SOURCE CHIROPRACTIC

1716 Memorial Dr
Clarksville, TN 37043
p. 931.591.3740
f. 931.614.6196

Personal Information

Full Name: _____
LAST *FIRST* *M.I.*

Address: _____
STREET ADDRESS APT/UNIT #

_____
CITY STATE ZIP CODE

Home Phone: _____ Cell phone: _____ Cell Carrier: (for text reminders) _____

Email: _____ Appointment Reminder Preference: ☐ Phone call ☐ Text ☐ Email

Birthdate: _____/_____/_____ Social Security #: _____-_____-_____

Emergency Contact: _____ Emergency Contact Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Physician Information

A report will be sent to the following physician:
Type of Physician: ☐ Primary Care Physician ☐ Specialist

Physician Name: _____

Address: _____
STREET ADDRESS SUITE/UNIT #

_____
CITY STATE ZIP CODE

Health Insurance Information

Please present your Insurance Card to the front desk.

Are you the insured party? ☐ Yes ☐ No (If no please fill out the Policy Holder Information)

Policy Holder Information

Fill out only if Policy Holder is different from yourself.

Relationship to you: _____

Full Name: _____
LAST *FIRST* *M.I.*

Address: _____
STREET ADDRESS APT/UNIT #

_____
CITY STATE ZIP CODE

Birth Date: _____/_____/_____ Social Security #: _____-_____-_____

Responsible Party

Are you the Responsible Party? ☐ Yes ☐ No (If no, please fill out the Responsible Party Information)

Relationship to you: _____

Full Name: _____
LAST *FIRST* *M.I.*

Address: _____
STREET ADDRESS APT/UNIT #

_____
CITY STATE ZIP CODE

Financial Policy

Source Chiropractic is happy to work with our patients to provide the best quality of services. This letter is to acquaint you with our office billing procedures. Please read the following carefully and initial the appropriate method of payment. If you have health insurance, we will do our best to help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. When possible, we will call your insurance company to verify your benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Our office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other that supply factual information as necessary. You are responsible for the items listed above as well as any services considered "not medically necessary" by your insurance company. We participate with most insurance companies; however, if we do not participate with your insurance company, you are responsible for all out of network deductibles and co pays. **You are ultimately responsible for knowing your insurance benefits and the balance for services rendered.**

Claims are sent out to insurance companies periodically. Upon receipt of payment for services rendered, you will also receive statements from your insurance company, referred to as explanation of benefits (EOBs), which will inform you of any payments made. Since there are no guarantees of payment from the insurance company, you the patient are held liable for unpaid balances. On occasion, the insurance company will send a check for payment of services to the patient; should that occur, please endorse the check and bring payment directly to Source Chiropractic.

We encourage you to ask any questions you may have regarding our financial policy, so that you may have a clear understanding. Our goal is to concentrate on returning you to optimal health and to establish overall well-being. We have prepared the following checklist in order to help our patients determine their responsibility toward payment for chiropractic services. Please check the statement that applies to you:

_____ **PRIVATE INSURANCE**: I understand that as a service to me, Source Chiropractic will bill my insurance company for services rendered, however; **I fully understand that it is my financial responsibility to be liable for all healthcare expenses , as well as any services considered "not medically necessary" by my insurance company**. I agree to assume all financial responsibility.

_____ **MEDICARE**: I am eligible to Medicare and I understand Medicare will cover the chiropractic adjustment only and for active conditions only. Medicare does not cover chiropractic adjustments for maintenance or additional modalities or therapies. Medicare supplemental policies will cover only those charges that Medicare also allows. I understand that I am responsible for my Medicare deductible and all coinsurance.

_____ **PRIVATE PAY (CASH)**: As I have no insurance or third parties (bodily injury claim) liable for my healthcare expenses, I agree to assume all payment responsibility and keep my account current. (Please be sure to talk with our office about payment options).

