

HEALTH4LIFE CHIROPRACTIC

2805 D Old Fort Parkway, Murfreesboro, TN 37128

NEW PATIENT INFORMATION

Name: _____ Date: _____

Preferred Name: _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Date of Birth _____ Age _____

Gender _____ # of children _____

Employer _____

Work Address _____

Work Phone _____

Type of Work _____

Marital Status S M D W

Social Security # _____

E-mail Address _____

SPOUSE INFORMATION OR EMERGENCY CONTACT

Name _____

Employer _____

Type of Work _____ Phone _____

EXPERIENCE WITH CHIROPRACTIC

Who may we thank for referring you to this office?

Have you been adjusted by a chiropractor before? Yes No

Reason for those visits? _____

Doctor's name _____ Date of last visit _____

Has any adult in your family seen a chiropractor? Yes No

Has any child in your family seen a chiropractor? Yes No

General Questions

Does your mother, father, brother, sister, or children have similar problems? Yes No

REASON FOR THIS VISIT

Current Health Concerns/Reasons for consulting our office

1. _____

2. _____

3. _____

Is the purpose of this appointment related to:

Job Sport Auto Fall Home Injury

Chronic Discomfort Wellness Check

If Job related, have you made a report of you accident to your employer Yes No

When did this condition begin? _____

Has this condition:

gotten worse stayed constant comes and goes

Does this condition interfere with:

work sleep daily routine Other Activities

Please explain _____

Has this condition occurred before? Yes No

Please Explain _____

Have you seen other doctors for this condition?

Yes No Doctor's Name _____

Treatment _____ Results _____

Family Physician _____ Location _____

PRIVACY NOTICE

Consent for Use of Disclosure of Health Information

We are concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose you health care information:

1. We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes.

We reserve the right to change our privacy practices as described in this notice. If we make changes to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree with your restrictions. However, if we agree to your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke any of your authorizations at any time, however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing the consent form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

Information that we use or disclose based on the authorization you are giving us, may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not effect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time.

Tennessee Chiropractic Association Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Tennessee Chiropractic Association (TCA). This disclosure will be made if we need the TCA's assistance to receive reimbursement for your services or, we need the TCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing the consent form, you are giving us authorization to send the TCA this information. You are also giving the TCA authorization to re-disclose your information to the party responsible for the payment of your services, the TCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf. You may inspect or copy the information that we may send to the TCA at any time.

Effective Date: This notice is effective as of March 22, 2005, and authorization will expire seven years after the date on which you last received services from us.

I have read your Privacy Notice and agree to its terms. I authorize you to use or disclose my health information in the manner described in the Privacy Notice.

Print Patient Name _____ Signature _____ Date _____

Patient Representative _____ Signature _____ Date _____

Office Representative _____ Date _____

Health4Life Chiropractic

2805 Old Fort Parkway, Suite D, Murfreesboro, TN 37128

Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each practice member understands both the objective and the method that will be used to attain it. This will prevent any confusion or misunderstanding.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. **Our only practice objective** is to eliminate interference to the expression of the body's innate intelligence. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature _____ Date _____

Optimal Spine – Optimal Health

Health4Life Chiropractic, Inc

Print Patient Name _____ Date _____

OUR GOAL IS TO KEEP CLEAR, OPEN COMMUNICATION BETWEEN OUR OFFICE AND PRACTICE MEMBERS. WE WILL STRIVE TO INFORM YOU IN ADVANCE OF ANY PROCEDURES TO BE PERFORMED AND ANY ASSOCIATED FEES.

1.) CONSENT FOR CARE

I, the undersigned, hereby authorize the doctors at Health4Life Chiropractic and whomever they designate as their assistant(s) to perform diagnostic tests including, but not limited to, radiographs, and to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that this office will prepare reports/forms to assist me in getting reimbursed from my insurance company. I clearly understand and agree that all service rendered to me are charges directly to me and that I am personally responsible for payment.

Patient Signature _____ Date _____

2.) AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of my x-rays / records or copies of such to be transferred to: Health4Life Chiropractic 2805 Old Fort Pkwy, Ste D. Murfreesboro, TN 37128 (615) 893-5133

Patient Signature _____ Date _____

3.) Fill out the section below if you have been in an automobile accident or a work injury.

I have been involved in a: () automobile accident-Date: _____ () work injury- Date: _____
Claim number: # _____ Adjustor's Name: _____
Adjustor's Phone Number: _____ Company Name: _____

4.) ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE (PI/WC)

I, the undersigned patient am directing my attorney, _____, to pay any outstanding bills out of my settlement and, in effect, to protect any such balance. I hereby make and declare the instructions here to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on the current status.

Patient Signature _____
Date _____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize the doctors at Health4Life Chiropractic and whomever they designate as their assistant(s), to perform diagnostic tests including, but not limited to, radiographs, and to administer treatment as he deems necessary to my (indicate relationship of the child) _____, (Child's name) _____.

Guardian's Signature _____ Date _____