Chiropractic Health History Form

Date: _____

Name: _____ Gender: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Email: _____ DOB: _____ Age: ___

Emergency Contact: _____ Phone: _____

Referred by: _____

Have you ever received Chiropractic care? Yes No If yes, by whom? _____

Is this visit the result of an auto accident? Yes No

Please note: All auto accident visits cannot be filed on your health insurance. You must be seen as a cash account.

Name of party responsible for payment: _____

Insurance Information:

Insurance Company Name: _____ ID Number: _____

Group Number: _____ Insured's Relationship: _____

Reasons we are seeing you today:

Primary Reason: _____ Date of Onset: _____

Secondary Reason: _____ Date of Onset: _____

Referring Physician: _____ Phone: _____

Have you had X-rays or MRI for the condition you are being seen for? Yes No

If so, where: _____ When: _____

Patient Name: _____

Please answer the following questions as they relate to your primary area of pain/complaint:

Does the pain radiate? Yes No

Please Describe: _____

Do you have numbness/tingling? Yes No

Please Describe: _____

Does the pain interfere with your sleep? Yes No

Please Describe: _____

Is the pain worse during certain times of day? (circle all that apply)

Morning | Afternoon | Evening | Overnight | N/A

Do you wear orthotics? Custom | Off the Shelf | No

If custom, who dispensed and when? _____

What aggravates your symptoms? _____

Does your pain Interfere with any of the following? (circle all that apply)

Sitting | Walking | Standing | Lifting | Traveling | Personal Care | Social Activities

Grade Intensity/Severity (circle one):

1 2 3 4 5 6 7 8 9 10 (Worst pain Imaginable)

Frequency of Pain (circle one): Occasional | Intermittent | Only with certain movements |Constant

Previous interventions, treatments, medications, or surgery sought for this concern:

_____

_____

_____

Patient Name: _____

Past Health History:

1. Any significant current or previous illnesses? _____
2. Any previous Injuries or traumas? _____
3. Any Hospitalizations? _____
4. Have you ever broken any bones? Which? _____
5. Any sprains/ Strains? _____
6. Allergies: _____
7. List of current medications? (list on back If necessary)

   _____

   _____
8. Taking any vitamins/supplements? _____
9. Please list any medical/health history of family members: (heart disease, diabetes, cancer etc)

   _____

   _____
10. Occupation: _____ Employer: _____
11. Recreational activities: _____ Exercise habits: _____

Lifestyle

	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Exercise				
Sleep				
Water				
Appetite				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that If I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. Furthermore, I hereby certify that the statement, and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to Inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

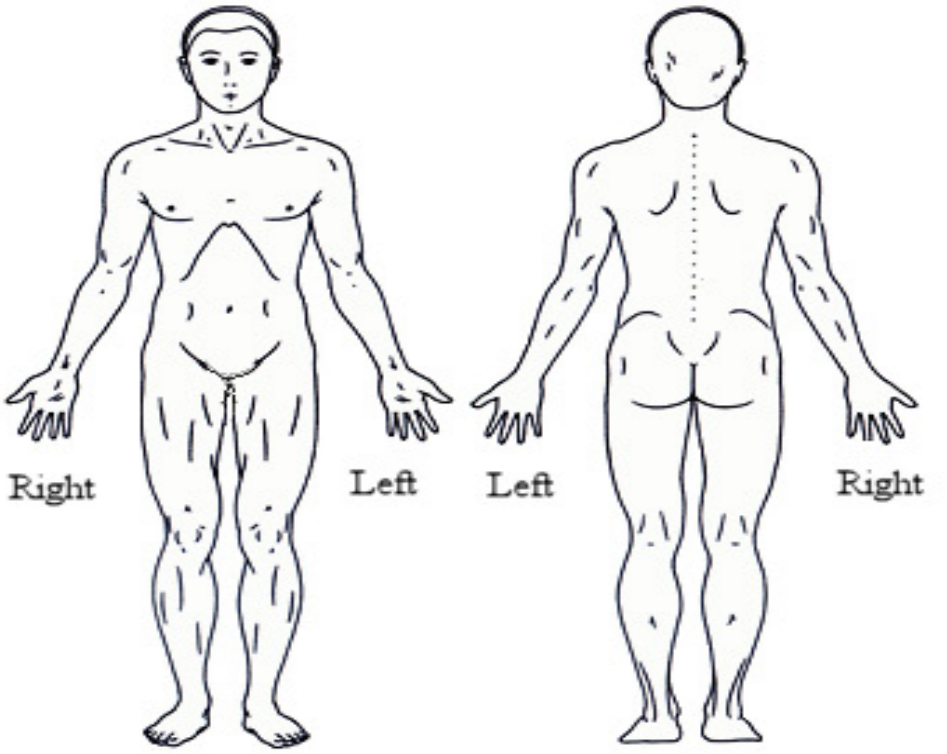
Patient /Gaurdians' Signature: _____ Date: _____