_____ **WORKERS COMPENSATION**: I have been injured on the job and understand that my care may be paid for under my employer's Worker's Compensation insurance. I will inform my employer of the accident and obtain the name and address of their insurance carrier. I understand if my claim is not allowed, I will be responsible for all charges accrued during my care. Additionally, I will let you know if I am currently working with an attorney.

_____ **PERSONAL INJURY**: I agree to notify my auto insurance of my visit to your office immediately. I understand that although I am ultimately responsible for any charges accrued during my care, Source Chiropractic will wait for a settlement of my claim for up to 6 months after my care is completed. Once the claim is settled or if I suspend or terminate care all fees for services are due immediately. Additionally, I will let you know if I am currently working with an attorney.

My signature gives this office permission to give our any pertinent information to any insurance company, attorney, or adjustor who needs this information to facilitate the payment of a claim. **A photocopy of this form shall be deemed valid.**

_____	_____	_____
PATIENT'S NAME	SIGNATURE (RESPONSIBLE PARTY)	DATE

SOURCE CHIROPRACTIC

1990 Madison St. Suite 101
Clarksville, TN 37043
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Authorizations and Releases

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

INITIAL _____

Consent to Professional Treatment (Informed Consent)

- I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.
- There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.
- I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

INITIAL_____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

INITIAL_____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

INITIAL_____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

INITIAL_____

Signature_____ Date _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

SOURCE CHIROPRACTIC

Health History Form

Where applicable, specify the approximate date of you most recent: (month/year)

Spinal x-ray: _____/_____ CT scan: _____/_____

MRI: _____/_____ Other scans or x-rays: _____/_____

Medications taken on a regular or ongoing basis: Prescription, Over the Counter, Vitamins

_____

_____

Diet and Exercise

How much do you smoke? ☐ Less than one pack/week ☐ 1-2 packs/week ☐ 1 pack every two days ☐ 1 pack/ day ☐ More than 1 pack/ day ☐ None

How many alcoholic beverages do you consume per week? _____

Do you exercise regularly? ☐ Yes ☐ No If yes, how many days do you exercise each week? _____

Allergies

Has a physician ever diagnosed you with Allergies, if so please specify what type: _____

_____

Cancer History

Check if a physician has ever diagnosed you with any of the following cancers:

Check all that apply:

☐ Bladder ☐ Brain ☐ Breast ☐ Cervical ☐ Colon or Rectal ☐ Endometrial

☐ Eye ☐ Kidney ☐ Leukemia ☐ Lung ☐ Non-Hodgkin's Lymphoma

☐ Ovarian ☐ Pancreatic ☐ Prostate ☐ Skin – type: _____

☐ Stomach ☐ Thyroid ☐ Uterine

☐ Other: _____

Have any of your immediate family members have or had any of the above types or any other form of cancer:

(please describe)_____

Cardio-pulmonary/Circulatory Health History

☐ Anemia ☐ HIV/AIDS ☐Hemophilia ☐Hepatitis

☐ Stroke ☐ Raynaud's ☐Sinus Infections ☐ Hemorrhoids

☐ Wegener's Granulomatosis ☐Hypertension (high blood pressure) ☐ Hypotension (low blood pressure)

☐ Lung Disorders, please list: _____

Have any of your family members have or had any of the above conditions: (please describe)_____

_____

Endocrine – Gastrointestinal

☐ Bladder Disease ☐ Chicken Pox ☐Crohn's Disease ☐ Epilepsy ☐ Gall Bladder Problems

☐ Incontinence ☐ Mumps ☐ Kidney Disease ☐ Shingles ☐ Thyroid Dysfunction

☐ Liver Disease ☐ Candida ☐ Fibromyalgia ☐ Diabetes ☐ Chronic Fatigue Syndrome

☐ Measles ☐ Seizures ☐ Stomach Ulcers ☐ Irritable Bowel Syndrome (IBS)

☐ Headaches:

☐ Cluster ☐Tension ☐ Migraine ☐ Stress induced ☐ Sinus

☐ Autoimmune Disorders:

