MIDDLE TENNESSEE
CHIROPRACTIC
SPORTS + INJURY

7153 Nolensville Rd.
Nolensville, TN 37135
615-776-7246
DrJon@midtnchiro.com
www.midtnchiro.com

NEW PATIENT HISTORY

Name (including middle initial) _____ Date _____

☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D ☐ O Number of Children _____

Address _____

City _____ State _____ ZIP _____ Social Security Number _____

Age _____ Birth Date _____ Email Address _____

Home Phone _____ Cell Phone _____

Name of Spouse _____ Spouse Date of Birth _____

Spouse Social Security Number _____ Spouse Employer _____

Spouse Employer Address _____

Employment Information

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

Occupation _____ Employer _____

Employer Address _____

City _____ State _____ ZIP _____ Work Phone _____

Do you have medical insurance ☐ Yes* ☐ No Name of insurance company _____
*If yes, please provide us with a copy of the front and back of your insurance card(s).

Name of Emergency Contact _____

Phone Number _____

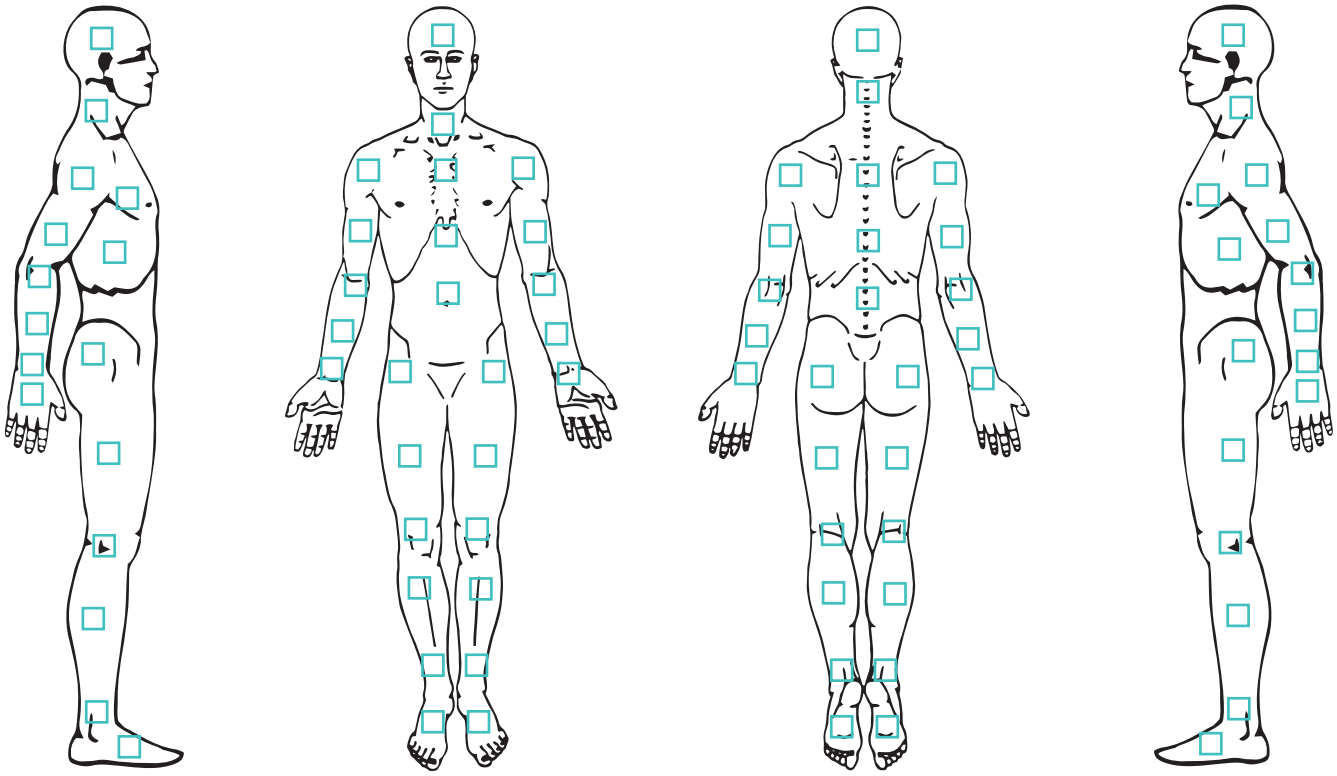
How do you prefer to be verbally addressed? _____

Whom may we thank for referring you in? ☐ Friend ☐ Relative ☐ Internet ☐ Physician ☐ Other _____

Patient Symptoms Medical History

Present Complaint _____

Mark on the picture where you have pain or other symptoms. Include symptoms of pain, numbness or tingling, etc.



When did your problems begin? Specific date if possible _____

How did your problem begin? _____

In the past have you had anything similar to this? ☐ Yes ☐ No

Please explain _____

Please describe the character of your current pain. You may check one or more answers.

