the severe pain, he went to see a chiropractor. He entered their office sideways. You see he was so bent over to the side from the pain that he actually had to turn sideways to fit through the door. After his first visit, he was able to sit with just slight pain, not excruciating, this gave my father hope and more than that, it opened up a window of alternative care that he never knew existed. We were all adjusted on his next visit, not because we had pain, but because my parents wanted our body to function at 100% enabling our health to soar! It was then that chiropractic became a lifestyle for our family.

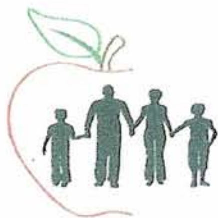
From middle through high school age, almost every project submitted, was done on chiropractic, health, nutrition, and wellness. In college, however, my path shifted to broadcast journalism and marketing. After graduating, I worked for WPCH-FM/WGST-AM to sell airtime. While on my way to work one morning, I was involved in a car accident. I had immediate neck pain. This brought me back to my chiropractor. When I walked out of the office after the first visit, I felt like a new person. My fatigue was gone, I was able to hold my head up without severe pain and I felt the life force in my body had returned! It was then that I realized what a gift it was to be able to use your hands to get people well. No drugs. No surgery – just your hands! I'm a chiropractor because I wanted to give people what I had received, their quality of life back.

Ours is a family practice. Since I was helped as an adolescent, I have a special interest in working with children. I am always delighted to help a youngster and possibly prevent some of the problems I see in our adult patients. Prevention makes a lot of sense, especially these days with the rising costs of disease treatment.

Congratulations on choosing chiropractic! Not only have you begun a program of care likely to help you with unwanted symptoms, it is one that addresses its underlying cause. For optimum results, follow the recommendations that have helped millions of chiropractic patients for over a century.

Warmest regards,

Dr. Deborah M. Brown



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770.978.4419 Fax770.978.2017

Dr. Deborah M. Brown

Consent for Treatment of a Minor

I (we) being the parent(s), legal guardian or custodian(s) of

_________________________________, a minor, the age of ________, do herby authorize, request, and direct Dr. Deborah M. Brown, and/or assigns, to perform, in her judgment, any and all necessary examinations, x-rays, and/or chiropractic treatment(s).

____
Please print minor patient's name

____
Please print parent/guardian's name

_________________________________ ____________________
Signature of parent/ guardian Date

Remarks:

____

____

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E-MAIL: drdeborahbrown@bellsouth.net

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

____________________ ____________________

Patient Name (printed) Relationship to patient

____________________ ____________________

Patient or legal Guardian Signature Date

____________________ ____________________

Witness Signature (office staff) Date

Dr. Deborah M. Brown, B.A.D.C.
Family Healthcare Clinic, Inc.

In order to accommodate the needs and requests of our patients, we are enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to know all of the individual requirements of each plan. Each plan has different stipulations in regard to payment for type of services. Example: initial exams, x-rays, manipulations, massage, etc. More importantly where those services may be performed. **Your insurance company decides all.**

Even with the same insurance company, the plans can differ depending on what type of contract your employer has negotiated.

Providing quality chiropractic care for our patients is our primary concern. We try to follow insurance guidelines as directed by your insurance company to us. However, you are responsible for payment not covered by your insurance company.

If services are provided and your coverage is not in effect on that day, the fees submitted and denied by your carrier will become your responsibility. We do use a collection agency for default of payments.

Your cooperation and help should allow you to receive all the benefits offered to you so we will be able to concentrate on your chiropractic needs.

I have read and understand the above office policy and agree to accept responsibility as described.

____

Print Name

____

Patient Signature Date

Patient Name: ______________________________ Date: ________________

Symptoms: Please check all symptoms which apply

LOW BACK
- [ ] Sharp stabbing pain
- [ ] Muscle spasms in low back
- [ ] Low back pain

HIPS, LEGS AND FEET
- [ ] Pain down leg
- [ ] Pain in buttocks
- [ ] Numbness
- [ ] Pins & needles sensation
- [ ] Leg cramps
- [ ] Knee pain

MID BACK
- [ ] Dull ache
- [ ] Sharp stabbing pain
- [ ] Pain around kidney area
- [ ] Muscle spasms in mid back
- [ ] Mid back pain

