Hillcrest Chiropractic
Hillcrest Physical Medicine and Rehabilitation Center

Check any current conditions

General:
o Weight loss or gain
o Fatigue
o Fever or chills
o Weakness
o Trouble sleeping

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

Head:
o Headache
o Head injury

Eyes:
o Glasses or contacts
o Pain
o Redness
o Blurry/double vision
o Flashing lights
o Specks

Nose:
o Sinus Pain
o Discharge
o Itching
o Hay fever
o Nose bleeds

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

Neck:
o Lumps
o Swollen glands
o Pain
o Stiffness

Respiratory:
o Cough
o Coughing up blood
o Shortness of breath
o Wheezing
o Painful breathing

Cardiovascular:
o Chest Pain
o Tightness
o Palpitations
o Shortness of breath
o Diffculty breathing while lying down
o Swelling

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

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

Vascular:
o Calf pain with walking
o Leg cramping

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

Neurologist:
o Dizziness
o Fainting
o Seizures
o Weakness
o Numbness

Hematologic:
o Ease of bruising
o Ease of bleeding

Endocrine:
o Hot or cold tolerance
o Sweating
o Frequent urination
o Change in appetite
o Thirst

Psychiatric:
o Nervousness
o Depression
o Memory loss
o Stress

Genital:

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

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

Breasts:
o Lumps
o Pain
o Discharge
o Self-exam

I have reviewed the above information with the patient. *(To be signed by Hillcrest Physical Medicine and Rehabilitation PC physician)

Karen Lee-Date

Physician's Signature-Date

Name: DOB: Date: _____/_____/_____

Hillcrest Chiropractic
Hillcrest Physical Medicine and Rehabilitation Center

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	□	□	□	Headaches	□	□	□	Polio
□	□	□	Bladder Trouble	□	□	□	Heart Trouble	□	□	□	Poor Circulation
□	□	□	Bone Fracture	□	□	□	Reproductive Disorders	□	□	□	Hepatitis
□	□	□	Cancer	□	□	□	High Blood Pressure	□	□	□	Rheumatic Fever
□	□	□	Chest Pain	□	□	□	Bowel Control Loss	□	□	□	Rheumatism
□	□	□	Concussions	□	□	□	Menstral Cramps	□	□	□	Scarlet Fever
□	□	□	Convulsions	□	□	□	Multiple Sclerosis	□	□	□	Serious Injury
□	□	□	Diabetes	□	□	□	Muscular Dystrophy	□	□	□	Stroke
□	□	□	Indigestion	□	□	□	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:** _____

Hillcrest Chiropractic LLC
Hillcrest Physical Medicine and Rehabilitation P.C.

Consent to Chiropractic and Medical Examination and Treatment

230 Hillcrest Drive Clarksville, TN 37043

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 & Support
Applications	Hot/Cold Therapy	Diagnostic Studies	Manual Therapy
Ultrasound Therapy	Traction/Decompression		Acupuncture/Dry
Laser Therapy	Rehabilitation	Electrical Muscle Stimulation	
Needling		Injections	
Palpation			

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 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.

Name: DOB: Date: _____/_____/_____

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 and our medical team 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, medical doctors, nurse practitioners, physician assistants, physical therapists, 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 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 of Parent/Guardian

Hillcrest Chiropractic LLC
Hillcrest Physical Medicine and Rehabilitation P.C.
Financial Policy

230 Hillcrest Drive Clarksville, TN 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 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 (parent of child): _____Date: _____

Hillcrest Chiropractic
Hillcrest Physical Medicine and Rehabilitation Center

Hillcrest Physical Medicine and Rehabilitation PC
&
Hillcrest Chiropractic LLC

230 Hillcrest Drive Clarksville, TN 37043
931-906-9679

Disclosure for Treatment, Payment, and Health Care Operations

• If you give us consent, we will use your health information for treatment. Example: A physician, a physician's assistant, a therapist or a counselor, a nurse, or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the health care team to do to treat you. Those other members will then document the actions that they took and their observations. In that way, the primary caregiver will know how you are responding to treatment. We will also provide physician, other health care professionals, or a subsequent health care provider copies, of your records to assist them in treating you once we are no longer treating you.

• If you give us consent, we will use your health information for payment. Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

• If you give us consent, we will use your health information for health care operations. Examples: Members of the medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

• *Business associates:* We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) what we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information. After February 17, 2010, business associates must comply with the same federal security and privacy rules as we do.

