

## **Lanier Chiropractic and Rehabilitation Information**

**4530 Nelson Brogdon Blvd., Suite B, Sugar Hill, GA 30024  
770-271-8949**

**Thank you for choosing Lanier Chiropractic and Rehabilitation!**

**It is our desire to help you achieve and maintain the healthiest lifestyle possible. Please feel free to ask us about any and all issues concerning your care.**

**Our office is open: Monday through Thursday 9:00 AM to 7 PM  
Closed on Friday  
Saturday 9 AM to 1 PM  
Available for Emergencies**

**Our initial office visit involves a thorough head to toe exam. The doctor will evaluate you on chiropractic, orthopedic and neurological levels. We do not take x-rays in this office. If upon examination the doctor feels an x-ray is warranted, we will make arrangements for you to receive those. Please bring with you any recently taken x-rays for the doctor to review. After your exam, the doctor will explain what you need, and how chiropractic care can benefit you. Your first adjustment will be given on the first visit unless your condition indicates otherwise. Doctor Seebach uses a "hands-on" approach and will explain every step to you during your treatment. Other modalities are available for your care if needed. These include Ultrasound, Laser, and Interferential treatment, to name a few. Dr Seebach is also versed in many different techniques to specifically treat your condition.**

**A financial policy is a necessary part of any business. It is our desire to operate as efficiently as possible. Our fees are competitive and we offer insurance filing of claims.**

**For accounts without insurance, we expect payment in full at the time of treatment. We also offer wellness memberships that may be beneficial for you.**

**If you have insurance, all deductibles and co-payment amounts are due at each visit. If your insurance cannot be verified prior to your visit, we require full payment on your first visit. We are happy to help you with your insurance claims. However, we ask that you remember that you are ultimately responsible for understanding your own policy. We will call to verify your insurance coverage and co-pay amounts as a courtesy to you, but we cannot be responsible for the information given to us by your insurance provider. Please refer to your insurance booklet to verify your coverage limits. Knowing the specifics of your policy will help you make informed health care decisions. Please be aware that if a service is denied we are obligated to bill you for that service. All payments are due upon request.**

**Any amount not paid to us within 60 days by an insurance company will automatically be billed to you for prompt payment. If an insurance payment is received after you have paid, we will gladly apply it toward any additional treatment or refund your money if your account has a zero balance. A finance charge and late fee will be added monthly once the account becomes past due.**

**We accept cash, personal checks, Visa, MasterCard, and American Express. There will be a \$25 charge for any check returned for insufficient funds.**

**Please let us know if you have any concerns, questions, or comments and our staff will gladly assist you.**

# WELCOME

Please check with our staff if you have any questions

Name (Last, First, MI) \_\_\_\_\_ Mr. Mrs. Ms. Dr. Sr. Jr.

I prefer to be called \_\_\_\_\_  Male  Female Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

For Appointment Reminder Calls and Emergency Cancellation Calls: Contact Phone # \_\_\_\_\_

Employer: \_\_\_\_\_ Work # \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Nearest Relative not living with you: \_\_\_\_\_ Relation \_\_\_\_\_ Home # \_\_\_\_\_

Address: \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Other Family Members seen by us: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

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Spouse's Name: \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

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Name of Insurance Company: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

(Person who has the insurance through work)

Policy Holder's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

*I affirm that the information I have given is correct to the best of my knowledge. I agree to inform this Office of any changes in my medical status. My signature affirms I have been given a copy of, have read, and/or Understand the office policy for Lanier Chiropractic and Rehabilitation.*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

**STOP!! PLEASE GIVE THE FRONT DESK THIS COMPLETED SHEET BEFORE CONTINUING WITH PAPERWORK**

# EXPLANATION OF CONDITION

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Please mark areas of injury or discomfort using the key below.