SHOULDERS
- [ ] Pain in shoulders
- [ ] Tension in shoulders

NECK
- [ ] Neck "pops"
- [ ] Neck muscle spasms
- [ ] Swelling in neck
- [ ] Stiff neck
- [ ] Pain in neck

HEAD
- [ ] Head feels heavy
- [ ] Dizziness
- [ ] Vertigo
- [ ] Light-headedness
- [ ] Severe headache
- [ ] Frequent headaches

RESPIRATORY
- [ ] Shortness of breath
- [ ] Wheezing
- [ ] Dry cough
- [ ] Coughing up blood
- [ ] Hard to breathe laying down
- [ ] Hard to sleep laying down

EARS
- [ ] Pain in ears
- [ ] Loss of hearing
- [ ] Vertigo
- [ ] Ringing in ears
- [ ] Discharge from ears

EYES
- [ ] Blurred vision
- [ ] Double vision
- [ ] Excessive tearing
- [ ] Eyes sensitive to light
- [ ] Itching

MOUTH AND THROAT
- [ ] Pain in throat
- [ ] Pain in mouth
- [ ] Abscessed teeth
- [ ] Difficult to swallow
- [ ] Dental work
- [ ] Bleeding gums

GASTROINTESTINAL
- [ ] Difficulty swallowing
- [ ] Indigestion
- [ ] Abdominal pain
- [ ] Nausea and vomiting
- [ ] Hemorrhoids
- [ ] Constipation
- [ ] Diarrhea
- [ ] Poor appetite

VENEREAL DISEASE
- [ ] AIDS
- [ ] Gonorrhea
- [ ] Syphilis
- [ ] Other

CARDIOVASCULAR
- [ ] Hypertension
- [ ] Fainting
- [ ] Chest pain
- [ ] Rapid heart beat
- [ ] Heart "jumps"
- [ ] Pounding heart beat

Patient Name: ___________________________________
Date: ___________________

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:
List Your Allergies to Medications/Environmental/Foods, Etc:

Consent for Treatment and Authorization to Perform X-Rays

By signing below, I authorize Dr. Deborah M. Brown to administer whatever treatment is deemed necessary to treat my problem or illness.

Executed this, the ________day of ____________________, 20___

Signed: ____

By signing below, I authorize Dr. Deborah M. Brown, if she deems necessary, to complete a radiographic examination in order to treat my present problem or illness. I understand that this includes taking X-Rays as deemed necessary.

Executed this, the ________day of ____________________, 20___

Signed: ____

For Women Only

To the best of my knowledge, I am not pregnant and Dr. Deborah M. Brown has my permission to X-Ray me for diagnostic interpretation.

Signed: ____

Dr. Deborah M. Brown, B.A., D.C.
Family Healthcare Clinic, Inc.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I,____, have been informed that a copy of the FAMILY HEALTHCARE CLINIC, INC. Notice of Privacy Practices is posted in the office. A copy will be furnished to me upon my request.

____ _________________________

Signature of Patient Date

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, or cell phone. However, we will confirm appointments by telephone. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I authorize Family Healthcare Clinic, Inc. to contact me at the following places:

Home telephone _____yes_____no Home #_____________________
Answering Machine _____yes_____no

Cell phone/Voice mail _____yes_____no Cell phone #_________________

Work telephone _____yes_____no Work #______________________

E-mail address _____yes_____ no ____________________________

Please list names of people with whom we may discuss your medical care:

Spouse Name_____________________________________ yes_____no_____

Parent Name_____________________________________ yes_____no_____

Other Name______________________________________ yes_____no_____

____ _________________

Signature of Patient/Guardian Date

Family Healthcare Clinic, Inc
Dr. Deborah M. Brown, D.C.

Patient's Name, please print ____ Today's Date ____________________

Using a scale of 1-10 (1=little or no pain; 10=most extreme or intense pain) rate the complaints(s) listed below.	
What is your major complaint?	Major Pain Rate:
List minor complaint(s):	Minor Pain Rate(s):
☐ I've had no symptoms since last visit.	How long have you had this condition?

