CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date: _____

Patient:_____

Address:_____

_____
City State Zip

Sex: M F Age:_____ Birthdate:_____

Single Married Widowed Separated Divorced

Patient SS#: _____

Occupation: _____

Employer: _____

Email :_____

INSURANCE

Subscriber's Name: _____

Primary Insurance: _____

Secondary Insurance: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. John Curtis all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:

_____

Relationship:_____Date:_____

PHONE NUMBERS

Home/Cell:_____

Work:_____

IN CASE OF EMERGENCY, CONTACT:

Name:_____

Relationship:_____

Contact Number:_____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Type of accident: Auto Work Home Other

Date of Accident:_____ State of Accident:_____

Have you filed a claim with your auto insurance? Yes No

Insurance Company:_____

Claim Number:_____

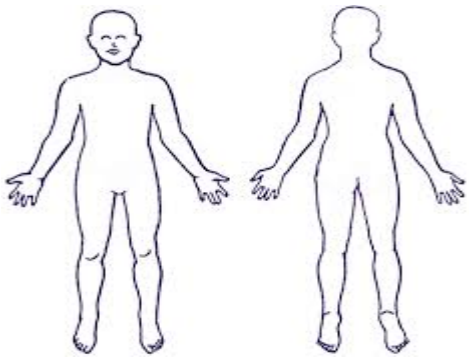
Attorney Name (if applicable): _____

PATIENT CONDITION

Reason for Visit: _____

When did your symptoms appear? _____ Is this condition getting progressively worse? Yes No

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1(least pain) to 10(severe pain):_____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

How often do you have the pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

HEALTH HISTORY

Have you already received treatment for your condition? Medication Surgery Physical Therapy Chiropractic None

Other: _____

Name and Address of other doctor(s) who have treated you for your condition: _____

Dates of Last:
Physical Exam:_____ Spinal X-Ray:_____-Facility:_____

Spinal Exam: _____ MRI, CT-Scan, Bone Scan:_____-Facility_____

Please check the □ to indicate if you have had any of the following:

□ AIDS/HIV
□ Alcoholism
□ Allergy Shots
□ Anemia
□ Anorexia
□ Appendicitis
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Breast Lump
□ Bronchitis
□ Bulimia
□ Cancer
□ Cataracts
□Chemical Dependency
□ Chicken Pox
□ Diabetes
□ Emphysema
□ Epilepsy
□ Fractures
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Gout
□ Heart Disease
□ Hepatitis
□ Hernia
□ Herniated Disk
□ Herpes
□ High Cholesterol
□ Kidney Disease
□ Liver Disease
□ Measles
□ Migraine Headache
□ Miscarriage
□ Mononucleosis
□ Multiple Sclerosis
□ Mumps
□ Osteoporosis
□ Pacemaker
□ Parkinson's Disease
□ Pinched Nerve
□ Pneumonia
□ Polio
□ Prostate Problems
□ Prosthesis
□ Psychiatric Care
□ Rheumatoid Arthritis
□ Rheumatic Fever
□ Scarlet Fever
□ Stroke
□ Suicide Attempt
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Tumors, Growths
□ Typhoid Fever
□ Ulcers
□ Vaginal Infections
□ Venereal Disease
□ Whooping Cough
□Other
_____

_____

EXERCISE

None Moderate

Daily Heavy

WORK ACTIVITY

Sitting Standing

Light Labor Heavy Labor

HABITS

Smoking Packs/Day_____

Alcohol Drinks/Week _____

Caffeine Drinks Cups/Day_____

High Stress Level Reason_____

Are you pregnant? Yes No Due Date:_____

Injuries/Surgeries you have had	Description	Date

Falls: _____

Head Injuries:_____

Broken Bones: _____

Dislocations: _____

Surgeries: _____

Other: _____

Ft. Campbell Chiropractic
1881-B Ft. Campbell Blvd.
Clarksville, TN 37042
931-920-0077

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Privacy

We are required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the health care you receive, and the payment for your health care.

