Chiropractic Health History Form

Date: _____

Name: _____ Gender: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Email: _____ DOB: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? Facebook - Google - Health Ins. Directory - Instagram

Or referred by: _____

Have you ever received Chiropractic care? Yes No If yes, by whom?_____

Is this visit the result of an auto accident? Yes No

Is this visit the result of a disability/worker's comp claim? Yes No

Please note: Knoxville Spine & Sports will not file with third party payers for auto/disability/worker's compensation claims. All visits must be self-pay. Statements will be provided for all expenses.

Reason(s) we are seeing you today:

Primary Reason: _____ Date of Onset: _____

Secondary Reason: _____ Date of Onset: _____

Referring Physician: _____ Phone: _____

Have you had X-rays or MRI for the condition you are being seen for? Yes No

If so, where: _____ When: _____

Patient Name: _____

Please answer the following questions as they relate to your primary area of pain/complaint:

Does the pain radiate? Yes No

Please Describe: _____

Do you have numbness/tingling? Yes No

Please Describe: _____

Does the pain interfere with your sleep? Yes No

Please Describe: _____

Is the pain worse during certain times of day? (circle all that apply)

Morning | Afternoon | Evening | Overnight | N/A

Do you wear orthotics? Custom | Off the Shelf | No

If custom, who dispensed and when? _____

What aggravates your symptoms? _____

Does your pain Interfere with any of the following? (circle all that apply)

Sitting | Walking | Standing | Lifting | Traveling | Personal Care | Social Activities

Grade Intensity/Severity (circle one):

1 2 3 4 5 6 7 8 9 10 (Worst pain Imaginable)

Frequency of Pain (circle one): Occasional | Intermittent | Only with certain movements |Constant

Previous interventions, treatments, medications, or surgery sought for this concern:

_____

_____

_____

Patient Name: _____

Past Health History:

1. Any significant current or previous illnesses? _____
2. Any previous Injuries or traumas? _____
3. Any Hospitalizations?_____
4. Have you ever broken any bones? Which? _____
5. Any sprains/ Strains? _____
6. Allergies: _____
7. List of current medications? (list on back If necessary)

   _____

   _____
8. Taking any vitamins/supplements? _____
9. Please list any medical/health history of family members: (heart disease, diabetes, cancer etc)

   _____

   _____
10. Occupation: _____ Employer: _____
11. Recreational activities: _____ Exercise habits: _____

Lifestyle

	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Exercise				
Sleep				
Water				
Appetite				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that If I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. Furthermore, I hereby certify that the statement, and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to Inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

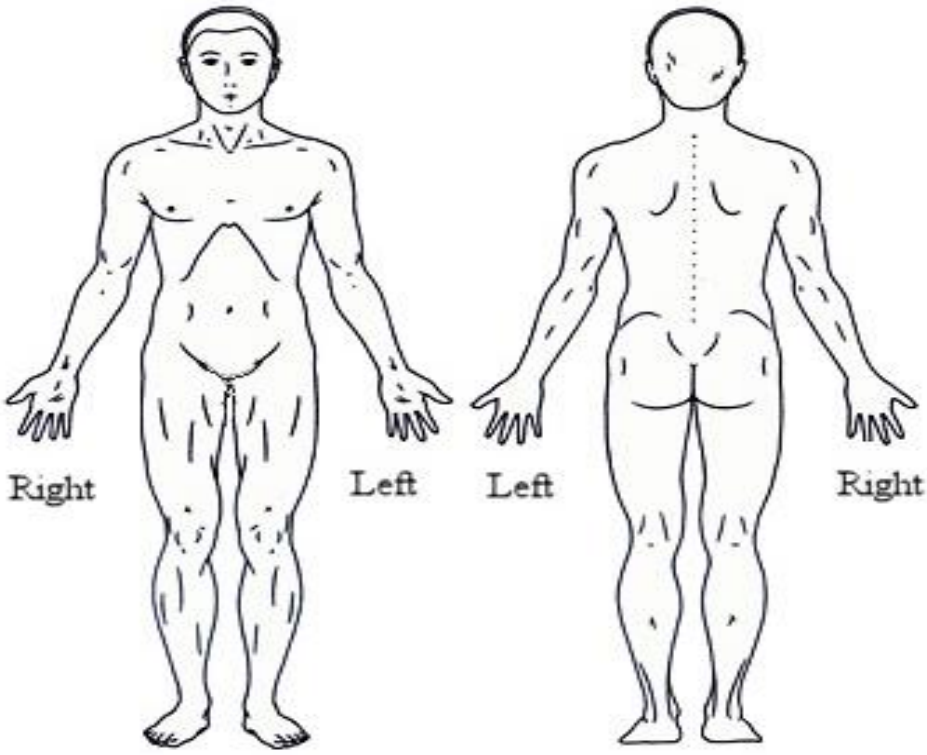
Patient /Gaurdians' Signature: _____ Date: _____

