CONFIDENTIAL PATIENT INFORMATION

PHONE 615-537-5520 | **FAX** 615-537-5521

DEMOGRAPHIC INFORMATION

PATIENT _____ **DOB** __ __/__ __/__ __ __ __ **SSN** __ __ __- __ __ - __ __ __ __

☐ Male ☐ Female **MARITAL STATUS** ☐ Married ☐ Single ☐ Other **NUMBER OF CHILDREN/AGES** _____

MAILING ADDRESS _____ Zip Code__ __ __ __ __

PHONE (__ __ __) __ __ __ - __ __ __ __ Service Provider for Appt. Reminders ☐ Cingulair ☐ AT&T ☐ NexTel ☐ Sprint ☐ T-Mobile ☐ Verizon ☐ Virgin

E-MAIL _____

HOW DID YOU HEAR ABOUT US? ☐ Friend ☐ Relative ☐ Internet ☐ Physician ☐Other _____

EMPLOYMENT INFORMATION

☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Unemployed

OCCUPATION _____ **EMPLOYER** _____

EMPLOYER ADDRESS _____ **BUSINESS PHONE** (__ __ __) __ __ __ - __ __ __ __ x _____

DO YOU HAVE MEDICAL INSURANCE? ☐ Yes ☐ No

⇒If yes, please provide us with a copy of the front and back of your insurance card(s).

EMERGENCY CONTACT NAME **PHONE** (__ __ __) __ __ __ - __ __ __ __ x _____

ALL PATIENTS | Family Physician _____ Clinic Phone (__ __ __) __ __ __ - __ __ __ __

May we share your information in our patient records with your above listed physician for integrated and coordinated care? ☐ YES ☐ NO

ATHLETES | Trainer / Coach _____ School Affiliation _____ Primary Sport _____

May we share your information in our patient records with your above listed coach or trainer for integrated and coordinated care? ☐ YES ☐ NO

IS TODAY'S VISIT DUE TO A WORK-RELATED INJURY OR AUTO ACCIDENT? ☐YES ☐ NO Date of Accident __ __ / __ __ / __ __ __ __

⇒*If YES, please check with the front desk. Additional Paperwork or Authorization may be required.*

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was *due I personally owe to you*.
4. I further agree that this Authorization of Assignment is irrevocable until all moneys owed to you (Active Spine and Joint Center) are **paid in full**.

X _____ **DATE** __ __ / __ __ / __ __ __ __

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

_____ _____

PRINTED NAME OF GUARDIAN(S)/GUARANTOR(S) IF PATIENT IS A MINOR

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Active Spine and Joint Center

PATIENT SYMPTOMS

PRIMARY COMPLAINT

Please describe your current symptoms (why you are here) _____

_____

Indicate Your Symptoms
Using the Following Codes:

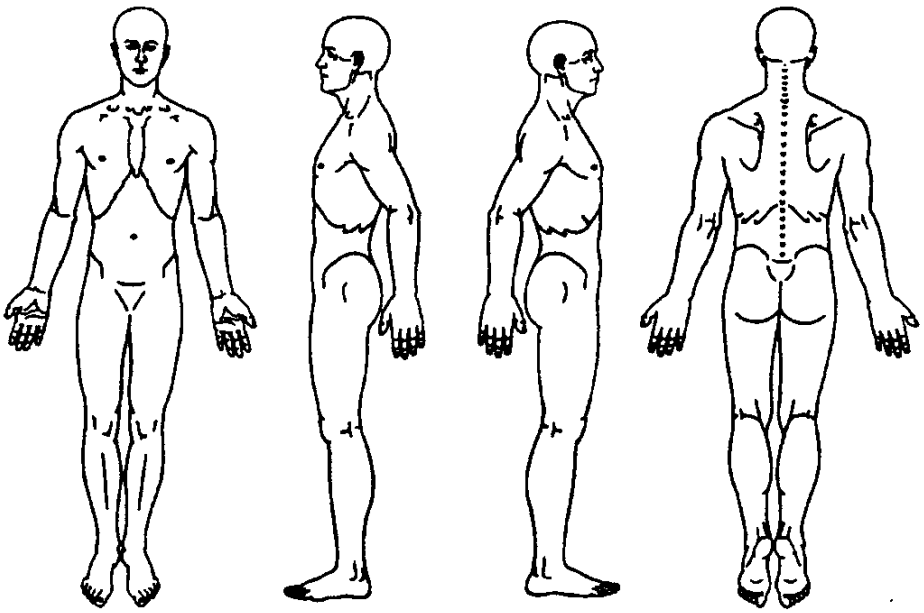
+++ Burning

Dull/Ache

*** Numbness/Tingling

=== Throbbing

000 Stabbing/Sharp



PAIN INTENSITY | Please indicate the pain level of your primary complaint

Within the last 24 hours	Within the last week
No Pain-0 1 2 3 4 5 6 7 8 9 10-Agonizing	No Pain-0 1 2 3 4 5 6 7 8 9 10-Agonizing

Describe what caused the pain _____

When did it start? _____ How often do you feel it? ☐ Constant ☐ Comes and Goes

What tends to worsen the problem? _____

What tends to lessen the problem? _____

SECONDARY COMPLAINTS

Please describe your any secondary symptoms _____

_____

ACTIVITIES OF DAILY LIVING

Please indicate any activities that currently interfere with your life and ability to function

☐ Sitting	☐ Rising Out of Chair	☐ Standing	☐ Walking	☐ Lying Down
☐ Bending Over	☐ Climbing Stairs	☐ Using a Computer	☐ Getting In/Out of Car	☐ Driving a Car
☐ Looking Over Shoulder	☐ Caring for Family	☐ Grocery Shopping	☐ Household Chores	☐ Lifting Objects
☐ Reaching Overhead	☐ Showering / Bathing	☐ Dressing Myself	☐ Love Life	☐ Getting to Sleep
☐ Staying Asleep	☐ Concentrating	☐ Exercising	☐ Yard Work	☐ Occupation

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Active Spine and Joint Center

PATIENT HISTORY

HEALTH RATING | In general, would you say your health is (pick one) ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor?

Have you had previous chiropractic care? ☐ YES ☐ NO

⇒If YES, for what problem? _____ Results _____

Doctors Name_____ City _____ State __ __

SYSTEM REVIEW

Do you or have you ever had any problem with the following areas?

☐ Musculoskeletal	☐ Neurological	☐ Head / ENT	☐ Cardiovascular
☐ Respiratory	☐ Gastrointestinal	☐ Genitourinary	☐ Endocrine
☐ Blood	☐ Skin		

⇒ Please describe any YES answers _____

PAST REVIEW

Have you ever experienced the problem which you are consulting us for? ☐ YES ☐ NO If Yes, when? _____

⇒Was treatment provided? ☐ YES ☐ NO By whom?_____ Outcome _____

Have you ever had any major surgeries, illnesses, or accidents? ☐ YES ☐ NO

DATE / AGE	SURGERY/ILLNESS/ACCIDENT	TREATMENT	OUTCOME

SOCIAL REVIEW

Tell us about your health habits and stress levels

Alcohol Use	☐ Daily	☐ Weekly How Much? _____	Prayer / Meditation	☐ YES ☐ NO
Coffee Use	☐ Daily	☐ Weekly How Much? _____	Job Pressure / Stress	☐ YES ☐ NO
Tobacco Use	☐ Daily	☐ Weekly How Much? _____	Financial Peace	☐ YES ☐ NO
Exercise	☐ Daily	☐ Weekly How Much? _____	Recreational Drug Use	☐ YES ☐ NO
Pain Relievers	☐ Daily	☐ Weekly How Much? _____	Family Life Stress	☐ YES ☐ NO
Soft Drinks	☐ Daily	☐ Weekly How Much? _____		
Water Intake	☐ Daily	☐ Weekly How Much? _____		

MEDICATIONS

Tell us about your current medications (attach list if necessary):

_____

OTHER

Is there anything else we should know about your current condition, your progress or ways your condition is affecting your life?

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INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: There are reported cases of stroke associated with common neck movements including rotation manipulation of the upper cervical spine. This technique is NOT used. Present medical and scientific evidence does not establish a definite cause and effect relationship between the cervical spine manipulation and the occurrence of stroke. There are reported rates of occurrence showing 1 in 1 million to 1 in 10 million will experience stroke. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. You are being informed of the possibility regardless of the extreme remote chance.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Other treatments including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery may be reasonable alternative procedures or treatment of my condition including, Medications. Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: *I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.*

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.
To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

X _____ **DATE** __ __ / __ __ / __ __ __ __

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

ASJC REPRESENTATIVE _____

CONFIDENTIAL PATIENT INFORMATION

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FINANCIAL POLICY / DISCLAIMER

INSURANCE VERIFICATION

Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. As a courtesy we provide an estimate based on the current fee schedule for your insurance carrier. This estimate may be slightly lower or higher than your actual incurred charges due to misinformation, case complications or additional or less therapies needed. Insurance companies review charges individually and make payment accordingly. Charges not covered by insurance are the patient's responsibility and due within 30 days of billing. We recommend each patient verify chiropractic benefits by referring to the plan summary provided by the insurance company or by calling the customer service phone number located at the bottom or back of your insurance card.

DEDUCTIBLE PAYMENTS

It is our policy to collect at time of service. Once we receive an "Explanation of Benefits" report form the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

COLLECTION OF PATIENT BALANCE

Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service. If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. Payment is due within 30 days of receipt of the bill.

In the event a bill is disputed, you must notify use within 30 days. If you do not notify us within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days will accrue interest at the rate of 18% per annum. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees, court costs or collection fees incurred by us.
All balances remaining unpaid after 30 days may be reported to a credit bureau and affect your credit rating.

RETURNED CHECKS

It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

APPOINTMENTS

If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a $20 charge added towards your account each visit that is missed. The patient will be responsible for payment. For Workmen's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your case manager and primary physician. This may jeopardize your claim.

FINANCIAL POLICY QUESTIONS

We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator, Cassie Hulme by contacting the office at 615-537-5520 or by e-mail at Cassie@ActiveSJC.com

HIPAA PRIVACY POLICY

Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you. By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies.

X _____ **DATE** __ __ / __ __ / __ __ __ __

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

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NOTICE OF INFORMATION PRIVACY PRACTICES |

HOW WE COLLECT INFORMATION ABOUT YOU:

Active Spine and Joint Center (ASJC) and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

WHAT WE DO NOT DO WITH YOUR INFORMATION:

Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

HOW WE DO USE YOUR INFORMATION:

Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between ASJC and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance, etc.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

INFORMATION WE DO NOT COLLECT:

We do not use cookies on our website to collect data from our site visitors. We do use some affiliate programs that may or may not capture traffic data through our site.

LIMITED RIGHT TO USE NON-IDENTIFYING PERSONAL INFORMATION FROM BIOGRAPHIES, LETTERS, NOTES, VIDEOS AND OTHER SOURCES:

Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of ASJC. Additionally, videos recorded in office may be used for educational or case research purposes. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising, promotional or educational purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information that you send to us will ever be publicly used without your direct or indirect consent.