Has anything aggravated your condition? ☐ Yes ☐ No

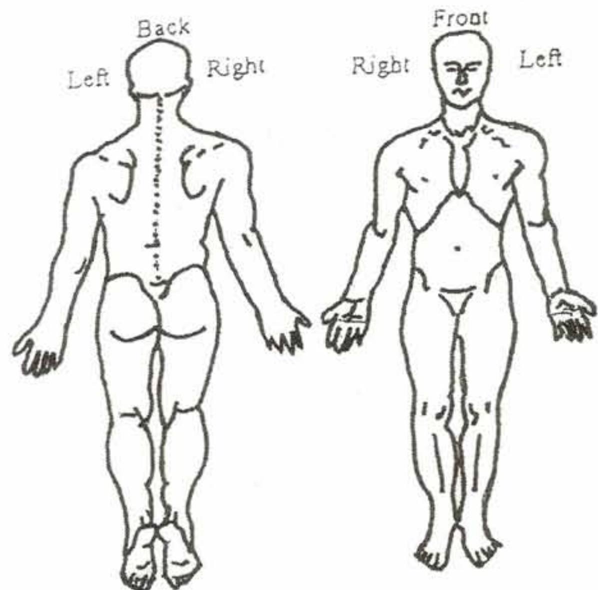
If yes, explain: ____

Is there anything else you feel Dr. Brown needs to know?

Please notify the receptionist if any personal information has recently changed.

Using the appropriate symbols, mark ALL areas of the body where you feel the described sensations

Burning x x x x x x x
Dull & Aching ***********
Numbness + + + + + + +
Pins & Needles ° ° ° ° ° ° ° °
Sharp / / / / / / / / / /
Weak > > > > > > >



Patient's Signature*

Parent/Legal Guardian Signature for treatment of a minor

*Your signature above indicates your responsibility for any/all charges incurred (and/or) which your insurance(s) does not pay or cover. Accounts with a 90 day past due balance will be assessed a 10% late fee. There is a $25 fee for all returned checks. Should it become necessary for legal collection action, your signature indicates agreement that any court proceedings will take place in Gwinnett County, Georgia, even if you should move out of the state of Georgia.

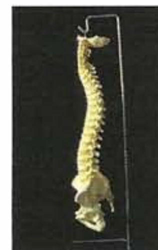
Next Appt: ________________ Doctor's Instructions: ____________________________________

WELCOME

Dr. Deborah Brown, D.C.

Family Healthcare Clinic, Inc

(Please Print)



Today's Date ____/____/____

PATIENT INFORMATION

Patient's Last Name First Middle	Age	Sex ☐ M ☐ F	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Birth Date	Home Phone No	Cell Phone No	Date of Last X-Ray	Are you Pregnant?

Street Address City State ZIP Code	Social Security	Email Address

Occupation	Employer	Employer Phone No.

Spouse Name	Spouse Social Security	Spouse Birth Date

Spouse Occupation	Spouse Employer	Employer Phone No.

Chose Clinic Because/Referred to Clinic by
(Please check one box & list name on line) ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital

❑ Family ____________ ❑ Friend ____________ ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________

Is this condition due to an accident or illness? If yes, give date. ____________

If this injury is the result of an automobile accident or job related injury/accident, inform receptionist and complete the Accident/Job Injury form.

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

The above information is true to the best of my knowledge. By signing below, I authorize Dr. Deborah M. Brown to administer whatever treatment is deemed necessary to treat my problem or illness. By signing below, I also authorize Dr. Deborah M. Brown, if she deems necessary, to complete a radiographic examination in order to treat my present problem or illness. I understand that this includes taking X-Rays as deemed necessary.

I understand that this will serve as an assignment of benefits for direct payment to Family Healthcare Clinic and/or Assigns. My signature authorizes the release of any/all information deemed pertinent to my case to any/all insurance companies, adjustors, attorneys or any party demonstrating a legitimate need for such records as determined by Family Healthcare Clinic. I fully understand and agree that all services rendered me are charged directly to me and are my sole financial responsibility and that insurance will be initially filed as a courtesy to me and in accordance with the information I have provided. I understand that should I suspend or terminate my care/treatment, any/all fees for services rendered will be due and payable in full.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

Cancellation Policy/After Hours Treatment

If you wish to cancel your appointment, you must do so within 24 hours of your appointment time, otherwise you will be charged a missed appointment fee of $30.00. We you ask you to please be courteous; everyone's time is valuable.

If you need to be treated after business hours due to a chiropractic emergency, Dr. Brown is glad to come in to the office and see that you receive the proper care necessary. Please be advised though, that the after hours treatment fee is $95.00 in addition to any services rendered, and this service is not billed to your insurance company and must be paid for when the services are rendered.

Patient/Guardian Signature ______________________________ Date ______________