Gabella Brain and Spine Clinic

P: (678) 902-4827 Fax: (678) 757-4633 Email: Dr.Gabella@gabellabrainandspineclinic.com
49 Long Island Terrance Atlanta, GA 30342

Patient Information

Name: _____
Last First MI

Mailing Address: _____ City _____ ST. . ZIP _____

Phone# (H)_____ (M) _____

Date of Birth: _____ Sex: ☐ Male ☐ Female SS#:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Employer:_____ Phone:_____

Email _____Can we leave a voicemail/message? ☐ Yes ☐ No

Who referred you to our practice? _____ ☐ Insurance Book ☐ Internet

Emergency contact: Name:_____ Relation:_____

Phone: (H)_____ (W)_____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other_____

Has it been reported? ☐ Yes ☐ No If yes to whom?_____

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 _____

We can not file your insurance if this section is left uncompleted and the bill will be sent to you.

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

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_____

HIPAA

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

PATIENT SIGNATURE (X)_____ DATE_____

HEALTH HISTORY

Who is your primary care physician (doctor and/or practice)? _____

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

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ 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:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ 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
- ❑ Other _____
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough

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 any allergies: _____

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

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- ❑ Heart Disease _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Depression _____
- ❑ High Blood Pressure _____
- ❑ Stroke _____

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

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a cervical pillow? ☐ Yes ☐ No

What is your daily/weekly intake of the following?

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

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 _____

Current Symptom(s)

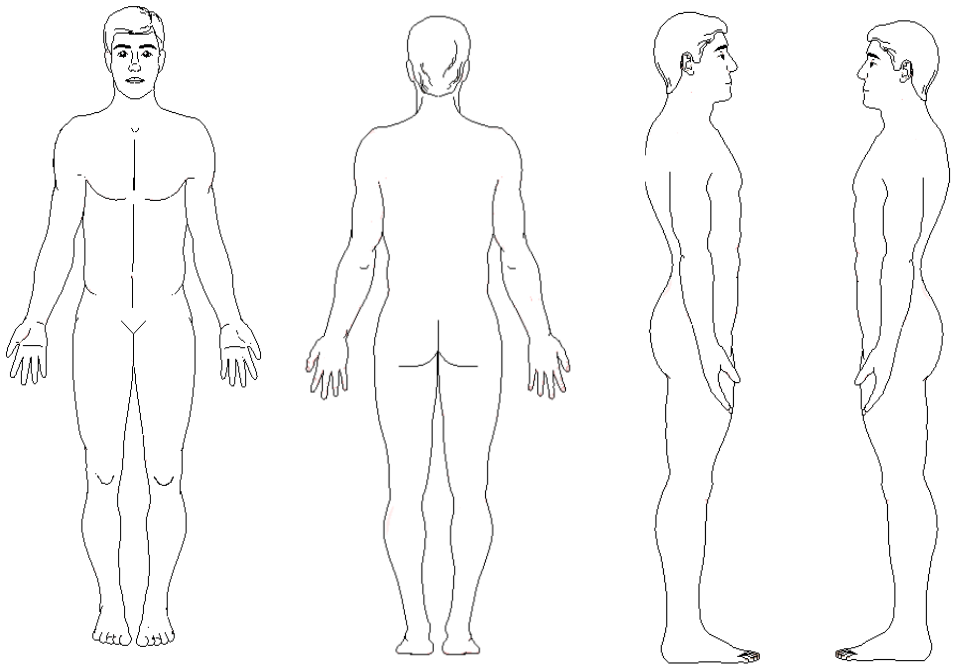
NAME: _____ DATE: _____

Reason for visit_____

_____

*** PLEASE USE THE LETTER (S) BELOW TO MARK THE DRAWING(S) WITH THE LOCATION AND TYPE OF SENSATIONS YOU ARE EXPERIENCING. PLEASE MARK ALL SYMPTOMS THOUROUGHLY SO WE CAN BETTER ASSIST YOU**

KEY:
P = Pain
D = Dull
N = Numb
B = Burning
T = Tingling
SH= Shooting
TH= Throbbing
O = Other
M = Muscle Spasm



* 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

When did you first notice the symptoms?_____

Did anything cause the pain/symptoms?_____

Is the pain: ☐ Constant OR ☐ intermittent (Come and Go)