**KEY:**

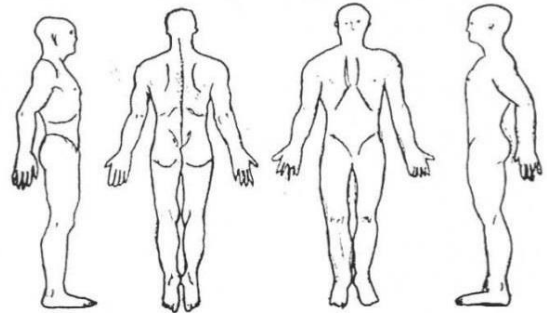
Numbness - - - -

Pins & Needles ooooo

Burning aaaaa

Aching xxxxx

Stabbing 0000



Your Chief Complaint is \_\_\_\_\_

When did your problem begin? \_\_\_\_\_

Describe how your condition occurred in detail: \_\_\_\_\_

Rate your pain: 0 1 2 3 4 5 6 7 8 9 10  
(Circle one) No Pain Extreme Pain

Are you worse in the morning? \_\_\_Yes \_\_\_No

Are you worse at the end of the day? \_\_\_Yes \_\_\_No

What position(s) aggravates your condition (please circle all that apply)

Sitting Standing Driving Walking Sleeping Sit to Stand

Did you do anything to relieve this problem? \_\_\_Yes \_\_\_No

If yes, please explain: \_\_\_\_\_

Did you use ice? \_\_\_Yes \_\_\_No Did you use heat? \_\_\_Yes \_\_\_No

Have you seen any other doctors for this condition? \_\_\_Yes \_\_\_No

If so, who? \_\_\_\_\_

Have you ever experienced this condition in the past? \_\_\_Yes \_\_\_No

If yes, explain \_\_\_\_\_

How much water do you drink each day? Glasses/Bottles \_\_\_\_\_

**FAMILY HISTORY**

**YOUR NAME** \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Date of last visit \_\_\_\_\_

Address: \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Please list any family (genetic) health problems: (like cancer, diabetes and heart disease)

Mother \_\_\_\_\_ Father \_\_\_\_\_

Siblings: \_\_\_\_\_ Grandparents \_\_\_\_\_

**MEDICAL HISTORY**

Your current physical health is:  Good  Fair  Poor

Have you been to a Chiropractor before?  Yes  No  
If yes, when and for what purpose \_\_\_\_\_

Name of Chiropractor \_\_\_\_\_

Do you take vitamins or minerals?  Yes  No  
If so, please list: \_\_\_\_\_

Do you think you need to take vitamins/minerals?  Yes  No

Are you taking any laxatives and/or sleeping pills?  Yes  No  
If so, how many, how often? \_\_\_\_\_

Are you under a lot of stress on a daily basis?  Yes  No

How long has it been since you really felt good? \_\_\_\_\_

During the day I (please circle) sit, stand, walk, desk work,  
Phone work, computer work, drive, mechanical work, heavy  
lifting.

Do you read in bed?  Yes  No

Is your mattress comfortable?  Yes  No

Are you right or left handed?  Right  Left

Do you smoke or use tobacco in any other form?  Yes  No

Have you ever been involved in a bicycle, bus, train  
motorcycle or car accident?  Yes  No  
Please explain \_\_\_\_\_

Were you ever knocked unconscious?  Yes  No

Have you broken any bones?  Yes  No  
Please explain \_\_\_\_\_

Have you had any impacts, falls or jolts that you  
feel may have injured you?  Yes  No  
Please explain: \_\_\_\_\_

Have you had any surgeries?  Yes  No  
Please list: \_\_\_\_\_

**FOR WOMEN:**

Are you taking birth control pills?  Yes  No  
Age Periods stopped and why \_\_\_\_\_

