Welcome to Bennett Chiropractic!

Dr. Amy L. Bennett • 10541 Cedar Grove Rd, Suite 140 • Smyrna, TN 37167 • Phone (615) 751-1001

Child New Patient Form

About the Child

Legal Name: ______________________ Preferred Name: ______________ Date: ___/___/___

Address: ______________________ City: ______________ State: ______ Zip: ________

Home Phone: ( ) - SSN: - - Sex: M F Birth Date: ___/___/___

Who may we thank for referring you? ______________________ E-mail: ______________

Have you ever had chiropractic care before? Y N If so, whom? ______________

About the Parent/Guardian

Parent/Guardian Name: ______________________ Employer: ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

Home Phone: ( ) - Work Phone: ( ) - Mobile: ( ) -

Child's Confidential Health History

Please list any surgeries or hospitalizations with dates: ______________

Please list any past serious accidents with dates: ______________

Please list any medical condition(s) you have or ever had: ______________

Up to date on all Vaccinations? (Please circle) Y N Any adverse reactions? ______________

Taking any medications? (Please circle) Y N If so, what? ______________

Who is your medical doctor? ______________ Doctor's Phone # : ( ) -

Reason for This Visit

Current health concerns or reason for visit: ______________

How did the injury occur? ______________ Date condition began: ___/___/___

Describe the pain and location: ______________

Is it getting (Please circle): Better Worse Constant Comes and goes No change

What makes it better? ______________ What makes it worse? ______________

Have you had this before? Y N If so, how was it treated? ______________

Has a medical physician treated this condition? Y N If so, whom? ______________

What changes (if any) in your child's health would you like to accomplished? ______________

Child's Past History

Please mark (**C**) for **C**urrent or (**P**) for **P**ast if your child has had any of the following conditions:

(While they may seem unrelated to the purpose of this appointment, all information is important).

- ☐ Allergies
- ☐ Sinus Problems
- ☐ Headaches
- ☐ Asthma
- ☐ Colic
- ☐ Constipation
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Frequent Colds
- ☐ Diabetes
- ☐ Broken Bones
- ☐ Poor Appetite
- ☐ Hyperactivity
- ☐ Irritability
- ☐ Attention Problems
- ☐ Withdrawal/Difficulty Interacting
- ☐ Chronic Earaches
- ☐ Sleeping Problems
- ☐ Skin Problems
- ☐ Seizures
- ☐ Swollen Joints
- ☐ Growing Pains
- ☐ Hernias
- ☐ Heart Condition

In the Event of an Emergency

Who should we contact? ______________________ Relation: ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

Home Phone: (   )   - ______ Work Phone: (   )   - ______ Mobile: (   )   - ______

I hereby authorize Dr. Amy Bennett to work with my child's condition through the use of adjustments to his/her spine, as she deems appropriate. I clearly understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment. Dr. Bennett will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis. I also understand that if I suspend or terminat my child's care, any fees for professional services rendered will become immediately due and payable. I authorize the provider to release information required to process insurance claims.

I understand the above information and completed this form correctly to the best of my ability.

______________________________   ____/____/____

Signature   Date

______________________________   ____/____/____

Parent/Guardian Signature   Date

PRIVACY NOTICE

Consent for Use of Disclosure of Health Information

We are 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 you health care information:

1. We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
2. 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.
3. We may need to use your health information within our practice for quality control or other operational purposes.

We reserve the right to change our privacy practices as described in this notice. If we make changes to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

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

Your Right to Revoke Your Authorization

You may revoke any of your authorizations 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 receive 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.

Appointment Reminders and Health Care Information Authorization

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 available, a message will be left on your answering machine or with the person answering the phone. By signing the consent form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.
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 be protected by the federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not effect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time.

Tennessee Chiropractic Association Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Tennessee Chiropractic Association (TCA). This disclosure will be made if we need the TCA's assistance to receive reimbursement for your services or, we need the TCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.
By signing the consent form, you are giving us authorization to send the TCA this information. You are also giving the TCA authorization to re-disclose your information to the party responsible for the payment of your services, the TCA's legal counsel, and sate or federal agencies that may be asked to intercede on your behalf. You may inspect or copy the information that we may send to the TCA at any time.

Effective Date: This notice is effective as of March 22, 2005, and authorization will expire seven years after the date on which you last received services from us.

I have read your Privacy Notice and agree to its terms. I authorize you to use or disclose my health information in the manner described in the Privacy Notice.

Print Patient Name ______________________________Signature_____________________________ Date ____________

Patient Representative___________________________ Signature_____________________________ Date ____________

Office Representative ____________________________ Date _______________

FINANCIAL POLICY

INSURANCE INFORMATION

It is your responsibility to understand your insurance benefits, as your insurance is a contract between you, the patient, and your insurance company. If you feel that your insurance company has incorrectly denied your claim or the explanation of benefits (EOB) is incorrect, you must contact them to dispute this. Our office files with your primary insurance as a courtesy to you. Any discrepancies must be taken to the insurance company.

PATIENT INFORMATION

Please notify our office of any changes in insurance, name, address, telephone, or beneficiary information. If the account is past due and we are unable to contact you via phone or mail, the account will be turned over to our collection agency.

PAYMENT POLICY

All co-payments are due at the time of service. Other amounts, such as coinsurance, deductibles, or non-covered services are due in full thirty (30) days after insurance response. If you have no insurance coverage, and are considered "self-pay", FULL payment is expected at the time of service. If no insurance has been filed due to incorrect information being provided to us, payment is due thirty (30) days after the date of service. If no payment has been received after sixty (60) days, the account will be forwarded to our collection agency. Our office accepts cash, personal checks, money orders, visa, master card, or debit card. Returned checks will have a $10 fee.

FINANCIAL ARRANGEMENTS

If you are experiencing financial hardships, you must contact us immediately. You may arrange a payment plan with our office. If a payment arrangement is in place, we must receive payment every thirty (30) days. If no payment is received on the outstanding account after sixty (60) days, your account will be forwarded to our collection agency.

BILLING ERRORS

If you feel that a billing error has been made, you must notify us immediately. You may contact us at (615) 751-1001. We will work to assure that the account is corrected accordingly. If we are not notified of an error, we will presume that all billing information is accurate.

AGREEMENT/SIGNATURE

By signing my name below, I certify that I have read the above information. My signature also certifies my understanding and agreement with the above policies.

______________________________	______________________
Patient (or Guardian) Signature	Date

Bennett Chiropractic, LLC
Dr. Amy L. Bennett
298 Sam Ridley Parkway E., Suite 170
Smyrna, TN 37167
(615) 751-1001 Office
(615) 625-3977 Fax

Consent to Treatment of a Minor

I, ______________________________, hereby authorize Dr. Amy L. Bennett, and whomever she may designate as her assistant, to administer treatment as she deems necessary to __________________________.

Signed and dated in Smyrna, Tennessee, this______ day of ________, 20____.

Signed ___________________________
Relation to Minor ___________________________

Witness ___________________________