We are required by law to provide you with this notice to tell you how it may use and disclose your PHI and to inform you of your privacy rights. We must follow the privacy practices as set forth in its most current Notice of Privacy Practices.

This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations and policies regarding informed consent for treatment.

Changes to this Notice

May change its privacy practices and the terms of this notice at any time. Changes will apply to PHI that already has as well as PHI that receives in the future. . Every privacy notice will be dated.

Use and Disclose of PHI?

May use/disclose your PHI for treatment, payment and health care operations without your authorization. Otherwise, your written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures Relating to Treatment, Payment and Health Care Operations

The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment and health care operations.

For treatment – Consistent with its regulations and policies, may use/disclose PHI to doctors, nurses, service providers and other personnel (e.g., interpreters), who are involved in delivering your health care and related services. Your PHI will be used to determine your eligibility for services, to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. Your PHI may be shared with other health care professionals and providers to obtain prescriptions, lab work, consultations and other items needed for your care.

To obtain payment -- Consistent with the restrictions set forth in its regulations and policies, may use/disclose your PHI to bill and collect payment for your health care services. may release portions of your

PHI to the Medicaid or Medicare program or a third party payor to determine if they will make payment, to get prior approval and to support any claim or bill.

For health care operations -- may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., JCAHO).

Appointment Reminders

may use PHI to remind you of an appointment or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses/Disclosures Requiring Authorization

Is required to have a written authorization from you or your personal representative with the legal authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment and health care operations unless an exception listed below applies. You may cancel an authorization at any time, if you do so in writing. A cancellation will stop future uses/disclosures except has already acted based upon your authorization.

Exceptions

- For guardianship or commitment proceedings
- For judicial proceedings if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- If you agree, verbally or otherwise, may disclose a limited amount of PHI for the following purposes:
    - **To Family and Friends** – may share information directly related to their involvement in your care, or payment for your care
- To correctional institutions, if you are an inmate
- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
- If required by law, or for law enforcement or national security
- To avoid a serious and imminent threat to public health or safety
- For public health activities such as tracking diseases and reporting vital statistics
- Upon death, to funeral directors and certain organ procurement organizations

Your Rights

You, or a personal representative with legal authority to make health care decisions on your behalf, have the right to:

- Request that DMH use a specific address or telephone number to contact you. DMH is not required to comply with your request.
- Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically.
- *Inspect and copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstances. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing.
- *Request additions or corrections to your PHI. DMH is not required to comply with a request. If it does not comply with your request, you have certain rights.
- *Receive a list of individuals who received your PHI from DMH (excluding disclosures that you authorized or approved, disclosures made for treatment, payment and healthcare operations and some required disclosures).
- *Ask that DMH restrict how it uses or discloses your PHI. DMH is not required to agree to a restriction.

Patient Signature:_____ **Date:**_____

Witness:_____ **Date:**_____

FT. CAMPBELL
- CHIROPRACTIC -

Informed Consent Form

Dear patient,

Every type of health care is associated with some risk of potential problem. This includes Chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with Chiropractic health care before consenting to treatment. This is called informed consent.

Consent to Treatment

The following points have been explained to me to my satisfaction and I have had the opportunity to discuss them with the doctor and / or other clinical personnel.

1. I understand that the Chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, and there may be an audible "pop" or "click" as a result of joint movement.
2. The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination (and the doctor's interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic health care is no different.
3. It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures which he/she feels at the time to be in my best interest.
4. Though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include soreness, sprains/strains, dislocations, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.
5. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We can , however, promise that we will give you our best care.
6. I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose Chiropractic Care.

I have read the above consent, or it has been read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided, and consent to Chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

1881 Ft. Campbell Blvd. Suite B
Clarksville, TN 37042

www.FtampbellChiro.com
FtCampbellChiro@gmail.com

Phone (931) 920-0077
Fax (931) 920-0058

FT. CAMPBELL
- CHIROPRACTIC -

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance before seeing the doctor.

