

Patient Re-Activation Form – New Condition

Title: Dr. Mr. Mrs. Ms. Miss (check one) **Gender:** Male Female **Date:** _____ / _____ / _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Cell Phone: (_____) _____ - _____ **Preferred contact method:** Cell Phone Home Phone Work Phone

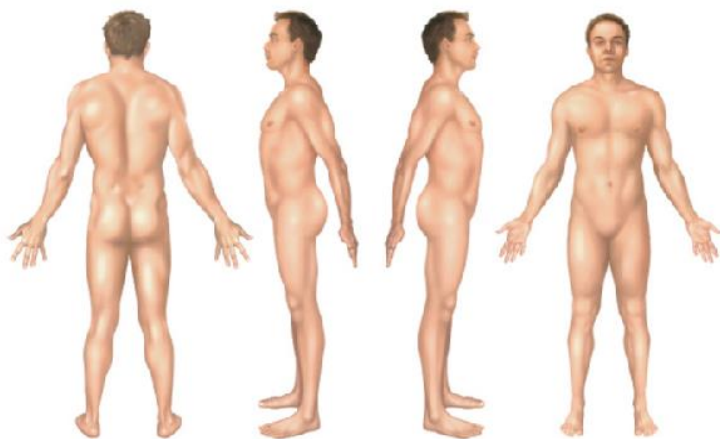
Email: _____

Primary Doctor: _____ **City:** _____ **State:** _____

When did your symptoms start or condition worsen? _____

What do you believe is causing your symptoms? _____

Please mark where your pain/symptoms are:



Please Grade your pain on a scale of 0-10:

And

[0= No Pain, 10= Extreme Pain]

Choose how Frequent the pain is present:

- **Neck:** 0 1 2 3 4 5 6 7 8 9 10
 Seldom - Intermittent - Frequent - Constant
- **Upper/Mid Back:** 0 1 2 3 4 5 6 7 8 9 10
 Seldom - Intermittent - Frequent - Constant
- **Lower Back:** 0 1 2 3 4 5 6 7 8 9 10
 Seldom - Intermittent - Frequent - Constant
- **Other:** _____
 0 1 2 3 4 5 6 7 8 9 10
 Seldom - Intermittent - Frequent - Constant

Circle the activities that aggravate your condition:

- | | | | | | |
|--------------|----------------|----------------|-------------|-------------------|------------------|
| • sitting | • standing | • walking | • bending | • stooping | • lifting |
| • sleeping | • sneezing | • coughing | • straining | • reaching | • twisting |
| • looking up | • looking down | • movement | • rest | • lying face down | • driving |
| • typing | • scooping | • house chores | • exercise | • lying face up | • stair stepping |

Other aggravating factors: _____

Circle activities that relieve your condition:

- sitting
- standing
- lying
- knees bent up
- support
- no movement
- movement
- heat
- ice
- topical gel
- ibuprofen
- medication
- rest
- stretching/exercising
- adjustments

Other relieving factors: _____

Circle which ones describe your symptoms:

- dull
- sharp
- throbbing
- burning
- deep
- aching
- tingling
- stabbing
- cramping
- numbness
- radiating
- stiffness

Other symptoms: _____

Have you ever had an auto accident or work injury? Yes No

- If so, Past Year Past 5 Years Over 5 Years
- If so, did you receive treatment? Yes No
- If so, please list treatment.

Have you seen any other providers for this condition? Yes No **List below who and when.**

Have you had any surgeries in the past 5 years? Yes No **List type and the date.**

Are you currently taking any medications? Yes No **List below.**

Have there been any changes to your health since your last office visit? Yes No

- Smoked/chewed tobacco? Yes No
- Allergies to Medications? Yes No
- Diagnosed with Hypertension? Yes No
- If Yes please explain changes below:
- Spinal Surgery Yes No
- Diagnosed with Diabetes? Yes No
- Diagnosed with Cancer? Yes No

Have you had any imaging taken since the last time you were seen in our office? Yes No

List below when and where:

For staff use (below):