☐ Sharp ☐ Stabbing ☐ Burning ☐ Shooting ☐ Aches ☐ Soreness
☐ Weakness ☐ Throbbing ☐ Numbness ☐ Dull ☐ Constricting ☐ Stiff ☐ Other _____

On a Scale from 0-10, with 10 being the worst pain you have experienced and 0 being no pain, what is your current scale of pain?

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

How often are the complaints present?

☐ Constant / 100% of time ☐ Frequent / 75% ☐ Intermittent / 50% ☐ Occasional / 25%

Comments _____

Is the pain:

☐ Increasing ☐ Decreasing ☐ Not Changing ☐ Varies

Pain is aggravated by:

☐ Walking ☐ Sitting ☐ Standing ☐ Riding in a car ☐ Lifting ☐ Bending ☐ Stretching
☐ Twisting ☐ Running ☐ Transitioning from seated to standing ☐ Other _____

Pain is reduced by:

☐ Rest ☐ Laying Down ☐ Sitting ☐ Walking ☐ Medicine ☐ Exercise ☐ Chiropractic
☐ Supplements ☐ Physical Therapy ☐ Other _____

What would you like to do, but can't, because of your pain? _____

Are your complaints affecting your ability to work or be active? _____

☐ No effect ☐ Some physical restrictions ☐ Unable to perform regular duties

Is there any dizziness associated with symptoms? ☐ Yes ☐ No

Any fever or chills? ☐ Yes ☐ No

Any change in bowel or bladder (bathroom) function? ☐ Yes ☐ No

Are your complaints affecting your ability to sleep? ☐ Yes ☐ No Explain _____

On average, how many hours of sleep do you get per night? _____

For your present complaint have you seen any other doctors or had any physical therapy? ☐ Yes ☐ No

If yes, who? _____ What treatment? _____

Family Doctor / Primary Care Physician _____
We normally keep your family doctor and/or referring physician informed regarding your care at this office.
Is that okay? ☐ Yes ☐ No

Please specify name and address _____

Medical History

☐ Anemia ☐ Arthritis ☐ Cancer ☐ Cardiovascular Problems ☐ Holter Monitor-currently wearing
☐ Pacemaker ☐ Depression ☐ Seizures ☐ Dizziness/Fainting ☐ Currently Pregnant
☐ Fractures ☐ Headaches ☐ Hepatitis /HIV ☐ Respiratory Problems ☐ Kidney Problems
☐ Diabetes: ☐ controlled ☐ uncontrolled ☐ Asthma: ☐ controlled ☐ uncontrolled
☐ COPD: ☐ controlled ☐ uncontrolled ☐ Low-Blood Pressure: ☐ controlled ☐ uncontrolled
☐ High-Blood Pressure: ☐ controlled ☐ uncontrolled
☐ Other _____

If checked **Yes** to any above, please explain:

_____

_____

_____

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)

____ Eyes ____ Muscles ____ Allergies ____ Ears, Nose, Mouth, Throat ____ Nerve
____ Heart ____ Joints/Bones ____ Blood ____ Psychological/Emotional ____ Urinary
____ Lungs/ Breathing ____ Intestines/Bowels ____ Skin ____ Internal Organs

Females only
____ Gynecological/Menstrual/Breast

Males Only
____ Prostate/Testicular/Penile

Please explain any above **Yes** answers:

_____

_____

Have you ever had any major surgeries, accidents, illnesses or hospitalizations? ☐ Yes ☐ No

Date /Age	Surgery/Illness/Accident/Hospitalization	Treatment	Outcome

Have you **ever** broken any bones? ☐ Yes ☐ No

Have you missed any days of work or school due to the current condition? ☐ Yes ☐ No

Dates missed _____

What **non-prescription** medication are you taking? ☐ Tylenol ☐ Ibuprofen ☐ Aspirin ☐ Aleve

What supplements are you taking? _____

Do you consume alcohol? ☐ Yes ☐ No How Much _____

What is your exercise routine? _____

What type of care are you interested in:
☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

Other health concerns:

_____

_____

_____

_____

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REQUEST FOR ASSIGNMENT OF BENEFITS TO HEALTH CARE PROVIDER

Name of Patient

Name of Insured (if different from patient)

Insurance Company

Health Care Provider: Middle Tennessee Chiropractic and Sports Injury, PLLC
9927 Sam Donald Court, Suite D
Nolensville, TN 37135

I am entitled to benefits under a policy of insurance written by the above insurance company. I have received treatment for an injury from the above health care provider.

As allowed by T.C.A. §56-7-120, I hereby assign to the above health care provider, from the benefits to which I am entitled, a sum of money sufficient to cover the charges of that health care provider for the services I have received. I hereby request that the above insurance company pay that money directly to the health care provider.

