Confidential Patient Data

PATIENT INFORMATION

Today's Date:_____
Name:_____Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____Work Phone: _____ Cell: _____
Email: _____Social Security #:_____ Age:_____
❑ Male ❑ Female Marital Status: ❑ Married ❑Single ❑Divorced ❑Other_____
Name of Spouse or Nearest Relative:_____ Phone:_____
Your Occupation_____ Your Employer:_____
How did you hear about us? _____
Name of Insurance Co.:_____Insured's Employer: _____
Insured's Social Security #:_____ Insured's Date of Birth: _____
Are you covered by more than one insurance company? ❑Yes ❑No **Name**: _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate **PAST conditions** that have been experienced prior to present complaint by marking boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	Heart Disease	❑	❑	❑	Dislocated Joints	❑	❑	❑	Neck Pain
❑	❑	❑	Anemia	❑	❑	❑	Epilepsy	❑	❑	❑	Nervousness
❑	❑	❑	Arthritis	❑	❑	❑	Measles	❑	❑	❑	Numbness
❑	❑	❑	Back Pain	❑	❑	❑	Back Pain	❑	❑	❑	Polio
❑	❑	❑	Bladder Trouble	❑	❑	❑	Headaches	❑	❑	❑	Poor Circulation
❑	❑	❑	Bone Fracture	❑	❑	❑	Heart Trouble	❑	❑	❑	Hepatitis
❑	❑	❑	Cancer	❑	❑	❑	Reproductive Disorders	❑	❑	❑	Rheumatic Fever
❑	❑	❑	Chest Pain	❑	❑	❑	High Blood Pressure	❑	❑	❑	Rheumatism
❑	❑	❑	Concussion	❑	❑	❑	Bowel Control Loss	❑	❑	❑	Scarlet Fever
❑	❑	❑	Convulsions	❑	❑	❑	Menstrual Cramps	❑	❑	❑	Serious Injury
❑	❑	❑	Diabetes	❑	❑	❑	Multiple Sclerosis	❑	❑	❑	Sinus Trouble
❑	❑	❑	Indigestion	❑	❑	❑	Muscular Dystrophy	❑	❑	❑	Stroke
				❑	❑	❑	Venereal Disease	❑	❑	❑	Tuberculosis

Have you been treated by a physician for any health condition in the last year?
❑Yes
❑No

Social History:

Smoke: ___ If So How Much: _____ **Alcohol**:___ If So How Much: _____ **Drugs**: ___ If So What/How Much _____

SURGICAL HISTORY:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND**?** _____
_____
ARE YOU PREGNANT ❑ NO ❑ YES ❑ MAYBE

Circle All Activities or Daily Living Affected By Current Condition

Self Care Sleeping Kneeling Climbing Stairs Lifting Recreation Driving
Sitting Chores Sit to Stand Social Life Squatting Exercise Bending
Twisting Turning Yard Work Concentration Work

Patient's Signature: _____ Date: _____

Consent to Chiropractic and Medical Examination and Treatment

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. The primary treatment provided by Doctors of Chiropractic is spinal manipulation therapy, also referred to as an adjustment. A Doctor of chiropractic uses his/her hands and/or mechanical instrument on the patient's body in such a way as to move the patients joints. This may cause an audible "pop" or "click", such as when a person "cracks" his knuckles. The patient may feel a sense of movement as well.

Other procedures commonly used by Doctors of Chiropractic and our Medical providers include the following:

Physical examination	postural analysis	vital signs	bracing and support applications
ultrasound therapy	hot/cold therapy	diagnostic studies	manual therapy
laser therapy	traction/decompression	electrical muscle stimulation	acupuncture/dry needling
palpation	rehabilitation		

The material risks associated with chiropractic and medical treatment

Chiropractic treatment utilizes very safe, non-invasive procedures performed in chiropractic offices to reduce pain, restore range of motion, and promote overall body wellness, among other various benefits. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for patients to experience temporal soreness after the first few treatments. In rare cases manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke.

The probability of those risks occurring

Fractions are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during examination and x-ray. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options may include the following

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxation, and pain-killers
- Hospitalizations/surgery

There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor. Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I understand and accept that:

1. I have right to withdraw from or discontinue treatment at any time and that Dr. Joshua Price will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor the practice of medicine is an exact science, and my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and an undesirable result does not necessarily indicate an error in judgment or treatment.
4. Dr. Joshua Price cannot guarantee any results with respect to any course of care or treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Patient: I have read the above explanation of chiropractic adjustment and related treatment. I hereby authorize Dr. Joshua Price, therapy assistants, associates and other appropriate persons to render care, to perform an examination and to provide an appropriate evaluation and treatment plan to address to complaints, problems, and medical history I have provided. I have discussed or been given the opportunity to discuss any questions, comments, or concerns with Dr. Joshua Price or associated staff and have had my inquiries answered to my satisfaction. By signing below, I state that I have weighed the risks and/or benefits in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Name _____

