MIDDLE TENNESSEE
SPINE & JOINT CENTER

Confidential Patient Information

Phone: (615)867-7782
Fax: (615)867-7783

Patient's Full Name: _____ Date: _____/_____/_____
Mailing Address: _____ City: _____
State: _____ Zip: _____ E-Mail: _____
Home Phone: _____ Cell Phone: _____
Referred by (☐ Friend, ☐ Relative, ☐ Physician or ☐ Newspaper):_____

Date of Birth: _____/_____/_____ ☐ Male ☐ Female Number of Children/Ages: _____
☐ Married (Spouse's Name :_____) ☐ Single ☐ Widowed ☐ Separated ☐ Divorced
Social Security # _____ - _____ - _____

Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed
Occupation: _____ Employer: _____
Employer Address: _____ Business Phone: _____

Primary Insurance Company: _____ ID#_____
Group#_____ Insured's Name_____ Date of Birth: ____/____/_____
Employer: _____ Relation to Insured: _____

Secondary Insurance Company: _____ ID#_____
Group#_____ Insured's Name_____ Date of Birth: ____/____/_____
Employer: _____ Relation to Insured: _____

Emergency Contact:_____ **Relationship:**_____ **Phone:** _____

Family Physician: _____ City: _____ State: ___ Phone: _____
May we share your information in our patient records with your above listed Physician for integrated care? ☐Yes ☐No
Previous Chiropractic Care: ☐Yes ☐No *If Yes*, for what Problem: _____
Doctor's Name _____ City: _____ State: _____

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three
What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____
_____

Your education level: ☐ High School ☐ Some College ☐ College Graduate ☐ Post Graduate ☐ Other: _____

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No **Date Of Injury:** _____
Is Today's Visit Due To An Auto Accident: ☐ Yes ☐ No **Date Of Injury:** _____
(If yes to either questions above, please check with receptionist, additional information is needed)

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 any 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 to you for the charges made for your service. I authorize you to prosecute said action 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 and Assignment is irrevocable until all moneys owed to you (Middle Tennessee Spine & Joint Center) are **paid in full**.

_____ Signature of Patient, Parent, or Guardian Date_____

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Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

In general, would you say your health is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: ☐ Yes ☐ No
If yes, when?:_____

Was treatment provided: ☐ Yes ☐ No If yes, By whom: _____ Outcome: _____

2. Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, when: _____

3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No
If yes, explain: _____

4. Have you ever had any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries? ☐Yes ☐No

Date	Injury/Fracture/Illness/Surgery	Treatment	Results

SYSTEMS REVIEW QUESTIONS:
Do you or have you ever had any problems with the following areas? (Please mark **Y** for yes or **N** for no in each of the following:)

1. _____ Eyes
2. _____ Ears, Nose, Mouth, Throat
3. _____ Heart
4. _____ Lungs/ Breathing
5. _____ Intestines/Bowels
6. _____ Urinary
7. _____ Muscles
8. _____ Nerves
9. _____ Joints/Bones
10. _____ Skin
11. _____ Internal Organs
12. _____ Blood
13. _____ Allergies
14. _____ Psychological/Emotional

Females only:

15. _____ Gynecological/Menstrual/Breast

Males Only:

16. _____ Prostate/Testicular/Penile

Please explain any above **Yes** answers:

_____

_____

_____

SOCIAL HISTORY:
Recreational Activities (Hobbies):_____

Yes No
☐ ☐ Do you exercise? _____ times per week
☐ ☐ Do you smoke? _____ packs per day
If you have quit smoking, when did you quit?: _____
☐ ☐ Do you use other forms of tobacco? What/How much per day?: _____
☐ ☐ Do you consume alcohol? How many drinks per week?: _____
☐ ☐ Do you eat a balanced diet? If no, explain: _____
☐ ☐ Do you get adequate sleep? If no, explain: _____
☐ ☐ Is work stressful to you? If yes, explain: _____
☐ ☐ Is family life stressful to you? If yes, explain: _____
☐ ☐ Do you use recreational drugs? If yes, explain: _____

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Chief complaint:_____

Secondary or related complaint(s) if a_____

Date of Onset/ When did your symptoms begin?: _____ Have you had this problem before? ☐ Yes ☐ No

Was the Onset: ☐ Gradual ☐ Sudden Since its' onset, has it gotten: ☐ Worse ☐ Better

Describe what caused the pain:_____

Have you detected any possible relationship of your current complaint with any of the following:
☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain: _____Results:_____

What medications are you currently taking?: _____

Are you currently pregnant? ☐ Yes ☐ No

Are you currently taking anti-coagulant or blood thinning medication? ☐ Yes ☐ No

PAIN CHART

Please Mark Areas of Pain using these Codes!