I understand that the amount which is paid to the above health care provider may be limited by the amounts owed to other health care providers who have provided services to me for the same injury and by the amount of medical benefits to which I am entitled under the policy. I also understand that the amount paid to the above health care provider may be deducted from any "bodily injury" award that I may receive.

If the above insurance company does not permit the assignment of benefits, I hereby request that the company disburse the sums to which I am entitled in the form of a check issued in the names of the insured and the above health care provider as joint payees and sent to the office of the provider.

I understand that if the benefits available to me under the policy are insufficient to cover the charges of the above health care provider, I am responsible for paying that portion of the provider's charges not covered by insurance.

I agree to give a 30 day notification in writing to the above health care provider before changing this assignment of benefits in any way.

Patient

Date

Witness

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CONSENT FORM

PRIVACY PROTECTION AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan, coordinate, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and accreditation. This includes release of information and notification of care to my primary health care and/or referring provider.

I hereby authorize Middle Tennessee Chiropractic and Sports Injury to release a complete report of services rendered including diagnosis, findings and details of treatment, and progress for the purpose of receiving payment for the services rendered to its authorized billing agents, my insurance carriers, employer's workers compensation insurance company, or other category of third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, any Professional Review Organization, attorney, or other intermediaries responsible for payment of my charges and hereby release Middle Tennessee Chiropractic and Sports Injury from any consequences thereof. I understand that I may revoke this consent at anytime by giving written notice.
Please list below the names of and your relationship to individuals whom you authorize Middle Tennessee Chiropractic and Sports Injury to release your protected health information.

Name and Relationship

_____ _____

_____ _____

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read or declined the opportunity to read and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Middle Tennessee Chiropractic and Sports Injury to ensure the privacy of my protected health information. I understand that this acknowledgment will be placed in my electronic file and maintained for six years. A copy of this notice is available at any me upon request.

AUTHORIZATION TO ACQUIRE HEALTHCARE INFORMATION

I hereby authorize Middle Tennessee Chiropractic and Sports Injury to obtain details regarding my current and/or prior health care status from my primary care provider, referring provider, and/or other providers to facilitate appropriate care. All health records, diagnostic imaging results, diagnostic testing results, surgical information, and any data that are held regarding my medical and health management are applicable for release. This release does NOT allow information pertaining to drug and/or alcohol abuse, or mental health information to be included. I understand that I may revoke this consent at any me, except to the extent that ac on has already been taken, with written notice.

ERISA AUTHORIZATION (EMPLOYEE RETIREMENT INCOME SECURITY ACT)

I hereby designate, authorize, and convey to Middle Tennessee Chiropractic and Sports Injury to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in ac on that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of ac on in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. (2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Middle Tennessee Chiropractic and Sports Injury and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

NOTICE OF OFFICE PROCEDURES AND COMMUNICATIONS

Many areas of our office are an open concept. While we do our best to discuss information regarding your treatment and/or accounts privately, at mes other patients may be able to overhear. We ask that if you would like to discuss something more privately that you let us know.

Communications from our office including but not limited to, patient bills, letters, thank you cards, and claims sent to insurance companies are all sent out in envelopes with our office name on them.

It is the policy of Middle Tennessee Chiropractic and Sports Injury to not leave messages via voicemail, e-mail, or with another party regarding your care, testing results, specific follow up instructions, or other situations involving your personal health or care provided in this office or elsewhere. When needed, communications will be limited in scope and nature with as little identifying or specific information as possible, o en requesting a return phone call to discuss pertinent information. However, with your consent, detailed information can be left via the following methods:

☐ I hereby authorize that Middle Tennessee Chiropractic and Sports Injury can leave detailed messages regarding my healthcare. Please check all that apply.

☐ Cell ☐ Home ☐ Work ☐ Email

☐ I hereby authorize that Middle Tennessee Chiropractic and Sports Injury can leave detailed messages regarding my healthcare via another person reached at the following phone numbers that I have provided:

☐ Cell ☐ Home

I, the undersigned, hereby certify that I have read, fully understand, and agree to be bound by these policies, assignment, and authorization pertaining to myself or my dependent. I have asked or have declined the opportunity to ask any pertinent questions regarding this information before applying my signature. A photocopy of this document shall be considered as effective as the original. I intend this certification to cover the en re course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

_____

Signature (Patient or Responsible Party)

_____

Print Name (Patient or Responsible Party)

_____

Date

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CONFIDENTIAL PATIENT INFORMATION

Patient Name _____ Date _____

EHR Information

Smoking Status: ☐ Everyday Smoker ☐ Occasional Smoke ☐ Former Smoker ☐ Never Smoked

Are you currently taking any medications? (Please include any regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5 mg per day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Family Medical History. Record the diagnosis in your family history (ex: cancer, arthritis, major illness, etc.) and the affected relative.

