WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

DR. HESSAM KHATAMI
CHIROPRACTIC PHYSICIAN

7815 NW Beacon Sq. Blvd.
Suite 101
BOCA RATON, FL 33487

PHONE: (561) 455-4850
FAX: (561) 455-4853
DRKHATAMI@ATLANTICGROVECHIRO.COM

Patient Consent

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

______________________________ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. the Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operataions. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice had the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________	______________________________
Name of Patient/Individual (Please Print)	Signature of Patient/Individual
______________________________	______________________________
Date Signed	Witness

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APPOINTMENT CANCELLATION POLICY

Time has been specifically reserved for your appointment, procdure, or treatment. Please call at least 24 hours ahead of time if you must cancel an appointment. There is a $25 charge if you fail to show up for a scheduled appointment or cancel with less than 24 hours notice.

Name of Patient / Individual (Please Print) ________________________

Signature of Patient / Individual ________________________

Date Signed ________________________

Witness ________________________

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S. Hessam Khatami, D.C.

Power of Attorney and Medical Release

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES REDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint S. HESSAM KHATAMI, D.C., and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said S. HESSAM KHATAMI, D.C., which checks, drafts or money orders are made payable for services which have been made by S. HESSAM KHATAMI, D.C., at the request or with the knowledge and approval for the undersigned and or the maker of the check, draft of money order.

Furthermore, the undersigned allows S. HESSAM KHATAMI, D.C., or any of it's agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said S. HESSAM KHATAMI, D.C., as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to release true copies of the same to S. HESSAM KHATAMI, D.C., or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assigned herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

Assignment of Benefits

I,________________________Hereby authorize, ____
(Name of Insured/Patient) (Name of Insurance Carrier)
to make medical payments otherwise payable to me for services rendered by S. HESSAM KHATAMI, D.C., but not to exceed the charges of those services, payable to and mailed directly to:

S. Hessam Khatami, D.C.
7815 NW Beacon Square Blvd.
#101
Boca Raton, FL 33487

Furthermore, I HEREBY IRREVOCABLY assign to S. HESSAM KHATAMI, D.C., the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and/or charges provided by S. HESSAM KHATAMI, D.C.

IN WITNES WHEREOF the undersigned have hereunto set their hands, this_____day of_____________,20____

_________________________________ _________________________________
PATIENT'S SIGNATURE **PATIENT'S NAME (Please Print)**

PERSONAL INJURY QUESTIONNAIRE (Auto Accident)

NAME:___________________________Claim#:________________ Date:_____________________

Have you filed a claim with an insurance company? ∆ Yes ∆ No

Date of Accident:________Where did the accident happen? Describe the accident in your own words:

____

____

____

What was your position in the car?

⌋ Driver: If Driver were your hands on the steering wheel? ∆ Left ∆ Right ∆ Both

⌋ Passenger: If passenger, were you sitting in ∆ Front ∆ Right Rear ∆ Left Rear?

Did your vehicle strike another vehicle? ∆ Yes ∆ No

Was your vehicle struck by another vehicle? ∆ Yes ∆ No

Angles of impact… First Collision: ∆ Front ∆ Back ∆ Left ∆ Right

If Second Collision: ∆ Front ∆ Back ∆ Left ∆ Right

Were you wearing a seat belt? ∆ Yes ∆ No

Did you brace for impact? ∆ Yes ∆ No … ∆ I braced with my hands ∆ I braced with my feet

Which way were you facing at the time of impact… ∆ straight ahead ∆ Left ∆ Right

Did you strike anything in vehicle at time of impact? ∆ Yes ∆ No

If yes, specify what part of your body struck what: ie… Head, Chest, Chin, Shoulder Right / Left, Knee

⌋ Steering Wheel________________________∆ Dashboard _____________________________

⌋ Windshield_________________________________∆ Roof _____________________________

⌋ Left Side Door_________________________∆ Right Side Door ___________________

⌋ Left Side Window____________________________∆ Right Window ____________________

⌋ Other____

Did the seat back bend / break? ∆ Yes ∆ No

Immediately following the accident, how did you feel? ∆ dizzy/dazed ∆ disoriented ∆ unconscious

⌋ nervous ∆ nauseous ∆ upset ∆ weak ∆ other _______________________________________

Did you go to the hospital? ∆ Yes ∆ No Were you admitted to the hospital? ∆ Yes ∆ No

If yes, how long? ______________

If you went to hospital, when? ∆ At time of accident ∆ Next day

How did you get to hospital? ∆ Ambulance ∆ Police Car ∆ Private Transportation

Name of Hospital:____

Attended by Dr. ____

What treatment was given?

☐ none ☐ placed in a cervical collar ☐ x-rayed ☐ given stitches ☐ bandaged

☐ given pain medication ☐ given instructions regarding concussions

☐ given instructions regarding sprains and strains ☐ physical therapy

☐ instructed to call an orthopedic surgeon ☐ instructed to call a private physician

☐ referred to this office for treatment ☐ other ______________________________

Have you seen any other doctor as a result of this accident? ∆ Yes ∆ No Doctor's name ___________

CHIEF Complaints or Symptoms:

☐Neck Pain
check off the areas that the pain runs into from the neck
☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand
☐right shoulder ☐right arm ☐right forearm ☐right hand

Are you experiencing..
☐Headache
☐Migraine Headache
☐Upper back pain

Ringing in Ears	☐Yes	☐No	☐Left	☐Right	☐Both Ears
Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists
Jaw Pain	☐Yes	☐No	☐Left	☐Right	☐Both Sides

☐dizziness ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability
☐fear of driving in a car ☐a loss of concentration ☐jaw clenching ☐grinding of teeth at night
☐nightmares ☐difficulty with sleeping at night

☐Low Back Pain
select the areas of radiation, if any...
☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee
☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐Left	☐Right	☐Bilateral
Knee Pain	☐Left	☐Right	☐Bilateral
Foot Pain	☐Left	☐Right	☐Bilateral

Numbness:
☐ Left Hand ☐Left Upper Arm ☐Right Hand ☐Right Upper Arm
☐ Left Foot ☐Left Leg ☐Right Foot ☐Right Leg

Additional Symptoms/ Complaints: ____
____
____
____

Have you lost any time from work due to your injuries? ∆Yes ∆No
If yes please give dates: ____
Type of employment: ____

Have you had previous injuries or accidents? ∆Yes ∆ No
Description of previous Accident: ____
Description of previous injuries: ____
Is there any residual pain from the previous injury? ∆Yes ∆No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) __________

Signature:______________________________________ **Date:**__________________