Patient Name: _____

Please circle the affected area and use the following letter to indicate TYPE and LOCATION of symptoms you are currently experiencing:

A: Dull Ache B. Burning S: Stabbing N: Numbness P: Pins and Needles

T: Throbbing D: Deep SH: Sharp TI: Tingling



Please mark each item below for each sign of symptoms you presently have or previously had:

GENERAL SYMPTOMS		__ Heart Attack		__Weight Loss/Gain
__Dizziness		__Poor Circulation		RESPIRATORY
__Fainting		__Cold Extremities		__Asthma
__Headache		__Strokes		__Chronic Cough
__Nervousness		__Swelling Ankles		__Difficulty Breathing
__Numbness		EAR/NOSE/THROAT		GENITO-URINARY
__Wheezing		__Earache		__Blood in Urine
__Cancer		__Enlarged Thyroid		__Frequent Urination
MUSCLES & JOINTS		__Frequent Colds		__Kidney Infection
__ Low Back Problems		__Nasial Blockage		__Prostate Problems
__Pain between Shoulders		__Nose Bleeds		__Loss of Bladder Control
__neck Problems		__Pain Behind Eyes		SKIN or ALLERGIES
__Arm Problems		__Poor Vision		__Bruising Easily
__Leg Problems		__ Sinusitis		__Eczema/Rash/Dermatitis
__Swollen Joints		__Sore Throat		__Itching
__ Stiff Joints		GASTRO-INTESTINAL		IF APPLICABLE
__Sore Muscles		__Constipation		__Birth Control _____
__ Weak Muscles		__Diarrhea		__Hormone Replacement
__Gait Issues		__Hemorrhoids		__Hot Flashes
__Sprains/Strains		__Liver/Gallbladder		__Irregular Cycle
__Scoliosis Diagnosis		__Nausea		__Miscarriage
__Sciatica		__ Ulcer		__Breast Pain
CARDIO-VASCULAR		__Poor Appetite		
__ High Blood Pressure		__Poor Digestion		Pregnant (currently): Y N

Appointment Reminder Consent

Complete this form and sign below to give permission for Knoxville Spine and Sports to provide automatic appointment reminder service by email or by cell phone text message*.

Send email messages to confirm appointments to: _____

Send cell phone text messages to confirm my upcoming appointments to: _____

*I recognize that normal text messaging rates may apply.

Appointment reminders will be sent 24 hours in advance of the appointment unless otherwise requested. We require a 24-hour notice for any changes to the schedule. Failure to notify the office of any appointment change without 24 hours' notice will result in a **$25.00 charge for Chiropractic Appointments, and a $50.00 charge for Physical Therapy Appointments.**

Any patient that arrives late to their appointment may incur a fee based on the time of arrival. A $25.00 fee will be applied for 15 minutes, a $50 fee will be applied for 30 minutes.

By signing below, I acknowledge that I have read the above information and acknowledge the financial policy of this office.

Patient Signature: _____ Date:_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Knoxville Spine and Sports to furnish care and treatment to (patient) _____ that Is considered necessary and proper in diagnosing or treating my/his/her condition.

RELEASE OF INFORMATION: Upon inquiry and to the extent allowed by law, Knoxville Spine and Sports may make available certain basic information about the patient in accordance with HIPAA regulations, including name, address, age, sex, general description of the reason for treatment, general nature of the injury, and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to Knoxville Spine and Sports for this purpose. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Knoxville, Spine and Sports may disclose portions of the patient's record including his/her medical record, to any person or entity which is or may be liable for all or any portion of Knoxville Spine and Sports' charges, including but not limited to government agencies (e.g, Insurance companies, health care service plans, or workers compensation carriers).

