INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date _____

Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Please circle one payment type: Cash Check Master Card/Visa American Express

Your Employer _____ Occupation _____ Years On Job ____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Your Social Security # _____

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Name of Spouse or Parent _____ Their Birthdate _____

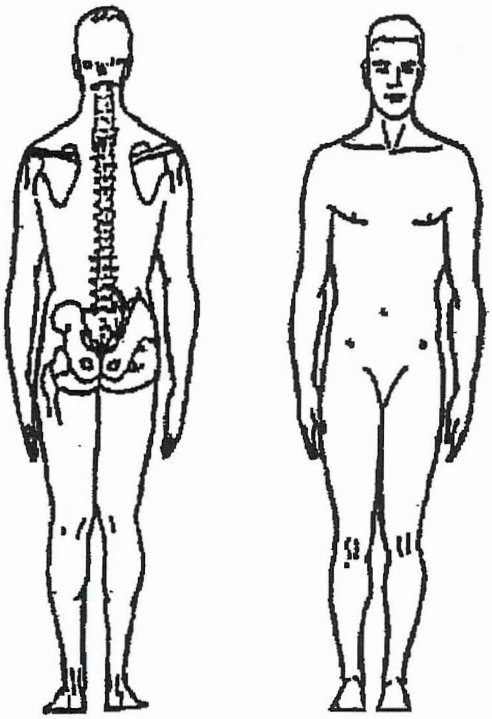
Spouse Employed By _____ Occupation _____ Years On Job ____

Employer Address _____ City _____ State _____ Zip _____

Office Phone # _____ Spouse's SS# _____

Driver's License # _____

Does your spouse have health insurance at work? Yes ____ No ____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

_____

_____

_____

_____

_____

Referred to our office by: _____

How payment will be made:

_____ Cash
_____ Check

Type of Insurance:

_____ Worker's Comp.
_____ Credit Card
_____ Health Insurance
_____ Automobile Insurance Policy

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

DON'T FORGET TO FILL OUT THE BACK!

INFORMATION/APPLICATION FOR CARE

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____
Or Guardian Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL F – FREQUENT
C – CONSTANT

GENERAL

O	F	C	
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors

MUSCLE & JOINT

☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen joints

GASTRO-INTESTINAL

O	F	C	
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood

EYES, EARS, NOSE &THROAT

☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental Decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

CARDIO-VASCULAR

O	F	C	
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles

RESPIRATORY

☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

SKIN

☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

GENITO-URINARY

☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine

FOR WOMEN ONLY

☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chorea
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria

Confidential Patient Case History

☐ Measles	☐ Miscarriage	☐ Pneumonia	☐ Scarlet fever	☐ Ulcers
	☐ Multiple sclerosis	☐ Polio	☐ Stroke	☐ Venereal disease
	☐ Mumps	☐ Rheumatic fever	☐ Tuberculosis	☐ Whooping cough
	☐ Pleurisy		☐ Typhoid fever	

What is your major complaint? _____

_____

List surgical operation and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers
☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others: _____

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable ☐ Do you use a bed board? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe: _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	
Used a cane, crutch, or other support?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Had a fractured bone?	☐	☐	
Been hospitalized for anything other than surgery?	☐	☐	

DO YOU:			
Now take vitamins or minerals?	☐	☐	
Think you may need vitamins or minerals?	☐	☐	
Have an allergy to any drug?	☐	☐	

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend **not living in your home**): NAME _____

ADDRESS: _____ PHONE: _____

HIPAA PRIVACY AUTHORIZATION FORM

Purpose and Laws: This form, when properly completed, permits the release of confidential information about a person receiving services (service recipient) governed and regulated by Title 33, Tennessee Code Annotated. Any information to be released under this form shall be released in accordance with the following confidentiality laws and regulations: Title 33, Tennessee Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. The records released through this Authorization are protected by the above named confidentiality laws and regulations. A general authorization for the release of medical or other information is NOT sufficient for the purpose of disclosing mental health or alcohol and substance abuse information. Federal rules restrict any use of alcohol and substance abuse information to criminally investigate or prosecute the person to whom the information pertains. Further disclosure of this information to parties other than those designated on this form is expressly prohibited without the express written consent of the person to whom the information pertains.

