ATHLETIC INJURIES OF ATLANTA

DR. COLLEEN M. PIO Ph: 770-521-5566 Fax: 888-255-0268 -2785 Buford Hwy, Ste. 102B, Duluth, GA 30096 Appt@AIOA.Net

PLEASE COMPLETE AND SIGN ALL FIVE (5) PAGES AS APPLICABLE

PATIENT INFO

FIRST NAME:	LAST NAME:		DATE: / /
PATIENT DATE OF BIRTH:	AGE:	GENDER: **M F**	MARITAL STATUS: **M S D SEP**
PRIMARY CARE PHYSICIAN:	REFERRED BY:		
STREET ADDRESS:	CITY:		STATE: ZIP:
PHONE- CELL:	HOME:		WORK:
EMAIL:	@		
EMERGENCY CONTACT:	PHONE:		RELATIONSHIP:

HISTORY

1. Describe your current complaint and how the problem began: _____
   How long have you had this condition? _____ Date of Onset: / /
2. How would you describe the pain?
   □ SHARP □ SORENESS □ THROBBING □ TINGLING □ DULL □ STIFFNESS
   □ SPASM □ BURNING □ ACHE □ WEAKNESS □ NUMBNESS □ SHOOTING
3. How would you rate the intensity of your pain? (Select the appropriate number)
   0 1 2 3 4 5 6 7 8 9 10
   (NO PAIN) (MODERATE PAIN) (TERRIBLE/UNBEARABLE PAIN)
4. How often is the pain present?
   Constant (81-100%) □ Frequent (51-80%) □ Occasional (26-50%) □ Intermittent (25%Or Less)
5. Since your problem began is the pain:
   □ Getting Worse □ Getting Better □ Staying The Same
6. What makes your problem better?
   □ Nothing □ Walking □ Standing □ Sitting □ Moving Around/Exercise □ Lying Down □ Inactivity
7. What makes your problem worse?
   □ NOTHING □ WALKING □ STANDING □ SITTING □ MOVING AROUND/EXERCISE □ LYING DOWN □ INACTIVITY
8. Are you currently taking any medications? Yes No
   If yes, please describe:
9. Were you previously treated for an earlier occurrence of this same condition? YES NO
   If yes, by whom? □ MD □ CHIROPRACTOR □ PHYSICAL THERAPIST □ OTHER _____
   Approx. dates, treatment type, results?
10. What is your physical activity at work?
    □ MOSTLY SITTING □ LIGHT MANUAL LABOR □ MODERATE MANUAL LABOR □ HEAVY MANUAL LABOR
11. Do you exercise?
    □ NO REGULAR EXERCISE □ 1-2TIMES A WEEK □ 3-4TIMES A WEEK □ 5-7TIMES A WEEK □ CARDIOVASCULAR
    □ STRETCHING □ WEIGHT MACHINE □ FREE WEIGHTS □ SPORTS (LIST TYPE)
12. What is your present general stress level:
    □ NO STRESS □ MINIMAL STRESS □ MODERATE STRESS □ GREATLY STRESSED
13. Is your problem affecting your ability to work or do other routine daily activities?
    □ NO EFFECT □ LIMITED PHYSICAL RESTRICTIONS, BUT FUNCTIONAL □ NEED ASSISTANCE WITH DAILY ACTIVITIES □ CANNOT WORK

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Past or Present Symptoms, Conditions or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

SYMPTOM	PAST	PRESENT	SYMPTOM	PAST	PRESENT
NECK PAIN	☐	☐	HIGH BLOOD PRESSURE	☐	☐
SHOULDER PAIN	☐	☐	HEART CONDITION	☐	☐
ARM/ELBOW PAIN	☐	☐	RESPIRATORY CONDITION	☐	☐
HAND PAIN	☐	☐	DIGESTIVE PROBLEMS	☐	☐
UPPER BACK PAIN	☐	☐	KIDNEY/BLADDER PROBLEM	☐	☐
LOWER BACK PAIN	☐	☐	MENSTRUAL PROBLEMS	☐	☐
PAIN IN UPPER LEG OR HIP	☐	☐	BREAST SORENESS/LUMP	☐	☐
PAIN IN LOWER LEG OR KNEE	☐	☐	SINUS CONDITIONS	☐	☐
PAIN IN ANKLE OR FOOT	☐	☐	ALLERGIES/ASTHMA	☐	☐
JAW PAIN	☐	☐	CANCER	☐	☐
SWELLING/STIFFNESS OF JOINTS	☐	☐	STROKE	☐	☐
HEADACHES	☐	☐	EXCESSIVE WEIGHT LOSS/GAIN	☐	☐
DIZZINESS	☐	☐	SKIN CONDITION	☐	☐
FAINTING SPELLS	☐	☐	ARTHRITIS	☐	☐
CONVULSIONS	☐	☐	DIABETES	☐	☐
GENERAL PROLONGED FATIGUE	☐	☐	PROSTATE CONDITION	☐	☐
CONDITION OF UTERUS/OVARIES	☐	☐			