Is it getting progressively worse? ☐ No ☐ Yes

Type of Pain? ☐ Tight ☐ Stiff ☐ Ache ☐ Sharp ☐ Shooting
☐ Throbbing ☐ Burning ☐ Dull ☐ Numb ☐ Tingling ☐ Other

Does anything make it worse?_____

Does anything make it better?_____

Does it radiate? ☐ No ☐ Yes ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

Do you experience the pain at a particular time of day?_____

Do you experience night pain? ☐ No ☐ Yes, explain_____

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?_____

PATIENT SIGNATURE (X)_____ DATE_____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME _____ DATE _____

For any YES answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment: _____
12. Do you have difficulty maintaining your balance? NO YES
    Comment: _____
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment: _____
14. Do you suffer from a reduced hearing capacity? NO YES
    Comment: _____
15. Do you suffer from ringing in your ears? NO YES
    Comment: _____
16. Do you have bladder or bowel control problems on a regular basis? NO YES

Comment: _____

Gabella Brain and Spine Clinic

Dr. Angela Gabella DC, DACNB, FABBIR
4930 Long Island Terrace Atlanta, Ga 30342 (678) 902-4827

PATIENT HEALTH INFORMATION CONSENT FORM

Gabella Brain and Spine Clinic wants you to know how your Patient Health Information (PHI) will be used in this office and what your rights are concerning those records. Before we will begin any health care operations we require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like more details please request a **HIPPA PRIVACY NOTICE** available at the front desk, before signing this consent.

1. The patient understands and agrees to allow Gabella Brain and Spine Clinic to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Our office will limit the release of all PHI to the minimum needed for correspondence with other healthcare providers and insurance companies.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request corrections and to know what disclosures have been made and may submit, in writing, any further restrictions on the use of their PHI. However, changes and restrictions made and agreed to by us must be within the scope of State and Federal laws.
3. The patient's written consent need only be obtained one time for all subsequent care given at Gabella Brain and Spine Clinic.

4. The patient may provide a written request to revoke consent at any time during their care. Please note: this request would only apply to records from the date of the request forward, and does not include use of records prior to the request.

5. Gabella Brain and Spine Clinic may contact you periodically regarding appointments, treatments, products, services, payments, or charitable work performed. You have the right to "opt-out" of any marketing or fundraising communications at any time.

6. Gabella Brain and Spine Clinic enforces the "right to privacy". All our staff is trained in handling patient records and enforcing privacy. A privacy official has been designated to ensure those procedures are implemented and adhered to in our office. Your records are not readily available to those who do not need them.

7. The patient has a right to file a formal complaint with our privacy official and with the Secretary of HHS about any possible violations of these policies and procedures, without retaliation by Gabella Brain and Spine Clinic.

8. Gabella Brain and Spine Clinic reserves the right to make changes to this notice and make new notice provisions effective for all protected health information that it maintains. If changes are made, you will be provided with the new notice.

9. Refusal to sign this consent may result in Gabella Brain and Spine Clinic's right to refuse care.

I, _____ (patient name or patient representative), have read and understand how my PATIENT HEALTH INFORMATION (PHI) will be used and agree to the above policies and procedures.

_____ _____

Patient or Patient Representative's Signature Date

Gabella Brain and Spine Clinic

Dr. Angela Gabella DC, DACNB, FABBIR

4930 Long Island Terrace Atlanta, Ga 30342 (678) 902-4827

POLICY ON PATIENT ACCOUNTS AND CONDITIONS OF TREATMENT

Gabella Brain and Spine Clinic is a private institution that operates for the benefit of people who seek the services of our medical staff. We provide quality care at what we believe to be a fair and reasonable fee. Since we do not receive financial assistance from any outside source we must recover the cost of providing services for our patients. It is our policy, that the responsibility of paying for care, will be placed upon those who receive it; therefore, all accounts will be under the following guidelines:

1. **Missed Appointment(s)**: If you are unable to keep a scheduled appointment we require sufficient time (24 hours) to fill that time spot. If you **NO SHOW** or do not call 24hrs in advance, you may be charged a **$40** fee, which is at the discretion of Gabella Brain and Spine Clinic.

2. **Cost of Service**(s): The cost of service(s) rendered varies based on the extent, focus and testing required at your visit. Some of the services or supplies offered or suggested by this office may be considered non-covered items under your insurance plan; you will be held responsible for these services and /or supplies at the time of service. A fee schedule is available at the front desk

3. **SELF-PAY**: Any self-paying patient will be required to pay charges for their visit and the obligation to pay for medical services may not be deferred for ANY reason. A 20% discount is offered to self-pay patients at the “time of service” (same-day). However, if payment is not made at the “time of service” the FULL amount will be billed.

