Integrative Healthcare of Atlanta

Patient Application Form

WELCOME TO OUR OFFICE. We specialize in assisting people to achieve their highest level of health through our unique and advanced protocols.

It is very important that you fill out the New Patient Paperwork completely. If there is a question that does not apply to you, please write N/A. The doctor will use this information and the information from your consultation to determine if you are a good candidate for care in our office.

I agree and understand that should I receive a consultation on my case as outlined in this paperwork, that Dr. Lawrence is assessing my case on the basis of her chiropractic license. I agree and understand that it is my responsibility to seek appropriate medical care in such cases. I verify that the information I have provided is truthful to the best of my knowledge.

_____ **Today's Date:**_____/_____/_____

Print Name

_____

Sign Name

PLEASE BRING ALL COMPLETED PAPERWORK TO YOUR SCHEDULED APPOINTMENT. YOU MAY ALSO EMAIL PAPERWORK TO: FRONTDESK@IHCOA.COM
OR FAX TO: 678-804-6450 ANY LABS/DIAGNOSTIC TESTING IN THE LAST 12 MONTHS.

IF YOU HAVE LABS OR DIAGNOSTICS (MRI/CT/ULTRASOUND/X-RAY), PLEASE PROVIDE THOSE DOCUMENTS PIROR TO YOUR APPOINTMENT.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may have to disclose your health information to Science Based Nutrition™ to obtain test results and reports.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy for our privacy notices.

I authorized Integrative Healthcare of Atlanta to contact me with information related to my personal health needs and interests. The physician's office may use any phone number or email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine or voice mail service. I may be contacted about the following:

- Appointment reminders or schedule changes.
- Information about alternative treatments, presentations or events
- Other health related information that may be of interest to me

To contact me, I _____ authorize Integrative Healthcare of Atlanta to use and disclose the following information:

- My Name, Address, Email and Phone Numbers
- The Name of my Physician and the Clinic where I was treated

NOTE: NO DIAGNOSIS OR TREATMENT INFORMATION WILL BE USED OR DISCLOSED.

Patient Name: _____ Date of Birth:_____
(PLEASE PRINT)

Address of Patient:_____ Phone:_____
(STREET)

_____ Email:_____
(CITY, STATE, ZIP CODE)

Integrative Healthcare of Atlanta fully supports the protection of health information. Only the physician and office staff will use this information to contact you. While we retain the standard rights of disclosure as provided under HIPAA, this authorization allows us to access only the above authorized information for contact purposes.

This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time or request to receive a copy of the protected health information to be used by writing Practice Name and Address Here. In this case, every effort will be made to discontinue future communications.

_____ _____

Signature (PATIENT OR PERSON AUTHORIZED) Date

Nutrition Patient Questionnaire

Date:_____ Height_____ Weight_____

Name_____ Date of Birth_____

Address_____ City/State_____

E-Mail _____ Zip Code _____

By documenting your email address on this page, you are agreeing that health information for yourself can be freely shared via email between yourself and Integrative Healthcare of Atlanta. While usually considered safe, email is not the most secure method of sharing personal information.

Telephone: Home_____ Work_____

Place of Employment_____ Occupation_____

Married_____ Single_____ Divorced_____ Widow(er)_____ # of Children_____

Spouse's Name_____ Place of Employment_____

In case of emergency, who should we contact?
Name_____ Phone_____ Relationship_____

How did you hear about our office?_____

Patient's Signature_____ Date_____

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above.

Signature_____ Date_____

Harbins Healthcare Inc.

Dr. Natalie Lawrence, D.C.
1342 Auburn Rd., Suite 114
Dacula, GA 30019
770-237-5534 phone
770-237-5532 fax

WELCOME: Dr. Lawrence is honored to be a part of your journey to achieve better health. This consent outlines our practice, policies and your consent to care.

FUNCTIONAL HEALTH: Doctors of Chiropractic practicing in a functional health model view health as a continuum from optional health to hidden imbalances to disease. Rather than treating disease (e.g. cancer, hypothyroid or multiple sclerosis), we address underlying metabolic, physiologic and functional imbalances, intervening at root causes. One effect may be the ability to reduce or eliminate the need for medications which must be done by your prescribing provider. As Doctors of Chiropractic, we do not prescribe drugs or perform surgery. Therefore, all changes to prescription medications must be made by your prescribing provider.

ALTERNATIVES: Alternatives include doing nothing, relying solely on drug therapy, or consulting with other providers. Chiropractic is a branch of the healing arts distinct from other branches (e.g. nursing, osteopathic, or allopathic). I understand that the doctors in this practice are Doctors of Chiropractic who have post graduate education in functional endocrinology functional neurology and clinical nutrition. Nonetheless, we encourage you to communicate with your other health providers about the care you receive.

RISKS: Nutritional remedial measures and supplements used in our practice are generally considered safe, however, they may involve some risks including, without limit, changes in blood sugar or gastrointestinal upset. They may also interact with certain drugs and may be inappropriate during pregnancy. Chiropractic adjustment involves some risks including, without limit, fractures, disc injuries, dislocations and sprains. Additionally, hidden conditions may exist that are not detectable through x-ray or physical or neurological exams. This may include spinal tumors, weak or occluded arteries and aneurysms. Accordingly, there are some people that are at risk for stroke or vascular injuries.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case as care may not improve your condition or result in reducing medications. We can, however, speak of our experience treating functional imbalances and the success seen in our office has been excellent. Success includes documents subjective or objective functional improvement.

PAYMENT, INSURANCE AND REFUNDS: Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Often, we will not know if an insurer will cover any costs until we send a bill. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services whether or not they are covered by insurance. Prorated fees for unused, prepaid services will be refunded if you wish to cancel; however, no refunds are available for any product purchases.

QUESTIONS AND ANSWERS: I have read and fully understand this consent form and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND

_____ _____

Patient or Person with Authority to Consent **Date**

INTEGRATIVE HEALTHCARE OF ATLANTA

CHIROPRACTIC INFORMED CONSENT

1. **PROCEDURE:** I authorize the Doctor of Chiropractic to perform chiropractic adjustment to correct misalignments and to compliment the body's natural healing processes.

2. **ALTERNATIVES:** Alternatives include doing nothing. Additional alternatives include consulting with a medical doctor for medical interventions.

3. **RISKS:** This consent is given with understanding that chiropractic treatment involves some risks including, without limit, fractures, disc injuries, dislocations, and sprains. Additionally, hidden conditions may exist that are not detectable through x-ray or physical or neurological exams. This may include spinal tumors, weak or occluded arteries, and aneurysms. Accordingly, there are some people that are at risk for stroke or vascular injuries.

4. **NO GUARANTEE:** I understand that every individual responds to care differently. I understand that no guarantee or assurance has been made as to the results of chiropractic care and that it may not improve my condition. Nonetheless, I desire to proceed.

5. **QUESTIONS AND ANSWERS:** I have read and fully understand this consent form, and understand that I should not sign this form if all items, including all my questions, have not been explained to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND THIS FORM!

_____ _____

Patient or Person with Authority to Consent Witness

_____

Signature

_____ _____

Date Date

DOCTOR DECLARATION: I have explained the contents of this document to the patient or person with authority to consent and have answered all their questions. To the best of my knowledge, they are adequately informed and have consented to the above procedure.

_____ _____

Doctor's Signature Date

INTEGRATIVE HEALTHCARE OF ATLANTA

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date