Carthage Family Chiropractic, LLC
615-735-9336

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

Home Phone: _____ Cell Phone: _____ [ ] Male [ ] Female SS # _____

E-Mail: _____ Age: _____ Date of Birth: ____/____/_____

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

[ ] Married [ ] Single [ ] Widowed [ ] Separated [ ] Divorced Number of Children/Ages: _____

Occupation: _____ Hours/Week: _____ Employer: _____ Work Phone: _____

Spouse's Name: _____ DOB: _____ Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family Physician: _____ City: _____ State: _____ Phone: _____

May our office inform your physician of presenting condition(s), exam findings, diagnosis and treatment plan? [ ] Yes [ ] No

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

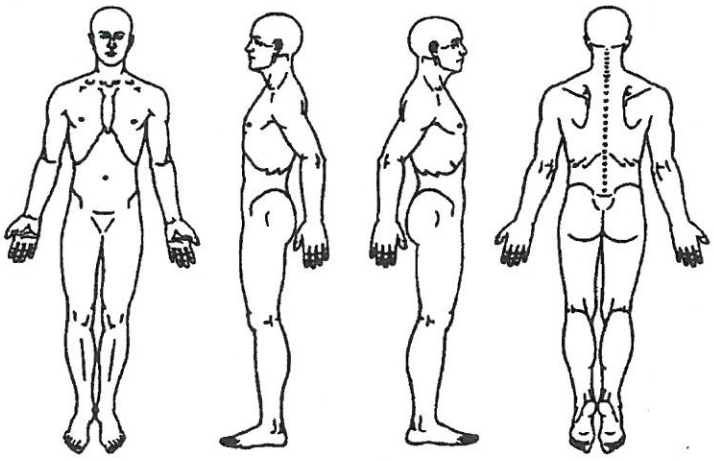
How did you hear about us? Friend, Relative, Physician… Name: _____ Other: _____

****If yes to either of the questions below, please see receptionist, additional information is needed****

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 Pains / Problems On The Picture



In Order of Importance, List Your Pains / Problems

Complaint #1: _____

Onset Date: _____

Severity: 0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable Pain

Complaint #2: _____

Onset Date: _____

Severity: 0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable Pain

How did complaint #1 start? (ex. Fell on ice): _____

What makes it worse? [ ] Bending [ ] Standing [ ] Sitting [ ] Walking Other: _____

What makes it better? [ ] Laying down [ ] Sitting [ ] Standing [ ] Walking Other: _____

What does the pain feel like? [ ] Sharp [ ] Dull/Ache [ ] Throbbing [ ] Tingly/Numb/Burn Other: _____

When does it bother you the most? [ ] Morning [ ] During day [ ] Evening [ ] Lying in bed Other: _____

What percentage of the day do you experience it? [ ] 0-25% [ ] 25-50% [ ] 50-75% [ ] 75-100%

Have you ever experienced complaint #1 before? [ ] Yes [ ] No If yes, when? _____

- Was treatment provided? [ ] Yes [ ] No If yes, by whom? _____ Outcome: _____

Have your pains resulted in any: [ ] Muscle weakness [ ] Bowel/Bladder Control [ ] Digestion Issues [ ] Heart/Breathing Issues

Have you tried ice, heat, stretches, or taken any medication (over the counter or prescribed) for your current pain? [ ] Yes [ ] No

- If yes, explain: _____ Results: _____

What is your goal from treatment (ex. Play a round of golf without pain)? _____

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 an anticoagulant or blood thinner? [ ] Yes [ ] No

Have you ever had any major illnesses, injuries, hospitalizations, or surgeries? [ ] Yes [ ] No

Date	Major Injury/Fracture/Illness/Surgeries	Treatment	Results

Please list any allergies: _____

Please list any supplements or medications you currently take: _____

_____

Please check body areas or systems where you may have problems:

[ ] Eyes	[ ] Intestines/Bowels	[ ] Joints/Bones	[ ] Allergies
[ ] Ears/Nose/Mouth/Throat	[ ] Urinary	[ ] Skin	[ ] Psychological/Emotional
[ ] Heart	[ ] Muscles	[ ] Internal Organs	[ ] Gynecological/Menstrual/Breast
[ ] Lungs/Breathing	[ ] Nerves	[ ] Blood	[ ] Prostate/Testicular/Penile

Please explain check marks: _____

_____

I am interested in diet and lifestyle counseling to help with high blood pressure, gut issues, low energy, pain, etc. [ ] Yes [ ] No

[ ] Yes [ ] No Do you exercise? Times per week: _____

[ ] Yes [ ] No Use tobacco? Type: _____ Packs/cans per day: _____ If you quit, when did you quit? _____

[ ] Yes [ ] No Consume alcohol? How many drinks per week? _____

[ ] Yes [ ] No Healthy diet? If no, explain: _____

[ ] Yes [ ] No Get adequate sleep? If no, explain: _____

[ ] Yes [ ] No Is work/school stressful to you? If yes, explain: _____

[ ] Yes [ ] No Family life stressful to you? If yes, explain: _____

[ ] Yes [ ] No Use recreational drugs? If yes, explain: _____

Family History and Health Status (list ay hereditary diseases or major illnesses which affect your mother/father/sister/brother):

_____

_____

How do you sleep? [ ] Well [ ] Fair [ ] Poor Do you use a pillow? [ ] Yes [ ] No

Do you use orthotics or arch supports? [ ] Yes [ ] No Do you have a latex allergy? [ ] Yes [ ] No

Females: Date of last gynecological and breast exam: _____ Possible pregnancy? [ ] Yes [ ] No

Date of last menstrual cycle: _____

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

Signature: _____ Date: _____

Quadruple Numerical Rating Scale

Patient Last Name	Patient First Name		Date of Birth (MM/DD/YYYY) ____/____/____
Provider Last Name Cripps	Provider First Name Melanie	Provider Phone (area code first) (615)735-9336	

Instructions: Please circle the number that best describes the question being asked.

Note: Answer each question for an individual complaint and label above the indicated score, the area of complaint.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 worst possible pain

1. What is your pain **RIGHT NOW**?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

2. What is your **TYPICAL** or **AVERAGE** pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

OTHER COMMENTS:

_____

_____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature _____ Date _____

Carthage Family Chiropractic, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in

a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.50 per each page and a $20.00 administration fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Semi-open Adjusting Environment: *This office utilizes a "semi-open adjusting" environment for ongoing patient care. "Semi-open adjusting" involved several patients being seen in the same adjusting room at the same time. Patients are often within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality healthcare and health information. If you choose not to be adjusted in an open-adjusting environment, please let us know and other arrangements will be made for you.*

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Samantha Sanders, Carthage Family Chiropractic, LLC
Telephone: 615-735-9336 Fax: 615-281-8449

Patient Signature: _____ Date: _____

Parent/Guardian Signature_____ Relationship: _____

Print Name:_____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from Carthage Family Chiropractic LLC, 906 Main Street North, Carthage, TN 37030 ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider 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 action 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 action 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 Provider 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.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horners' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Dx_____

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed Name of Patient

X_____ _____
Signature of Patient Date

X_____ _____
Signature of Representative (if patient is minor or handicapped) Date

X_____ _____
Witness to Patients' Signature Date

Doctor: _____