☐ Lupus ☐ Rheumatoid arthritis ☐ Scleroderma ☐Sjogren's Syndrome

☐ Other: _____

Neurological Health History

Check if a physician has ever diagnosed you with any of the emotional or mental conditions:

☐ Anger Disorders ☐ Anxiety ☐ Asperger Syndrome ☐ Attention Deficit Disorder with Hyperactivity (ADHD)
☐ Autism ☐ Bipolar ☐ Eating Disorders ☐ Borderline Personality Disorder
☐ Depression ☐ Narcolepsy ☐ Mood Disorders ☐ Obsessive Compulsive Disorder
☐ Phobias ☐ Suicidal ☐ Schizophrenia ☐ Restless Leg Syndrome
☐ Other: _____

Sensory Health History

Check if a physician has ever diagnosed you with any of the following:

☐ Blindness ☐ Cataract ☐ Cholesteatoma ☐ Deafness or Hearing loss ☐ Ear ringing
☐ Eczema ☐ Glaucoma ☐ Laryngitis ☐ Macular Degeneration ☐ Mumps
☐ Psoriasis ☐ Rhinitis ☐ Nasal Polyps ☐Meniere's Disease ☐ Sinusitis
☐ Vertigo ☐ Perforated Eardrum ☐ Unusual Vision Impairment
☐ Other: _____

Musculoskeletal Health History

Check if a physician has ever diagnosed you with any of the following:

☐ Gout ☐ Herniated Disc ☐ Lyme Disease ☐ Multiple Sclerosis ☐ Muscular Dystrophy
☐ Polio ☐Osteoporosis ☐ Rheumatism ☐ Pinched Nerve ☐Parkinson's Disease
☐ Sciatica ☐ Temporomandibular Joint Disease (TMJ)
☐ Numbness or tingling in hands ☐ Numbness or tingling in feet
☐ Arthritis, please specify which type: _____
☐ Other: _____

Surgical History

Please list any surgeries with dates: _____

Reproductive Health History

Check if a physician has ever diagnosed you with any of the following:

☐ Chlamydia ☐ Dysplasia ☐ Erectile Dysfunction ☐ Genital Herpes ☐ Human Papillomavirus (HPV)
☐ Impotency ☐ Syphilis ☐ Infertility ☐ Cystitis ☐ Prostate Enlargement
☐ Gonorrhea ☐ Impotency ☐ Menopause ☐ Impotency ☐ Vaginal Yeast Infection
☐ Uterine Fibroid ☐ Testicular Dysfunction
☐ Other: _____

Females Only:
Date of last menstrual period: _____/_____/_____
How many births vaginally? _____ How many births by C-section? _____

Please list any other concerns you may have concerning your health: _____
_____

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to increase movement, correct the cause of pain, and correction of whatever is malfunctioning in their bodies.

Your Doctor will weigh your needs and desires when recommending your treatment program.
Please check the desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care:** Symptomatic relief of pain or discomfort.
☐ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
☐ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care.
☐ **I want the doctor to select the type of care appropriate for my condition**

Patient's Signature **Date**

Doctor's Signature: _____ **Date:** _____

Patient Name: _____

Referred by: _____

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PRIMARY COMPLAINT

Describe the primary reason for your visit: _____

Which word describes the frequency of you discomfort? (What % of awake time do you have the pain)
□ Constant (76%-100%) □ Frequent (51%-75%) □ Intermittent (26%-50%) □ Occasional (0%-25%)

Was the onset: □ sudden □ gradual When did your symptoms first begin? _____

Are the symptoms getting? □ Worse □ Better □ The same (relatively unchanged)

What activities are *aggravated* by your discomfort? (select one or more)

□ Bending	□ Bowel Movements	□ Coughing	□ Daily Routine
□ Driving	□ Getting up	□ Lifting	□ Lying down
□ Pulling	□ Pushing	□ Reading	□ Sitting
□ Sleeping	□ Sneezing	□ Standing	□ Turning my head
□ Urination	□ Walking	□ Working	