ALL DEDUCTIBLES/COPAYS ARE DUE AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE IN ADVANCE TO TREATMENT.

WE ACCEPT CASH, CHECKS,VISA/MASTERCARD,AMERICAN EXPRESS, AND DISCOVER.

Regarding Insurance

We require all deductibles and co-pays be paid at time of service. The bill is ultimately your responsibility. Your deductibles co-pay, and services not covered by your insurance company become your responsibility as well. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, the balance will automatically be transferred to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due at the time of services are rendered. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment f or our patients and we charge what is usual and customary for our area.

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Medical Release

I authorize you to release any information you deem appropriate concerning my physical condition to any insurance company, attorney
or adjuster in order to process any claim for reimbursement of charges incurred by me.

Adult Patients/Minor Patients

Adult patients are responsible for payment at time of service. The adult accompanying a minor and the parents(or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been
pre-authorized to an approved credit plan, Visa, Mastercard and American Express, or payment by cash or check at time of service
has been verified.

Accounts sent to collections will have a 35% collections/attorney fee added to the balance on the account.

Thank You for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Patient Signature:_____ Date:_____

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FT. CAMPBELL
- CHIROPRACTIC -

Communication Between Practice Members

In an effort to improve the lines of communication with our staff and practice members, we ask that all new patients provide their cell phone number to help easily communicate with each other regarding appointment changes and to also inform you of important issues that sometimes require immediate attention. For example: office closings related to inclement weather.

We are mindful of your time and recognize that we all live busy and productive lifestyles and sometimes, we just can't get to our phones. We also recognize that the interruption of our day to respond to unwarranted phone calls from telemarketers and having to delete spam from our emails also places a strain on out time. That is why we want to assure you that our correspondence to you will be kept to a minimum and that our correspondence will mainly involve scheduling of appointments, notifications of missed appointments and annual birthday recognitions. You always have the option of opting out if you choose to do so.

Please feel free to respond to us at your convenience by replying to our texts directly or if you prefer, just give us a call. We can be reached 24 hours a day, 7 days a week!

Cell Phone:_____ Phone Carrier:_____

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FT. CAMPBELL
- CHIROPRACTIC -

In an attempt to make your visits here at Ft. Campbell Chiropractic as safe and comfortable as possible, we request that all patients purchase a set of muscle stimulation pads. The cost of these pads are $16.00, and this amount is due at the time of your first visit. You will receive two sets of pads and they usually last for approximately 20 treatments. These pads will be in your record and only used, with you, during your visit. These are considered non-covered items and almost in all instances, insurance companies do not pay for them. It is not mandatory for you to purchase pads, but if you do not, a common set will be used.

In addition, your insurance company might not cover braces, supports, cervical pillows, topical analgesics, etc that they consider not medically necessary.

We request that you pay for these non-covered items at the time of service. We are sorry for any inconvenience this may cause.

I, _____, understand that the above mentioned items and/or services may not be a covered benefit through this office and has not been authorized by my insurance company. I would like to purchase a set of pads to be used for only me.

SIGNATURE_____ DATE _____

OR

***Ft. Campbell Chiropractic has fully explained to me the reasons why they request I have individual muscle stimulation pads. With this knowledge, I do not wish to purchase a set at this time. I understand a common set will be used on me and I fully accept the risks thereof, and will not hold Ft. Campbell Chiropractic or any members of the staff liable. ***

Patient Signature:_____ Date:_____

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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

Patient Name:_____

Preferred method of communication (Circle one): Email / Phone / Text

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Race (Circle one): American Indian / Asian / Black or African American / Caucasian / Hawaiian or Islander

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency

Allergies	Reaction

Patient Signature: _____Date: _____

DX:_____ Xrays: Cervical - 72040 Thoracic - 72070 Lumbar – 72100

Height: _____ Weight:_____ Blood Pressure:_____/_____ HR_____