I, _____, authorize **Tri-State Clinic North** (520 Cherokee Blvd,
(printed name of patient)

Chattanooga, TN 37405) to use and disclose the protected health information (PHI) to the following individual(s):

Name:	Contact number	Relationship to Patient

Effective Period: (Please initial your request)

_____ This authorization for release of information covers the period of healthcare from:
_____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

or

_____ All past, present, and future appointment periods.

or

_____ I choose to not have my medical information shared with individuals outside of myself.

(This page has a back)

Voice mail messages & emails: (Please initial your request)

Please **initial** where we have your permission to leave a confidential voice mail (e.g. appointment reminders, financial information). Leave the space(s) blank if you **do not wish** to receive voice mails or emails.

Home Phone _____ Cell Phone _____ Work Phone _____ Email _____

Best contact number/email to reach you: _____

By signing this form, I (the service recipient) understand that if the person or organization designated on this form to receive the information is not a Health Plan or Health Care Provider, some of the released information may no longer be protected by the above named confidentiality laws and regulations. I also understand that signing this Authorization is voluntary, and that I am not required to sign this Authorization in order to get treatment, payment, enrollment, or eligibility for benefits. I also understand that I may revoke this Authorization by doing so in writing at any time; except to the extent that action has been taken in reliance on the information, and that the revocation does not affect any information that was released before the revocation. Even if I do not revoke this Authorization, **the Authorization expires automatically one (1) year from the date of signature or as follows:**

_____
(mm/dd/yyyy)

_____ _____ _____ _____
(patient signature) (mm/dd/yy) (witness signature) (mm/dd/yy)

** If the individual signing this form is acting on behalf of the service recipient, the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the guardian ad litem of the service recipient but only for the purposes of the litigation in which the guardian ad litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased service recipient; and (6) the treatment review committee, acting within the authority and scope of Tennessee Code Annotated Section 33-6-107. Appropriate documentation of proof of this individual's authority to act on behalf of the service recipient must be submitted to the entity being asked to release the information **before** any information will be released.

_____ _____
(signature of recipient acting as legal gardian) ** (mm/dd/yyyy)

TRI-STATE
CLINIC NORTH

520 Cherokee Boulevard
Chattanooga, Tennessee 37405

AGREEMENT WITH FINANCIAL POLICY

All co-pays, deductibles, or co-insurance are due at the time the service is rendered. TRI-STATE CLINIC NORTH gladly accepts cash, check card/check, Visa, MasterCard, or Discover. There is a fifty (**$50**) dollar fee for all returned checks. TRI-STATE CLINIC NORTH is not obligated to accept health care/medical insurance.

1. **I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT TIME OF SERVICE UNLESS OTHER WRITTEN FINANCIAL ARRANGEMENTS OCCUR PRIOR TO TREATMENT.**

2. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and act in my name as you see fit and further authorize you to compromise, settlement or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me.

3. I understand that whatever amounts TRI-STATE CLINIC NORTH does not collect from any the insurance companies, whether it is all or part of what is due, I personally owe and agree to pay to TRI-STATE CLINIC NORTH.

4. I understand and agree that all account(s) not paid–in–full within forty–five [45] calendar days from the date of service shall incur an additional finance/interest charge of one and one–half percent [1.5%] per month, and all accounts not paid–in–full within forty–five (45) calendar days from date of service shall be deemed "delinquent." I understand and agree that should any account(s) become delinquent then I shall be in default of this Agreement, and my delinquent account(s) may be turned over for further collection activities, which I agree is fair and reasonable.

5. I understand and agree to pay reasonable collection costs and attorney fees calculated at one–third (1/3) of the following: **(a)** Delinquent principal amount(s) owed; **(b)** Finance charges/interest accrued on my delinquent account(s); **(c)** Dishonored check fee(s); **(d)** Credit/debit card fee(s); and **(e)** All incidental discretionary collection costs and expenses incurred to recover the principal obligation.

6. I understand and agree to pay all court costs should legal action ensue. By signing the Agreement I understand and agree the terms and conditions set-out herein are fair and reasonable.

7. I understand and agree that each payment shall be applied as follows:
   - First (1st) to all returned check/debit charges;
   - Second (2nd) to the unpaid 18% finance charge; and
   - Third (3rd) to services provided starting with the oldest date of service.