□ Other (please describe): _____

What helps *relieve* your discomfort? (select one or more)
□ Ice □ Heat □ Medication □ Nothing helps □ Other: _____

My pain is: □ worse in the morning □ worse in the afternoon □ worse at night □ it does not change

Does your pain travel to any other area? _____

SECONDARY COMPLAINT (If no other complaints please continue on back)

Please describe any other complaints: _____

Which word describes the frequency of you discomfort? (What % of awake time do you have the pain)
□ Constant (76%-100%) □ Frequent (51%-75%) □ Intermittent (26%-50%) □ Occasional (0%-25%)

Was the onset: □ sudden □ gradual When did your symptoms first begin? _____
Are the symptoms getting? □ Worse □ Better □ The same (relatively unchanged)

What activities are *aggravated* by your discomfort? (select one or more)

□ Bending	□ Bowel Movements	□ Coughing	□ Daily Routine
□ Driving	□ Getting up	□ Lifting	□ Lying down
□ Pulling	□ Pushing	□ Reading	□ Sitting
□ Sleeping	□ Sneezing	□ Standing	□ Turning my head
□ Urination	□ Walking	□ Working	

□ Other (please describe): _____

What helps *relieve* your discomfort? (select one or more)
□ Ice □ Heat □ Medication □ Nothing helps □ Other: _____

My pain is: □ worse in the morning □ worse in the afternoon □ worse at night □ it does not change

Does your pain travel to any other area? _____

Have you tried other medical treatments for this condition? □ Yes □ No
If so what type:

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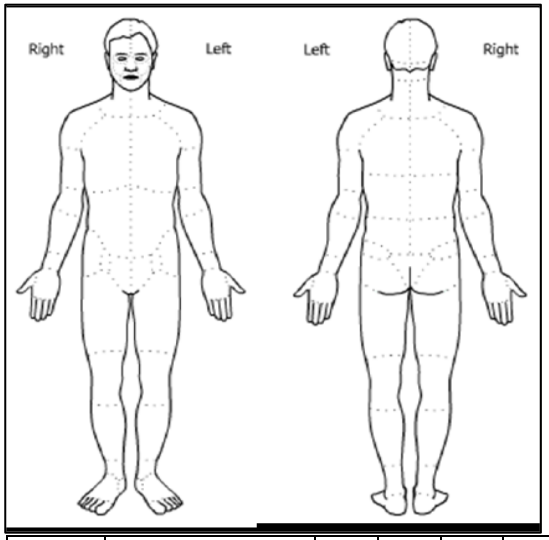
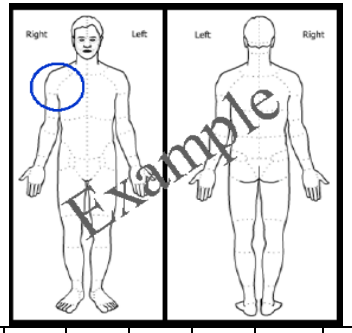
Please help us fully understand your symptoms. Identify your areas of discomfort with circles using the illustration to the right and creating a description of the effected body part(s) below. An example is listed for your convenience. For any questions regarding this form our staff would be happy to assist you.





What is impacted by your current condition?

- ☐ Activities of daily living (*cleaning, bathing, etc)*
- ☐ Relationships (*impatience, irritability, motivation)*
- ☐ Work
- ☐ Sports or fitness
- ☐ Other:_____

What are you goals with treatment?

_____

_____

		Effected Body Part	Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness											
Example	L X	*Shoulder*			X			X				Severity of Pain	1	2	3	4	5	6	X	8	9	10
	L R											Severity of Pain	1	2	3	4	5	6	7	8	9	10
	L R											Severity of Pain	1	2	3	4	5	6	7	8	9	10
	L R											Severity of Pain	1	2	3	4	5	6	7	8	9	10
	L R											Severity of Pain	1	2	3	4	5	6	7	8	9	10