• *Directory:* Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

• *Notification:* We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, location, and general condition.

• *Communication with family:* Unless you object, health professionals, using their best judgment, may disclose to a family member, another relative, a close personal friend, or any other person that you identify health information in your care or payment related to your care.

Name: DOB: Date: _____/_____/_____

• *Research:* We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

• *Funeral directors:* We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

• *Marketing/ continuity of care:* We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

• *Fundraising:* We may contact you as part of a fundraising effort. You have the right to request not to receive subsequent fundraising materials.

• *Food and Drug Administration (FDA):* We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

• *Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

• *Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

• *Correctional institution:* If you are an inmate of a correctional institution we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

• *Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

• *Health oversight agencies and public health authorities:* If members of our work force or business associates believe in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the department of health.

• *The Federal Department of Health and Human Services (DHHS):* Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards.

Effective Date: _____

Signature: _____

Title: _____

Covered Entity: Hillcrest Physical Medicine and Rehabilitation PC Hillcrest Chiropractic LLC

By signing below I certify that I have reviewed and agree to the above information:

_____ _____

Patient Signature Date

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.

Understanding your MEDICAL HEALTH record information

Each time that you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as the following:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care that you received.
- Means by which you or a third-party payer can verify that you actually received the services billed for.
- Tool in medical education.
- Source of information for public health officials charged with improving the health of the regions they serve.
- Tool to assess the appropriateness and quality of care that you received.
- Tool to improve the quality of health care and achieve better patient outcomes.

Understanding what is in your health records and how your health information is used helps you to:

- Ensure its accuracy and completeness.
- Understand who, what, where, why, and how others may access your health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

Your rights under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed the records, you have the following rights with regard to the information contained therein:

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: section 164.502(a)(2)(i) (disclosure to you) section 164.510(a)(for facility directories, but note that you have the right to object to uch uses), or section 164.512(uses and disclosures not requiring a consent or an authorization). The latter uses and disclosure include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction, except in the situation explained below. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate on the consent from for treatment, payment, and health care operations. If, however, you request restriction on a disclosure to a health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.

- Obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a hard copy upon request.

• Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right to access to the following:

» Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.

» Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.

» Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. section 263a, to the extent that fiving you access would be prohibited by law.

» Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.

In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:

» A licensed health care professional, such as your attending physician, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.

» PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonable likely to cause substantial harm to such other person.

» The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representation is reasonably likely to cause substantial harm to you or another person.

For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny your access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost based fee for making copies.

• Request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:

» We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.

» The records are not available to you as discussed immediately above.

» The record is accurate and complete.

If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

• Obtain an accounting of nonroutine uses and disclosures, those other than for treatment, payment, and health care operations until a date that the federal Department of Health and Human Services will set after January 1, 2011. After that date, we will have to provide and accounting to you upon request for uses and disclosures for treatment, payment, and health care operations. We do not need to provide an accounting for the following disclosures:

» To you for disclosures of protected health information.

» For the facility directory or to persons involved in our care or for other notification purposes as provided in section 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representative, or other persons responsible for your care, of the location, general condition, or death).

» For national security or intelligence purposes under section 164.512 (k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).

» To correctional institutions or law enforcement officials under section 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).

» That occurred before April 14, 2003.

• We must provide the accounting within 60 days. The accounting must include the following information:

» Date of each disclosure.

» Name and address of the organization or person who received the protected health information.

» Brief description of the information disclosed.

» Brief statement of the purpose of the disclosure that reasonable informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.

• The first accounting in any 12 month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

• Revoke your consent and authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

Our responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

• Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.

• Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.

• Abide by the terms of this notice.

• Train our personnel concerning privacy and confidentiality.

• Implement a sanction policy to discipline those who breach privacy/ confidentiality or our policies with regard thereto.

• Mitigate (lessen the harm of) any breach of privacy/confidentiality. We will not use or disclose your health information without your consent or authorization, except as described in the notice or otherwise required by

How to get more information or to report a problem

If you have questions and/or would like additional information, you may contact Hillcrest Physical Medicine and Rehabilitation PC and Hillcrest Chiropractic LLC 931-906-9679.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS THAT YOU HAVE GIVEN US.

I certify that I have been given and reviewed the above information.

Patient Signature _____ Date _____

Employee Signature _____ Date _____