Patient Name: _____

Please circle the affected area and use the following letter to indicate TYPE and LOCATION of symptoms you are currently experiencing:

A: Dull Ache B. Burning S: Stabbing N: Numbness P: Pins and Needles

T: Throbbing D: Deep SH: Sharp TI: Tingling



Please mark each item below for each sign of symptoms you presently have or previously had:

GENERAL SYMPTOMS
__Dizziness
__Fainting
__Headache
__Nervousness
__Numbness
__Wheezing
__Cancer

MUSCLES & JOINTS
__ Low Back Problems
__Pain between Shoulders
__neck Problems
__Arm Problems
__Leg Problems
__Swollen Joints
__ Stiff Joints
__Sore Muscles
__ Weak Muscles
__Gait Issues
__Sprains/Strains
__Scoliosis Diagnosis
__Sciatica

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__Poor Circulation
__Cold Extremities
__Strokes
__Swelling Ankles

EAR/NOSE/THROAT
__Earache
__Enlarged Thyroid
__Frequent Colds
__Nasial Blockage
__Nose Bleeds
__Pain Behind Eyes
__Poor Vision
__ Sinusitis
__Sore Throat

GASTRO-INTESTINAL
__Constipation
__Diarrhea
__Hemorrhoids
__Liver/Gallbladder
__Nausea
__ Ulcer
__Poor Appetite
__Poor Digestion
__Weight Loss/Gain

RESPIRATORY
__Asthma
__Chronic Cough
__Difficulty Breathing

GENITO-URINARY
__Blood in Urine
__Frequent Urination
__Kidney Infection
__Prostate Problems
__Loss of Bladder Control

SKIN or ALLERGIES
__Bruising Easily
__Eczema/Rash/Dermatitis
__Itching

IF APPLICABLE
__Birth Control _____
__Hormone Replacement
__Hot Flashes
__Irregular Cycle
__Miscarriage
__Breast Pain

Pregnant (currently): Y N

Appointment Reminder Consent

Complete this form and sign below to give permission for Knoxville Spine and Sports to provide automatic appointment reminder service by email or by cell phone text message*.

Send email messages to confirm appointments to: _____

Send cell phone text messages to confirm my upcoming appointments to: _____

Cellular provider: _____

*I recognize that normal text messaging rates may apply.

Appointment reminders will be sent 24 hours in advance of the appointment unless otherwise requested. We require a 24-hour notice for any changes to the schedule. Failure to notify the office of any appointment change without 24 hours' notice will result in a $25.00 charge for Chiropractic visits and a $50.00 charge for Physical Therapy visits.

Patient Signature: _____

Date:_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Knoxville Spine and Sports to furnish care and treatment to (patient) _____ that Is considered necessary and proper in diagnosing or treating my/his/her condition.

RELEASE OF INFORMATION: Upon inquiry and to the extent allowed by law, Knoxville Spine and Sports may make available certain basic information about the patient in accordance with HIPAA regulations, including name, address, age, sex, general description of the reason for treatment, general nature of the injury, and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to Knoxville Spine and Sports for this purpose. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Knoxville, Spine and Sports may disclose portions of the patient's record including his/her medical record, to any person or entity which is or may be liable for all or any portion of Knoxville Spine and Sports' charges, including but not limited to government agencies (e.g, Insurance companies, health care service plans, or workers compensation carriers).

BENEFIT ASSIGNMENT: I hereby assign medical benefits to which I am entitled by private insurance and third-party payers, to Knoxville Spine and Sports. A photocopy of this assignment is to be considered as valid as the original.

FINANCIAL AGREEMENT: The patient is responsible for providing payment at the time of service for all co pays, deductibles, coinsurance and any remaining balance due from services that are not covered by the patient's insurance carrier. I understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed including original charges, Interest, collection agency fees, and attorney fees.