4. **Payment Options:** Payment options include cash, check, visa, mastercard, American express, money order, traveler check or certified check and insurance. If you have special financial needs please discuss this with the billing department to see if you qualify for a payment plan or an extension of credit terms. Interest accrues on all charges not paid after 30 days of the first bill, at a rate of 1.5% per month (18% per year) until paid in full (ORS 30.701).

5. **Account Balance:** If you have a balance on your account you will receive monthly statements until the account is paid in full. Bills are due and payable upon receipt of your statement.

6. **INSURANCE:** We will bill your insurance carrier as a courtesy to you. **Your insurance contract is an agreement between you and the insurance company. As the subscriber/member you are responsible for the terms of that agreement.** Your insurance should make payments directly to this office. The member is responsible for any deductibles, co-payments, co-insurance and /or other patient balances not covered by insurance. This service does not guarantee payment for your treatment and as the insured member, you are ultimately responsible for all charges incurred.

7. **Medicare:** We do not accept Medicare, Medicare supplement or affiliates, nor can we accept patients who are currently Medicare members, even though they may wish to self-pay. Please see the list of insurance we do not accept.

8. **Authorization for disclosure of information:** I _____ hereby authorize, Dr. Angela Gabella and her team, to disclose all or part of the medical record of (**patient’s name**) _____ to any company that may be responsible for payment of all or part of this patient’s medical charges. Disclosure of records may be necessary to determine eligibility for liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing except to the extent that Gabella Brain and Spine Clinic has already taken action on my claim.

_____

PRINT PATIENT’S NAME

X_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Gabella Brain and Spine Clinic

Dr. Angela Gabella DC, DACNB, FABBIR

4930 Long Island Terrace Atlanta, Ga 30342 (678) 902-4827

INFORMED CONSENT FOR CHIROPRACTIC FUNCTIONAL NEUROLOGY TREATMENT

I, _____ (responsible parties name), consent to the performance of chiropractic functional neurology treatments and **any other associated procedures**: physical examinations, tests, diagnostic x-ray, physio-therapy, physical medicine, physical therapy procedures, massage therapy etc, on me, by the doctor of chiropractic and or his assistants and/or his other licensed practitioners within Gabella Brain and Spine Clinic.

**I understand, as with any health care procedures, that certain complications may arise during chiropractic functional neurology treatments.

Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complication and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) at Gabella Brain and Spine Clinic, and/or with office personnel, the nature and purpose, as well as, risks of chiropractic functional neurology treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic functional neurology treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic functional neurology and neurology procedures at this health care clinic. I have decided, freely and voluntarily, that it is in my best interest to receive chiropractic functional neurology care. I give my consent to that treatment. This consent will cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____

PRINT PATIENT NAME

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

_____ _____

WITNESS SIGNATURE DOCTOR SIGNATURE

Gabella Brain and Spine Clinic
Dr. Angela Gabella DC, DACNB, FABBIR
4930 Long Island Terrace Atlanta, Ga 30342 (678) 902-4827

EMAIL CONSENT FORM

Gabella Brain and Spine Clinic offers our patients the ability to communicate with us via email. However, email is not always the most secure and confidential way of communicating. This being said, due to HIPPA regulations, we need the consent of our patients before we are able to send or receive any emails including but not limited to; chart notes, ledgers, appointments, intake and history information, x-ray lab results, etc.

Please initial ALL of the following:

_____ I understand that all emails are not 100% secured and that Gabella Brain and Spine Clinic is not liable.

_____ I give my consent to communicate by email with Gabella Brain and Spine Clinic.

_____

OFFICE MANAGER

X_____ _____

SIGNATURE OF PATIENT DATE

FINANCIAL AGREEMENT FOR PRIVATE HEALTH INSURANCE

I understand that my copay is ____ per visit and will be paid at time of service.

I understand that I am responsible for my insurance deductible and coinsurance.

I understand that it is my responsibility to inform Gabella Brain and Spine Clinic of any changes with my insurance coverage.

I understand that supplements and products are not a covered benefit under my private health insurance, and must be paid at the time they are purchased.

_____ _____

OFFICE MANAGER DATE

X_____ _____

SIGNATURE OF PATIENT DATE