Diagnosis (Write in Below)	Father	Mother	Sibling	Offspring

Preferred Language _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Race: ☐ Black or African American ☐ White (Caucasian) ☐ Other ☐ Decline to Answer

☐ I choose to decline receipt of my clinic summary after every visit.

(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

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INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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PATIENT FINANCIAL POLICY

Please read our financial policy in its entirety. If you have any questions or concerns please feel free to ask any questions that you may have. Your clear understanding of our Patient Financial Policy is important to our professional relationship.

Insurance

It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will copy for our records. We will request a copy at each annual office visit, or if you have not been seen in the past six months. If your insurance information changes at any time during your treatment, it is ultimately your responsibility to provide us with the new information as soon as it becomes active. If current information is not obtained at the time of service it will be the patient's responsibility to pay the entire balance until current information is provided to our office.
It is the patient's responsibility to know their benefits and coverage.

Your insurance policy is a contract between you and the insurance company. As a courtesy and pursuant to contractual obligations we will file all your claims for you. However, we will not become involved in any disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, copays, and non-covered charges.

Referrals

Some insurance policies require you as the policy holder to obtain a referral from your primary care physician, or student health center prior to receiving treatment at our office. It is your responsibility to obtain this documentation and present it to our office at the time of service. If this information is not obtained, you will be responsible for the entire balance of your account.

Copays

Copays are due at the time of service. Copays are usually collected PRIOR to you seeing the doctor but may sometimes be collected after you have received treatment. *** If your copay is not paid at the time of service you will be charged a $10 service fee to cover the cost of billing you for the copay.*

Medicare

If you are a Medicare patient you will be responsible to pay for your exam on your first visit, at the time of service. While Medicare requires an exam they do not cover it. Exams are typically $80. Xrays are also not covered by Medicare and the cost would be your responsibility and would also be due at the time of service.

Cash Plans

Cash plans are available for patients who do not have insurance or wish to not bill to insurance. These plans differ and can be discussed with your doctor. Cash plan payments are due at the time of service. ***If payment is not made at the time of service a $10 service fee will be charged to cover the cost of billing you for the charges.*

Supplements/Merchandise

Payments for supplements and merchandise purchased in our office are due at the point of sale. We cannot bill insurance, worker's compensation, or personal injury accounts for these items. These charges are the patient's responsibility and are not covered by any insurance carrier. These items include but are not limited to, swiss balls, DVDs, supplements, water pillows, backpacks, braces, heel lifts, orthotics, and cold packs.

Unpaid/Outstanding Balances

We ask that full payment be made at the time of service unless prior arrangements have been made, either with your doctor or our billing office. If you have a deductible plan, once insurance has paid you will be mailed a statement. Prompt and timely payment is appreciated. You may call our billing office to set up a payment plan if necessary. Any overdue balances will be considered for collections.

Returned Checks

The charge for a returned check is $25. This can be paid by cash, money order, or charge. This will be applied to your account in addition to the original amount owed.

Missed Appointments

We ask that you keep all scheduled appointments. In the event that you are unable to keep your appointment we ask that you provide at least a 24 hour notice.

Credit Balances

From time to time you may accrue a credit balance. Credit balances will be refunded at the patient's request. Refunds are made by check. After the request for a refund has been made, please allow time for review of your entire account and processing through our accounting department. Once approved please allow 30-45 days for your refund check to arrive.

I have read Middle Tennessee Chiropractic and Sports Injury Clinic's, PLLC Financial Policy and acknowledge my responsibility with my signature below.

A photocopy of this document will be treated as an original

Patient Name (Please Print)	Date
Patient/Responsible Party Signature	MTCSI Staff Witness

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TO OUR PATIENTS REGARDING CANCELLATIONS AND NO-SHOWS

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make a difference between responding to treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatment. If you show up for treatment, it will enable you to get better. Other than that all you need to do is follow your doctor's instructions, and you should achieve your treatment goals.

We require 24 hours notice in the event of a cancellation.

It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full number of prescribed treatments that week whenever possible.

There is a $20 charge for a cancellation or no-show without proper notice.

This charge will not be covered by you insurance, but will have to be paid by you personally.

For Workmen's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your case manager and primary physician. This could jeopardize your claim.

Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally eliminated. Either condition should not be a reason not to come in: 1) Your pain is gone or 2) Your pain is worse. If the pain is gone, now is the time to really begin rehabilitating the injured area to prevent recurrence. If your pain is worse, we can do something to help.

When you don't show as scheduled, three people are hurt.

1) You, because you didn't get the treatment you need as prescribed by your doctor;
2) The doctor who now has a hole in their schedule;
3) The person that couldn't get in when you had your appointment scheduled.

Thank you for cooperating with us on this matter.

We are looking forward to working with you.

Patient Signature _____ Date _____