Tennessee Back Pain Center — Confidential Patient Information

3242 Memorial Blvd C Murfreesboro, TN 37129 Phone (615) 900-5187 Website: www.tennesseebackpaincenter.com

Date:_____/_____/_____ Patient's Full Name _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

☐ Male ☐ Female Age:_____ Date of Birth:_____/____/_____ Social Security # _____ - _____ - _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children/Ages_____

Spouse's Name:_____Employer:_____ Business Phone:_____

Emergency Contact:_____ Relationship:_____ Phone: _____

Your Educational level**:** ☐ High School ☐ Some College ☐ College Graduate ☐ Post Graduate ☐ Other: _____

Status**:** ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed

Occupation:_____ Hours/Week_____ Employer:_____ Business Phone_____

Family Physician: _____ City: _____ State:_____ Phone_____

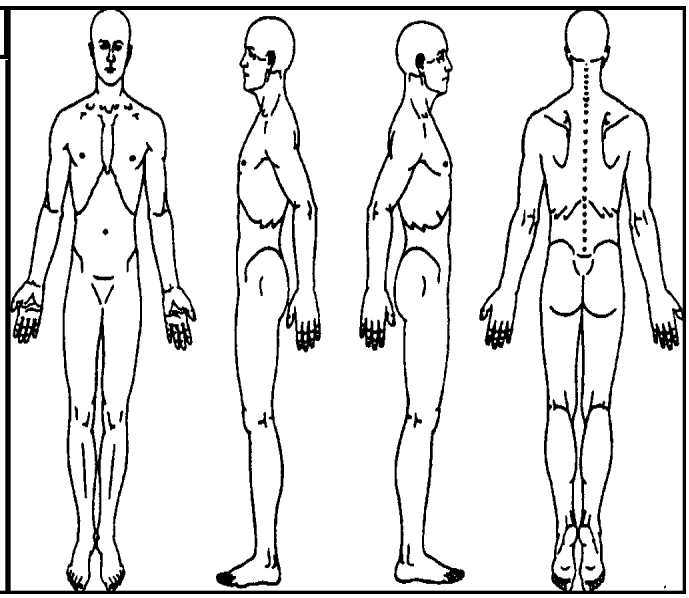
Previous Chiropractic Care: ☐ Yes ☐ No Dr's Name _____ City/State:_____

Who can we thank for referring you to our office (Friend, Relative, Physician, Facebook, Google, etc):_____

Have you had an X-ray/CT Scan within the last 12 months? If yes, did you bring the CD of images for the doctor to review? _____

Is Today's Visit Due To An On the Job, Work Related Injury: ☐ Yes ☐ No
Is Today's Visit Due To An Auto Accident: ☐ Yes ☐ No **Date Of Injury:**_____

****** Mark Your Areas of Pain on the Picture** →



SEVERITY OF PAIN

Chief Complaint: _____Onset Date:_____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

Have you had this problem before? ☐ yes ☐ no

#2 Complaint: _____Onset Date:_____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

Have you had this problem before? ☐ yes ☐ no

How did your **Chief Complaint** start? (ex. fell on ice)_____

Was the Onset: ☐ Gradual ☐ Sudden. Since it's onset, has it gotten: ☐ Better ☐ Worse

What makes your pain worse? ☐ bending ☐ standing ☐ sitting ☐ walking Other:_____

What makes your pain better? ☐ laying down ☐ sitting ☐ standing ☐ walking Other:_____

What is the quality of your pain? ☐ sharp ☐ dull/ache ☐ throbbing ☐ tingling/numbness/burning ☐ Other:_____

What is the worst time for your pain? ☐ morning ☐ during day ☐ evening ☐ lying in bed ☐ Other:_____

How much of the day do you experience your chief complaint? ☐ 0 — 25% ☐ 25 — 50% ☐ 50 — 75% ☐ 75 — 100%

Has your current complaint caused any of the following: ☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory

Have you tried any self-treatment (ice, heat, exercises) or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain:_____Results:_____

What is your goal from treatment? (e.g. play a round of golf without pain)_____

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Overall your **General Health** is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you ever experienced your present problem before: ☐ Yes ☐ No If yes, When:_____