ASSIGNMENT OF INSURANCE BENEFITS: It is the patient's responsibility to maintain all prescriptions, referrals, and authorizations as required by your insurance company. We have called your insurance company for estimated insurance benefits, and they are reflected on the "Verification of Benefits" form.

CANCELLATION AND MISSED APPOINTMENT POLICY: Failure to provide 24 hours advance notice of cancellation or appointment change will incur a $25.00 fee for Chiropractic visits, and a $50 fee for Physical Therapy visits, automatically charged to your account. In instances of repeated non-compliance with our scheduled visits, we also reserve the right to discontinue care. In those rare cases, we will inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

WORKER'S COMPENSATION CLAUSE: The above financial policy does not apply to those patients that are considered Workers Compensation. However, be advised that if you claim Workers Compensation benefits and are subsequently denied, you will be held responsible for any remaining balance on your account. At the time, our Financial Policy will apply to you.

I have read the above information and understand my responsibilities.

_____	_____	_____
Patient's Name (Print)	Patient's / Guardian Signature	Date

HIPAA RELEASE/PRIVACY FORM

Patient Name: _____ Date of Birth: _____

RELEASE of Information:

- I authorize the release of information including the diagnosis, records, examination, rendered to me and claims information

This Information may be released to :

- Knoxville Spine and Sports
- Spouse: _____
- Children: _____
- Other: _____
- Information is NOT to be released to anyone.

This release of Information will remain In effect until terminated by me In writing.

For phone messages, please call my...

- Home Phone: _____
- Cell Phone: _____
- Work Phone: _____

If unable to reach me,

- You may leave a detailed message
- Please leave a message asking me to return your call
- Do not leave a message

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health Information to carry out: treatment (including direct or Indirect treatment by other healthcare providers Involved In my treatment), obtaining payment from third party payers (i.e. insurance companies), and the day to day healthcare operation of Knoxville Spine and Sports.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, then you are bound to comply with this restriction. I understand that I may revoke this consent in writing at any time.

_____ _____ _____

Patient's Name (Print) Patient's / Guardian Signature Date

Electronic Health Records Intake Form

In compliance with requirements for the government EHR Incentive program

First Name: _____ Last Name: _____

DOB: _____ Gender: _____ Preferred Language: _____

Please circle responses: (CMS requires providers to report both race and ethnicity)

Preferred method of communication for patient reminders: Email Phone Mail

Smoking Status: daily smoker occasional smoker former smoker never smoked

Race: American Indian or Alaska Native Asian Black or African American

White (Caucasian) Native Hawaiian or Pacific Islander Other Decline to Answer

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to Answer

Are you currently taking any medications? (Include regularly used over the counter medications)

Medication	Dosage/ Frequency

Do you have any medication allergies?

Medication	Reaction	Onset

- I choose to decline receipt of my clinical summary after every visit (these summaries are often blank because of the nature and frequency of chiropractic care)

Patient's / Guardian Signature _____ Date: _____

For office use only:

Height	Weight	Blood Pressure	Pulse R R A C

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Patient Acknowledgement Form for Non-Covered Services, Products, and Other Situations

Patient Name: _____

Your health insurance plan requires you to be responsible for co-payments, co-insurance, and deductibles for covered services and products as well as those services/products that exceed certain benefit limits. You are also financially responsible for all non-covered services and products, as well as any product we provide whose allowed fee is less than our office's cost.

Your health insurance plan either does not cover the product type or service noted below, or allows less than our purchase price. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay the office's charge.

PRODUCT OR SERVICE	REASON FOR NON-COVERAGE	PATIENT RESPONSIBILITY
AIS		$30.00 (per 15 mins)
ART		$30.00 (per 15 mins)
Deep Tissue Laser Therapy		$40.00 (per 8 mins)
Deep Tissue Massage		$30.00 (per 15 mins)
Dry Needling		$40.00 (per region)
Shock Wave Therapy		$40.00 (per 8 mins)
Scraping		$30.00 (per 15 mins)
Therapeutic Exercise		$30.00 (per 15 mins)

Patient Acknowledgement:

I _____ **(patient name), acknowledge that I have been told in advance by this office that my health insurance plan either does not cover the product or service listed above or pays less than this office's purchase price, and I agree to pay for this product at the time of service. I have been told that there may be other products available at lower cost that still meet my insurance plan's medical necessity requirements.**

Patient Signature: _____ **Date:** _____