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____

Verification Question: (chose only one question and provide the answer to the question selected)

- | | |
|---|---|
| <input type="checkbox"/> What is the name of your favorite pet? | <input type="checkbox"/> What street did you grow up on? |
| <input type="checkbox"/> In what city were you born? | <input type="checkbox"/> What was the make of your first car? |
| <input type="checkbox"/> What high school did you attend? | <input type="checkbox"/> When is your anniversary? |
| <input type="checkbox"/> What is your favorite movie? | <input type="checkbox"/> What is your favorite color? |
| <input type="checkbox"/> What is your mother's maiden name? | |

Verification Answer to the chosen question: _____

Patient Signature: _____ **Date:** _____

What is a verification question used for?

The verification question chosen above will be used to connect you to your Health Record using our patient portal.

How can I access this Patient Portal?

After your initial visit, we will enter this question you have selected as well as an email address that you have provided. You will then receive a registration email explaining how you can register. You must register for an account. This ensures that only you know your login credentials and helps to maintain the security of your data. If you do not receive a registration email please follow the simple steps below:

>Go to <https://portal.fh-cloud.com>

>On the login page, click the **Register Account** link below the **Sign In** Button.

>Complete the form. (Hint: Your email address is your username. Be sure to use the same email address that your provider has on file.)

>Click Sign Up

>Check your email for a Registration Code link. Click it to go to the Registration Validation page.

>Enter your password and click **Validate Registration**.

What is a Patient Portal?

Your patient portal is your link to information supplied by your healthcare provider. Here, you can download documents that your provider sends to you, exchange secure electronic messages with your provider, and download educational resources that your provider makes available to you.

How do I navigate through the portal?

Once you have successfully logged into the Patient Portal you will notice that everything is blank. On the left hand side you will find a tab that says **Manage**. Selecting this tab you will then need to select **Clinic Links**. You will then find our clinic listed. Once you hit **Approve** it will prompt you to enter the answer for the Verification Question you selected. After the clinic has been linked, you can now view documents under your **Dashboard** tab.

What if I forget my password?

Click the **Forgot Password** link on the login screen then enter your email address. Portal emails you a temporary password. Use it to login and reset your password.

If you have any further questions in regards to linking our clinic or how to download and view documents, we have sent please feel free to ask at your next appointment and we would be happy to assist.

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Authorization, Consent and Release

I consent and authorize the providers of Atlantic Chiropractic Associates, P.A. to examine and/or treat me / my child/legal dependent, if patient is a minor, today and during future office visits.

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me / my dependent during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay benefits directly to Atlantic Chiropractic Associates, P.A., for the services rendered. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all co-pays, deductibles, and any other subscriber liabilities at the time that services are rendered, as are allowable.

Signature of Patient or Parent/Guardian of Minor Patient Date

Financial Policy

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.** For your convenience, we accept Visa and MasterCard.

Your Insurance

We have made prior arrangements with many insurers and health care plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event that your health coverage plan determines a service to be "not covered," **you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not participate, **payment is expected at the time that services are rendered.** We will provide you with a receipt from our office for you to submit to your insurance carrier. Your insurance company should then send the payment directly to you.

Missed Appointments

In order to provide the best possible service and availability to all our patients, there may be a \$15.00 fee for any doctor appointment not canceled at least 24 hours in advance. Also, due to the scheduling of massage therapy, there may be a fee of 75% of our regular massage charges for appointments not canceled at least 24 hours in advance. Please call us as early as possible if you know you will need to reschedule your appointment. More than three (3) "no show" appointments without a valid reason may result in discharge from our practice.

I have read and understand the financial policy of the practice; and, I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Acknowledgment of Privacy Practices

Our practice is committed to protecting privacy and confidentiality. With my consent, Atlantic Chiropractic Associates, P.A., may use and disclose Protected Health Information (PHI) about me or my dependant to perform treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices of Atlantic Chiropractic Associates, P.A. for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

Signature of Patient or Parent/Guardian of Minor Patient Date