Was treatment provided: ☐ Yes ☐ No If yes, By whom:_____ Outcome:_____

Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, when: _____

Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No If yes, explain:_____

Are you currently taking **anti-coagulant** or **blood thinning medication**? ☐ Yes ☐ No

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

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Please List current **supplements or drugs** you may be taking: _____

_____

_____

_____

Systems Review Questions: place check marks by body areas or systems where you may have problems:

1. ____Eyes
2. ____Ears, Nose, Mouth, Throat
3. ____Heart
4. ____Lungs/ Breathing
5. ____Intestines/Bowels
6. ____Urinary
7. ____Muscles
8. ____Nerves
9. ____Joints/Bones
10. ____ Skin
11. ____Internal Organs
12. ____Blood
13. ____Allergies
14. ____Psychological/Emotional
15. ____Gynecological Menstrual/Breast
16. ____Prostate/Testicular/Penile

Please explain check marks:_____

_____

_____

Recreational Activities/Hobbies:_____

Your education level: ☐ Highschool ☐ Some college ☐ College Graduate ☐ Post Graduate ☐ Other: _____

Yes	No		
☐	☐	Do you exercise? _____	Times per week
☐	☐	Use tobacco? Type_____	Packs/Cans per day (If you have quit, when did you quit?)_____
☐	☐	Consume alcohol?	How many drinks per week? _____
☐	☐	Have a healthy diet?	If no, explain: _____
☐	☐	Get adequate sleep?	If no, explain: _____
☐	☐	Is Work/School stressful to you?	If yes, explain: _____
☐	☐	Family life stressful to you?	If yes, explain: _____
☐	☐	Use recreational drugs?	If yes, explain: _____

FAMILY HISTORY AND HEALTH STATUS: list any diseases or major illnesses which affect your family (mother/father/sister/brother):

_____

How do you sleep ☐ Back ☐ Side ☐ Stomach Do you use a pillow : ☐ Yes ☐ No

Do you wear orthotics or arch supports ☐ Yes ☐ No

Females: Date of last gynecological and breast exam:_____

For X-Ray Purposes: Possible pregnancy? ☐ Yes ☐ No Date of last menstrual cycle: _____

I hereby state that all the information I have provided is complete and truthful and that I have fully disclosed my health history.

SIGNED: _____ Date:_____

Witnessed: _____ Date:_____

TENNESSEE
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INFORMED CONSENT

Medical doctors, chiropractors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent.

I_____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. These the procedures may consist of chiropractic manipulations/adjustments, physical therapy, and exercises.

Although spinal and extremity manipulation is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: I am aware Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Injury: I am aware that underlying pathologies such as osteoporosis, degenerative disc, etc. may increase the susceptibility to bone or joint injury. This office will take extra caution when these conditions are detected.

Stroke: I am aware that nerve, brain damage, or stroke is reported to occur once in a million to once in ten million chiropractic treatments. Once in a million is about the same chance as getting hit by lightning. This office goes one step further by only utilizing the safest forms of manipulation.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I understand that there are great physical benefits associated with chiropractic care including decreased pain, improved mobility and function, and reduced muscle spasm. However, as with medical or any other form of healthcare, I appreciate that there is no certainty nor has guarantee been made of these benefits.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing

ALTERNATIVE TREATMENTS AVAILABLE

Medications: These can be used to reduce pain & inflammation. I am aware of the risks involved with non-prescription or prescription medications. Long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks

Rest/Exercise: I understand that rest or exercise is not likely to reverse pathology but may reduce symptoms; and that rest could worsen my case. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness.

Surgery: Surgery may be necessary for some cases, but contains risks of unsuccessful outcome, pain / reaction to anesthesia, or prolonged recovery.