8. Should any account become delinquent, such account may be turned over to an attorney for purposes of collection. If any of my Account(s) are submitted for collection then my treatment may be suspended until all sums due are paid–in–full.

9. Acceptance by TRI-STATE CLINIC NORTH of any late payments or partial payments shall not be deemed to be a waiver of any of its rights under this Agreement. Acceptance of a check or other written form of payment inscribed "Paid–In–Full" or other words to that affect shall not constitute a final payment of the account unless the payment, is in fact, a payment for the total amount(s) claimed, as provided in Paragraph 3, herein.

10. *I also understand that failure to agree to and sign this form shall convert my account(s) to "self–pay status," which would require payment of all charges in full at the time of service unless other arrangements are made, and agreed to, in writing.*

11. I further understand, agree, and hereby *irrevocably authorize, assign, and direct* my automobile insurance carrier(s), to provide any and all medical benefit payments, health care treatment benefits, medical payment benefits [*i.e.,* "MED–Pay benefits"], and personal injury protection benefits [*i.e.,* "PIP benefits"] directly to TRI-STATE CLINIC NORTH.

12. Furthermore, I shall ensure any payments made by any at–fault third (3rd) party insurance carrier(s) shall be used to pay TRI-STATE CLINIC NORTH's bill and/or subrogation interest. If my treatment is in connection with a motor vehicle collision then my insurance carrier at the time of accident is/was:

_____.

[please provide proof of motor vehicle insurance so we may obtain a copy for our records].

13. I read and fully understand the above acknowledgment and agreement regarding my financial responsibility obligations provided herein, and shall not authorize any legal representative to interfere with the terms and conditions provided herein.

_____ _____

Signature **Date**

# # #

As patient's parent, legal guardian, or legal representative, I consent to treatment reasonably necessary for _____ [Patient Name], and agree to pay same pursuant to the terms and conditions provided above.

_____ _____

Print Full Name **Date**

_____

Signature of Parent, Legal Guardian, or Personal Representative

If patient's treatment is in connection with an injury claim then please provide the patient's attorney contact information: _____.

AUTHORIZATION AND ASSIGNMENT FORM

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.

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

3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in this State of _____

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization and Assignment will be in continual effect until revoked by both parties.

_____ _____

PATIENT SIGNATURE **DATE**

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

- We may have to disclose your health information, including your records, to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment.
- We may have to disclose your examination, treatment, and billing records to another party such as an insurance carrier, a HMO, a PPO or your employer if they are potentially responsible for payment of your services.
- We may need to use your health information and records for quality control purposes or for other administrative purposes (ex: auditing).
- We may need to use your name, address, phone number and clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information of interest to you. If you are not at home, a message may be left on your answering machine to remind you of an appointment.
- We may need to use your name, address and phone number to show our appreciation to you in ways such as but not limited to: Thank you cards, flower delivery, birthday cards, newsletters, notification of Patient Orientation Class, return phone calls, sharing success stories, introduce you to other patients, etc.

You have the right to refuse authorization to contact you about appointment reminders, treatment alternatives, and other health related information. If you do not give us authorization, it will not affect the treatment we provide you or the methods we use to obtain reimbursement for your care.

OUR PRIVACY PLEDGE

We have and always will respect your privacy. Other than the uses and disclosures described above, we will not sell or provide any of your health information to any outside marketing organization.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your authorization to us at any time; your revocation must be in writing. There is a circumstance under which we will not be able to honor your request:

- If we have already released your health information before receiving your request.

If you wish to revoke your authorization, please write us at:

TRI-STATE CLINIC NORTH
520 CHEROKEE BLVD
CHATTANOOGA TN
37405

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you as an inmate.
- If we provide health care services to you in an emergency.
- If we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers in communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than circumstances described in the proceeding examples; any other use or disclosure of your health information will only be made with your written authorization.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you **DO NOT** want us to disclose your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we do agree, the restriction is binding on us.

If we do not agree, you may drop your request or you are free to seek care from another health care provider.

YOUR RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

You have the right to inspect and/or copy your health information for seven years from the date that the records were created. We require your request to be in writing.

IF YOU WOULD LIKE TO OBTAIN A COPY OF THIS NOTICE, PLEASE CONTACT THE FRONT DESK.

SIGNATURE:_____ DATE:_____