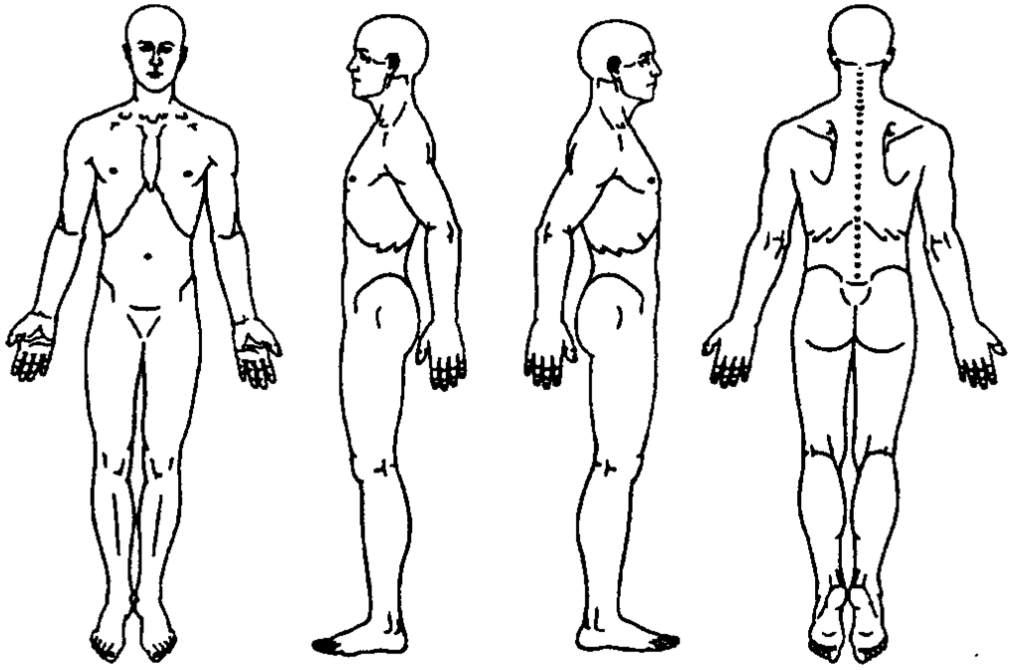
+++ Burning

Dull/Ache

***** Numbness/Tingling**

=== Throbbing

000 Stabbing/Sharp



SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain.

1. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

2. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

3. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

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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 the 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 Vertebrobasilar Artery (VBA) stroke associated with common neck movements including manipulation of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between the cervical spine manipulation and the occurrence of stroke. The most current research has concluded that the increased risk of VBA stroke associated with chiropractic and primary care visits is likely due to patients with headache and neck pain from VBA dissection seeking care before their stroke. The study also found "no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care." (*Spine*, Volume 33, Number 45, pp. 5176-5183.) You are being informed of the possibility regardless of the extreme remote chance.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

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

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

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.

_____ Signature of Patient, Parent, or Guardian Date_____

_____ Signature of Witness Date_____

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FINANCIAL/PRIVACY POLICY AND DISCLAIMER

INSURANCE VERIFICATION

Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. 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.**

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. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us.

All balances remaining **unpaid after 90 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.

Missed Appointments

All missed appointments and same day cancellations will be charged a cancellation fee. This fee is **$30.00** and will be billed to your account immediately. This fee can only be waived in the case of emergency or illness.

FINANCIAL POLICY QUESTIONS

We are happy to address questions regarding you account at any time. Please direct accounting questions to our office coordinator.

HIPPA PRIVACY POLICY

Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you**.**

By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.

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Notice of Information Practices and Privacy Statement

For Middle Tennessee Spine and Joint Center, LLC

How We Collect Information About You: Middle Tennessee Spine and Joint Center (MTSJC) 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 MTSJC 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, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of MTSJC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, 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 or photos that you send to us will ever be publicly used without your direct or indirect consent.