Are you pregnant?  Unsure  Yes  No  
Are you nursing?  Yes  No

**DO YOU HAVE OR HAVE YOU EXPERIENCED THE FOLLOWING? PLEASE CHECK ALL THAT APPLY**

- Abnormal Bleeding
- Alcohol Abuse
- Allergies
- Arthritis
- Anemia
- Artificial Bones
- Artificial Joints
- Artificial Valves
- Asthma
- Blood Transfusion
- Cancer
- Chemotherapy
- Chicken Pox

- Colitis
- Congenital Heart Defect
- Depression
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Fainting Spells
- Fatigue
- Fever Blisters
- Glaucoma
- Gout
- Hay Fever

- Headaches
- Heart Disease/Problems
- Hemophilia
- Hepatitis
- Herpes
- High Blood Pressure
- HIV+ /AIDS
- Hospitalized
- Kidney Problems
- Kidney Stones
- Leukemia
- Liver Disease/Problems
- Low Blood Pressure
- Lupus

- Migraine
- Mitral Valve Prolapse
- Obesity
- Pacemaker
- Persistent Cough
- Psychiatric Problems
- Radiation Treatment
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Sciatica
- Scoliosis
- Seizures

- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Pacemaker
- Persistent Cough
- Psychiatric Problems
- Radiation Treatment
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Sciatica
- Scoliosis
- Seizures
- Suicidal Thoughts
- Thyroid Problems
- Tonsillitis
- Tuberculosis (TB)
- Ulcers
- Venereal Disease
- Other \_\_\_\_\_

**“BE IN YOUR BEST HEALTH NOW!”**

**Dr. Patricia Seebach  
(770) 271-8949  
lanierchiro-rehab.com**

**LANIER CHIROPRACTIC & REHABILITATION**  
4530 Nelson Brogdon Blvd  
Buford, GA 30518  
770-271-8949

**OFFICE POLICY**

- Our primary concern is providing quality chiropractic care to our patients. Dr. Seebach is currently participating in many managed care plans in an effort to accommodate our patients. It is impossible for our office staff to be aware of the specific requirements of each and every plan. There may be limitations by your plan on number of visits, referrals, etc. You must inform our staff of guidelines set by your insurance company. If you do not inform us of special guidelines and restrictions of your plan, and we subsequently bill your insurance for a specific procedure not covered by your insurance company – *payment of these services will become your responsibility.*
- I understand and agree that I will be responsible for any balances not covered by my insurance company. I understand and agree that I will be assessed a finance charge and a monthly \$10.00 late fee once the account becomes past due unless a specific payment plan has been arranged.
- Any NSF/returned checks will be assessed a \$25.00 fee

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

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**SIGNATURE ON FILE**

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my Insurance Companies, including all doctors' notes and record of services rendered.
- I understand that I am Responsible for my bill. If my insurance does not pay the full amount, I agree to pay the balance upon request. I agree to pay all co-pays at each visit.
- I authorize my doctor to act as my agent in helping me to obtain payment from my Insurance companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- I understand that if my insurance company requires pre-certification before my visit here, it is my responsibility to obtain this information. I understand that if this has not been done prior to my first visit here, I will be financially responsible for all services rendered.

Name (PLEASE PRINT) \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **LANIER CHIROPRACTIC & REHABILITATION**

4530 Nelson Brogdon Blvd, Suite B  
Buford GA 30518

I hereby acknowledge that I have been made aware that Lanier Chiropractic & Rehabilitation has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient, I acknowledge the following:

- Lanier Chiropractic has a privacy policy in effect.
- Lanier Chiropractic has made this policy available for review by placing a copy on this clipboard.
- I am entitled to a copy of the Privacy Policy if I desire a copy for my personal files.

Upon your review of our privacy policy, please sign at the bottom acknowledging that you have been advised of the policy implemented by Lanier Chiropractic and Rehabilitation and have read and understand the form. If you desire a copy of the Privacy Policy, please request one at this time.

\_\_\_\_ No, I do not wish to obtain a copy of the policy but I am aware one exists.

\_\_\_\_ Yes, I do want a copy of the Privacy Policy.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date