Non-treatment: I understand that refusing or neglecting care may cause increased pain, adhesion formation, restricted motion, possible nerve damage, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I hereby attest that I understand this explanation of chiropractic treatment in full. Any questions I had have been answered PRIOR to signing this consent form. I have made my decision freely and fully consent to treatment by my doctor or other person(s) of my doctor's choosing.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment:

X_____ Signature of Patient Date_____

_____Signature of Parent or Guardian (if a minor) Date_____

_____Signature of Witness (Office Use) Date_____

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INSURANCE INFORMATION:

Primary Insurance Company:_____ ID #: _____

Group # _____Insured's Name: _____Date of Birth: _____/_____/_____

Employer: _____ Relation to Insured: _____

Secondary Insurance Company:_____ ID #: _____

Group # _____Insured's Name: _____Date of Birth: _____/_____/_____

Employer: _____ Relation to Insured: _____

Third Insurance Company:_____ ID #: _____

Group # _____Insured's Name: _____Date of Birth: _____/_____/_____

Employer: _____ Relation to Insured: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:
1. You are authorized to release **any appropriate information** concerning my physical/emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim reimbursement of charges incurred by me.

2. I authorize the **direct payment to you** of any sum I owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based upon the charges made for services.

3. I hereby assign you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment for the charges made for your services and **refuses to make such payment** upon demand by you and authorize you to prosecute said action either in my name as you see fit. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit and understand that all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated. I understand that whatever amounts you do not collect, I **personally owe you**.

4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Tennessee.

5. I agree that this Authorization and Assignment is irrevocable until all moneys owed to Tennessee Back Pain Center are **paid in full.**

X_____ Signature of Patient Date_____

_____Signature of Parent or Guardian (if a minor) Date_____

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Financial/Privacy Policy and Disclaimer

Insurance Verification

- **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and are due within 30 days of billing.**

Collection of Patient Balance

- **It is our policy to collect deductibles, co-insurance and co-payments at the time services are provided.** Once we receive an "Explanation of Benefits" (EOB) from the patient's insurance company, we will bill or credit the account for the remaining balance. Patients will receive a bill outlining outstanding charges. Payment is due within 30 days of the receipt of the bill.
- **In the event the bill is disputed, you must notify use within 30 days.** If you do not notify us within that time, the bill will be presumed valid and due. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us. **After 90 days, it is the clinic's policy to turn unpaid accounts over to a collections agency.** Collection and/or legal fees incurred from the collections process are the responsibility of the patient in addition to the previous balance.

Returned Checks

- It is our policy to collect $25.00 for returned checks. This is to cover any fees that we incur from the transaction.

HIPAA Privacy Policy

- This office is fully HIPAA compliant and will uphold the Privacy Practices Policy set for by HIPAA for you. Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you.
- By signing below, the patient acknowledges that he/she has read the HIPAA Privacy Policy and understands and will comply with our financial policies.

X_____ Signature of Patient Date_____

_____Signature of Parent or Guardian (if a minor) Date_____

Missed/Cancelled Appointment Policy

Thank you for choosing Tennessee Back Pain Center. In order to provide you and our other patients exceptional care, we request that you follow our guidelines regarding missed and/or cancelled appointments. Please remember that we have reserved appointment time especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment.

Since our office does charge for missed or cancelled appointments, please realize how important it is to keep your reserved time. The charge for a missed / cancelled appointment is <u>$30.00</u>. *Discretion will be used for emergencies or extenuating circumstances.* Thank you for your understanding of our office policies; and for the opportunity to participate in your healthcare.

X_____ Signature of Patient Date_____

_____Signature of Parent or Guardian (if a minor) Date_____

*****Office Use Only*****

_____Signature of Witness Date_____

TENNESSEE
BACK PAIN CENTER

Notice of Information Practices and Privacy Statement
For Tennessee Back Pain Center

How we collect information about you: Tennessee Back Pain Center and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What we do not do with your information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to use, is held in strictest confidence

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How we do use your information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between Tennessee Back Pain Center and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance, etc.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime or fraud for any reason including willful or unwilful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information we do not collect: We do not use cookies on our website to collect data from our site visitors. We do use some affiliate programs that may or may not capture traffic data through our site.

Limited rights to use non-identifying personal information from biographies, letters, notes, and other sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become exclusively property of Tennessee Back Pain Center. We reserve the right to use non-identifying information about our clients (those who receive services or good from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names, or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct and indirect consent.