BENEFIT ASSIGNMENT: I hereby assign medical benefits to which I am entitled by private insurance and third-party payers, to Knoxville Spine and Sports. A photocopy of this assignment is to be considered as valid as the original.

FINANCIAL AGREEMENT: The patient is responsible for providing payment at the time of service for all co pays, deductibles, coinsurance, and any remaining balance due from services that are not covered by the patient's insurance carrier. I understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed including original charges, Interest, collection agency fees, and attorney fees.

ASSIGNMENT OF INSURANCE BENEFITS: It is the patient's responsibility to maintain all prescriptions, referrals, and authorizations as required by your insurance company. We have called your insurance company for estimated insurance benefits, and they are reflected on the "Verification of Benefits" form.

CANCELLATION, MISSED, AND LATE APPOINTMENT POLICY: Failure to provide 24 hours advance notice of a cancellation or appointment change will incur a $25.00 fee for Chiropractic visits, and a $50.00 fee for Physical Therapy visits, automatically charged to your account. Patients who arrive 15 mins past their appointment time may incur a $25.00 fee; patients who arrive 30 mins past their appointment time may incur a $50.00 fee. In instances of repeated non-compliance with our scheduled visits, we also reserve the right to discontinue care. In those rare cases, we will inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

WORKER'S COMPENSATION CLAUSE: The above financial policy does not apply to those patients that are considered Workers Compensation. However, be advised that if you claim Workers Compensation benefits and are subsequently denied, you will be held responsible for any remaining balance on your account. At the time, our Financial Policy will apply to you.

I have read the above information and understand my responsibilities.

_____	_____	_____
Patient's Name (Print)	Patient's / Guardian Signature	Date

HIPAA RELEASE/PRIVACY FORM

Patient Name: _____ Date of Birth: _____

RELEASE of Information:

- ☐ I authorize the release of information including the diagnosis, records, examination, rendered to me and claims information

This Information may be released to:

- ☐ Spouse: _____
- ☐ Children: _____
- ☐ Other: _____
- ☐ Information is NOT to be released to anyone.

This release of Information will remain in effect until terminated by me In writing.

For phone messages, please call my...

- ☐ Home Phone: _____
- ☐ Cell Phone: _____
- ☐ Work Phone: _____

If unable to reach me,

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Do not leave a message

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health Information to carry out: treatment (including direct or Indirect treatment by other healthcare providers Involved In my treatment), obtaining payment from third party payers (i.e. insurance companies), and the day to day healthcare operation of Knoxville Spine and Sports.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, then you are bound to comply with this restriction. I understand that I may revoke this consent in writing at any time.

_____ _____ _____

Patient's Name (Print) Patient's / Guardian Signature Date

Patient Acknowledgment Form for Non-Covered Services, Products, and other Situations

Patient Name _____

Your health insurance plan requires you to be responsible for co-payments, co-insurance, and deductibles for covered services and products as well as those services/products that exceed certain benefit limits. You are also financially responsible for all non-covered services and products, as well as any product we provide whose allowed fee is less than our office's cost.

Your health insurance plan either does not cover the product type or service noted below or allows less than our purchase price. Your acknowledgment below indicates that you have been advised of this information and that you agree to pay the office's charge.

Product or Service: All services listed below are based on region or time and will be charged accordingly

AIS (Active Isolated Stretching)

ART (Active Release Technique)

Cupping

DSTM (Deep Soft Tissue Massage)

Dry-Needling

Laser Therapy (Class IV)

Therapeutic Exercise

Shockwave Therapy

Patient Responsibility: $45.00 (Individual Rate)

Patient Acknowledgement:

I _____ (patient name), acknowledge that I have been told in advance by this office that my health insurance plan either does not cover the product or service listed above or pays less than this office's purchase price, and I agree to pay for this product at the time of service. I have been told that there may be other products available at lower cost that still meet my insurance plan's medical necessity requirements.

Patient Signature: _____ Date: _____