Patient Signature_____

Date_____

Signature and Printed Name of Parent/Guardian if Patient is a Minor_____

Patient Name: DOB: Exam Date:

Hillcrest Chiropractic LLC

Financial Policy

230 Hillcrest Drive Clarksville Tennessee 37043

Patient Name: _____ Sex: M F Birth Date: _____ Age: ____

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

SS #: _____ Home Phone: _____ Cell: _____ Marital Status: ____

Person Responsible for Account: _____ Relationship: _____

Insurance Co. _____

Thank you for choosing our office as your health care provider. We are committed to providing you with the highest quality health care, so that you may fully attain optimum health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided unless a payment plan is arranged. Our office accepts cash, personal checks and most major credit cards. Please note: Returned checks and/or declined credit cards will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 35%.

Do you have insurance?

As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course do all we can to make sure your estimate is as accurate as possible.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your chiropractic and medical care provider, our relationship is with you, our practice, nor with your insurance company. Our office is not a party to that contract.

Our practice is committed to providing the best treatment for 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.

We ask that you sign this form and/or any necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

Insurance payments are typically received within 30 to 60 days from the time of filing. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with regulations and request of your insurance company that may assist in the claim being paid. Our office will not, however enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to service you chiropractic health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my medical benefits directly to my chiropractic and medical office. The undersigned herby authorized to the Doctor to take x-ray's or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's needs. I also authorize the doctor to perform any and all forms of treatment and therapy that may be indicated. I understand that responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable as services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Patient Signature _____Date**:** _____

Parent or Guardian Signature if Patient is a Minor_____

Patient Acknowledegment receipt for consent to use and disclosure of Protected Health Information.

Use and disclosure of your Protected Health Information

Your PHI (Protected Health Information) will be used by Hillcrest Chiropractic LLC to authorize and disclose to others for purposes of treatment, obtaining payment, or health care operations of this office.

Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the current Notice of Privacy Practices for this health care facility. It describes your rights to the limited use of protected health information, including your demographic information.

You have the right to request a restriction or disclosure on the use of your PHI (Protected Health Information). This office may or may not agree to your request.

This office utilizes open or common areas for treatment however, private areas are available upon request.

You may refuse to sign this acknowledgement and authorization and revoke this consent to use PHI. This must be done in writing.

I authorize contact from this office to confirm my appointments, treatment, and billing information by means:

Patient Acknowledgement Contact

☐ Cell phone ☐ Home phone ☐ Text message

☐ Email ☐ All of the above

I acknowledge receipt of a copy of the office "Notice of Patient Privacy Policy"

_____ _____

Patient or legal authorized individual signature Date

_____

Printed name of Patient

_____ _____ _____

Sign Guardian of Patient Relationship Date

Office use only- As compliance office, attempt to obtain patients signature of this notice was not obtained because:

_____

Signature of Privacy officer

Patient Name: DOB: Exam Date:

Circle any and all that you are currently experiencing or have experienced in the past.

General
Weight Loss
Fatigue
Fever or Chills
Weakness
Trouble Sleeping

Skin
Rashes/Itching
Lumps
Dryness
Color changes
Hair/Nail Changes

Head
Headache
Head injury

Nose
Sinus Pain
Discharge
Itching
Hay Fever
Nosebleeds

Throat
Bleeding
Sore tongue
Sore throat
Hoarseness
Thrush
Non-healing sores

Neck
Lumps
Swollen glands
Pain
Stiffness

Breast**:**
Lumps
Pain
Discharge

Respiratory
Cough
Coughing up blood
Shortness of Breath
Wheezing
Painful breathing

Cardiovascular
Chest pain
Tightness
Palpitations
Shortness of breath
Difficulty breathing while lying Down
Swelling

Gastrointestinal
Swallowing difficulties
Heartburn
Change in appetite
Nausea
Change in bowel habits
Rectal bleeding
Constipation
Diarrhea
Yellow eyes or skin

Urinary
Frequency
Urgency
Burning or pain
Blood in urine
Incontinence
Change in urinary strength

Vascular
Calf pain with walking
Leg cramping

Musculoskeletal
Muscle or joint pain
Stiffness
Back pain
Redness of joints
Swelling of joints
Trauma

Neurologist
Dizziness
Fainting
Seizures
Weakness
Numbness
Tingling
Tremor

Hematologic
Ease of bruising
Ease of bleeding

Endocrine
Hot or Cold tolerance
Sweating
Frequent urination
Change in appetite
Thirst

Psychiatric
Nervousness
Depression
Memory loss
Stress

Male**:**
Pain with sex
Hernia
Penile discharge
Sores
Masses or pain
Erectile Dysfunction
STD's

Female**:**
Pain with sex
Vaginal dryness
Hot flashes
Vaginal discharge
Itching or rash
STD's

_____
Patient Signature

Patient Name: DOB: Exam Date: