Carson Chiropractic Clinic

1502 McArthur Street
Manchester, TN 37355
(931) 723-4878

Today's Date: Patient Pin#

PATIENT INFORMATION

Patient's Last Name:	**First:**	**Middle:**	**Nickname** **(What you would like us to call you):**	**Sex:** ☐M ☐F

Pre Fix: Mr. Dr. Mrs. Ms. Miss	**Suffix:** Jr. Sr. II III IV	**DOB:** MM/DD/YYY	**Social Security:** _ _ _ - _ _ - _ _ _ _	**Marital Status:** ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Other

Address:	**City:**	**State:**	**Zip:**

Home Phone:	**Cell Phone:**	**Work Phone & Ext.**	**Preferred Contact Number:** ☐ Home ☐ Cell ☐ Work

Email:

Would you like to receive appointment reminders? Choose ONE: ☐ Text Message ☐ Phone Call ☐ Email ☐ None

Cell Phone Carrier: ☐ Verizon ☐ AT&T ☐ Sprint ☐ StraightTalk ☐ Other: _______________(Please List)

Case Type: ☐ BC/BS Insurance ☐ No Insurance ☐ Medicare ☐ Auto Injury ☐ Worker's Comp

Employment Status: ☐ Employed ______________________ ☐ Full-Time Student ☐ Part-Time Student ☐ Not Employed

Preferred Language: ☐ English ☐ Spanish ☐ Other: ______________________

Please check ALL races that apply: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Not Hispanic nor Latino ☐ Hispanic or Latino ☐ Declined to Answer

Current Medications:

1. Drug Name: ______________________________ Strength (eg. 10MG) _________Dose (e.g. 1 tab)___________
   Frequency (e.g. once daily) ___________________Date Started:________________
2. Drug Name: ______________________________Strength (eg. 10MG) _________Dose (e.g. 1 tab)___________
   Frequency (e.g. once daily) ___________________Date Started: ________________
3. Drug Name: ______________________________ Strength (eg. 10MG) _________Dose (e.g. 1 tab)___________
   Frequency (e.g. once daily) ___________________Date Started: ________________
4. Drug Name: ______________________________ Strength (eg. 10MG) _________Dose (e.g. 1 tab)___________
   Frequency (e.g. once daily) ___________________Date Started: ________________
5. Drug Name: ______________________________ Strength (eg. 10MG) _________Dose (e.g. 1 tab)___________
   Frequency (e.g. once daily) ___________________Date Started: ________________

Drug Allergies:

1. Drug Name __________________________ Reaction (e.g. hives) __________________ Date Started: ___________
2. Drug Name __________________________ Reaction (e.g. hives) __________________ Date Started: ___________
3. Drug Name __________________________ Reaction (e.g. hives) __________________ Date Started: ___________

Referred By:	Referring Physician?

Today's Date: Patient Pin#

PATIENT HISTORY

Please describe your past accidents:

1.Accident: ______________________________________ ❑Job ❑Auto ❑Other Date: _______________
2.Accident: ______________________________________ ❑Job ❑Auto ❑Other Date: _______________
3.Accident: ______________________________________ ❑Job ❑Auto ❑Other Date: _______________

Please describe your past surgeries:

1. Surgery: ____ Date: _______________
2. Surgery: ____ Date: _______________
3. Surgery: ____ Date: _______________

Do you have any implants? ❑Yes ❑No If yes, please describe ____

Are you currently pregnant? ❑Yes ❑No If yes, please list your due date: ___________________

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

AIDS	❑	Allergies	❑	Anemia	❑	Arthritis	❑
Asthma	❑	Back Pain	❑	Bladder Trouble	❑	Bone Fracture	❑
Cancer	❑	Chest Pain	❑	Concussion	❑	Constipation	❑
Convulsions	❑	Depression	❑	Diarrhea	❑	Dislocated Joints	❑
Epilepsy	❑	Fibromyalgia	❑	German Measles	❑	Headache	❑
Heart Trouble	❑	Hepatitis	❑	Herniated Disk	❑	High Blood Pressure	❑
High Cholesterol	❑	HIV/ARC	❑	Kidney Disorder	❑	Loss of Bowel Control	❑
Lung Disease	❑	Menstrual Cramps	❑	Migraine Headaches	❑	Multiple Sclerosis	❑
Muscular Dystrophy	❑	Neck Pain	❑	Nervousness	❑	Numbness	❑
Osteoporosis	❑	Parkinson's disease	❑	Pinched Nerve	❑	Polio	❑
Poor circulation	❑	Reproductive disorder	❑	Rheumatic Fever	❑	Rheumatism	❑
Rheumatoid Arthritis	❑	Scarlet Fever	❑	Scoliosis	❑	Serious Injury	❑
Sinus Trouble	❑	Stroke	❑	Thyroid Problems	❑	Tuberculosis	❑
Tumors or Growths	❑	Ulcers	❑	Venereal Disease	❑	_______________	❑

FAMILY HISTORY

Please indicate which conditions exist or have existed by marking the boxes below.

	Self	Mother	Father	Sister	Brother	Son	Daughter
Cancer	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑
Heart Failure	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑

Alcohol Use:	Drug Use:	Exercise:
☐ None ☐ Casual ☐ Moderate ☐ Heavy ☐ Drinks Beer ☐ Drinks Wine	☐ None ☐ Recreational User ☐ Addiction	☐ Never ☐ Daily ☐ Weekly ☐ Runs ☐ Walks ☐ Swims

Smoking Status: ☐ Never ☐ Current Everyday ☐ Current Someday ☐ Former Smoker
☐ Light ☐ Moderate ☐ Heavy

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Office Financial Policy

CASH

ALL patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff. This office may make payment plan arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.

INSURANCE

If you have Blue Cross Blue Shield Commercial insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
We accept assignment as a courtesy to you: you are responsible for your entire bill should your insurance company NOT pay ANY of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into and/or dispute with, as your contract is between you and your insurance company.

If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check. It will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

This office will resubmit a claim one time. We will not enter into any dispute with your insurance company. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

If the patient is referred to another specialists or discontinues care for any reason the bill is due and payable in full immediately; regardless of any claims submitted.

I have read and understand the terms of the Financial Office Policy and agree to abide by these terms.

Print Name: ______________________ **Signature:** __________________________ **Date:** ____/____/20___

Patient's Filing Insurance Please Read and Sign This Portion

About Co-Payments

If you are an enrollee of BCBS, an insurance plan that we are contracted with, you are required to pay the co-pay each time you are seen. This must be paid before you see the physician. If you are not prepared to pay the co-pay, the visit must be rescheduled.

About Annual Deductibles

In Addition to the co-payment, some plans also have an annual deductible. If you have not met your annual deductible, you are required to pay this at the time of service.

In the event that there is a balance due from after your insurance carrier has paid its portion, we will bill you. We only send three bills. Thereafter, no further bills will be sent and the account will be turned over to a national collection service without prior warning.

I have read the above and understand my obligations.

Print Name: ______________________ **Signature:** __________________________ **Date:** ____/____/20___

Carson Chiropractic Clinic

Consent for Use or Disclosure of Health information (HIPPA)

OUR PRIVACY PLEDGE

We are very 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 your health care information.

> We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health.
>
> 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.
>
> We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices; we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

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 any restrictions on the uses or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization:

You may revoke your consent to us 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 received 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.

I have read your consent policy and agree to its terms.

Print Name: ________________________ **Signature:** ____________________________ **Date:** ____/____/20___

APPOINTMENT REMINDERS

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 at home, a message will be left on your answering machine or cellular phone. By signing this section, you are giving authorization to contact you with these reminders and information.

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 by protected by the federal privacy rules.

I authorize Carson Chiropractic Clinic's staff to use or disclose my health information in the manner described above.

Print Name: ________________________ **Signature:** ____________________________ **Date:** ____/____/20___