TOBACCO USE:
☐ PAST ☐ PRESENT ☐ OCCASIONAL
☐ MODERATE ☐ HEAVY

ALCOHOL USE:
☐ PAST ☐ PRESENT ☐ OCCASIONAL
☐ MODERATE ☐ HEAVY

CAFFEINE USE: (COFFEE, TEA, COLAS)
☐ PAST ☐ PRESENT ☐ OCCASIONAL
☐ MODERATE ☐ HEAVY

PREGNANCY(IES):
☐ VAGINAL ☐ C-SECTION #_____

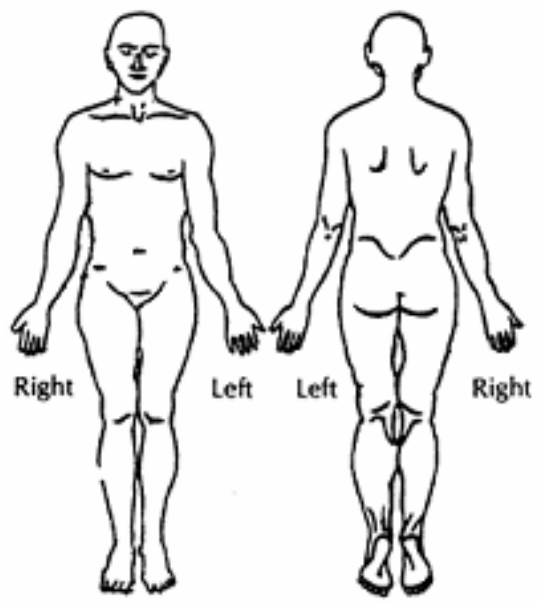
SURGICAL PROCEDURES/ DATE
1:_____/_____
2:_____/_____
3:_____/_____

Comments:

_____

_____

_____



× **Please shade in the figures to the left where you have pain or other symptoms.** *(You cannot modify the drawing, but please give this info to the doctor on your first visit.)*

I have reviewed the information on this form with the patient.

_____
Patient Name

_____
Providers Initials Date

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Authorizations

NAME _____ **CASE#** _____

1. CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Dr. **Colleen M. Pio** and whomever she may designate as her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account.

HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

2. AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize _____ to release any medical information pertinent to my treatment plan to my primary care physician or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to **Athletic Injuries of Atlanta, LLC.** is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

3. REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to ATHLETIC INJURIES OF ATLANTA, LLC. the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

4. X-Ray/Medical Records Release

I have requested the release of records of (patient's name)_____ which are a part of the records at (facility) _____ I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstract or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning that I may have had in the past, now have, or may have in the future. Please forward this to **Athletic Injuries of Atlanta, LLC.**, located at: **330 Prospect Place, Alpharetta, GA 30005.**

5. CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. **Colleen M. Pio** and whomever she may designate as her assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as she deems necessary to my:
(indicate relationship of child) _____ (child's name) _____

Guardian's Signature_____ Date_____ Witness_____

1. CONSENT FOR TREATMENT
2. AUTHORIZATION TO RELEASE MEDICAL INFORMATION
3. REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE
4. X-Ray/Medical Records Release
5. CONSENT FOR TREATMENT OF MINOR

Patient's Signature_____ Date_____ Witness_____

BY MY SIGNATURE(S) I CERTIFY: I AM THE RESPONSIBLE PARTY AND HAVE READ AND AGREE TO THE AUTHORIZATIONS LISTED ABOVE

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FINANCIAL POLICY

Print Patient name_____

(Please initial after each number)

1. _____It is the responsibility of the patient to confirm that the physician is on the insurance plan. Our office will file claims to your insurance company for professional services rendered.

2. _____Please remember, **INSURANCE COVERAGE IS A LEGAL CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY**. Benefits may differ depending upon what type of contract you have with the carrier on your behalf. It is NOT possible for our staff to keep track of the individual requirements of each plan.

3. _____If the patient's insurance plan requires a referral. It will be patient's responsibility to obtain this **PRIOR** to being seen by the practice.

4. _____ If the patient cannot keep the scheduled appointment, it is the patients responsibility to give our office at least 24 hours cancellation notice. There will be a **$ 50.00** for patients canceling with less than 24 hours notice.

5. _____We require payment in full for your portion at the time of service. Our office accepts Visa, MasterCard, Discover, checks, cash, and money orders. If a check is returned from your bank, there will be a **$ 40.00 return check fee** added. Ultimately, you are responsible for all charges incurred in our office.

6. _____Accounts are past due after non-payment 120 days from date of service. Accounts turned over to collections will be charged a **$ 50.00** processing / filing fee as well as a fee of **40** % of your balance added to your account that you will be responsible for.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED.

_____ _____

Patient, legal guardian or responsible party signature Date

Please note: Showing proof of insurance by presenting an insurance card, etc. does not guarantee payment of your bill / account. You will be responsible for any denied claims, annual deductibles, and copayments, coinsurance, charges for any non-covered, etc. The patient / insured are responsible for understanding the terms of coverage provided by their insurance company. The patient / insured are always responsible for the services rendered and charges incurred, regardless of any dispute with the insurance company.