Welcome to Bennett Chiropractic!

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

Personal Information

Legal Name: _____ Preferred Name: _____ Date: / /

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

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

SSN: - - Sex: M F Marital Status: S M D W Birth Date: / /

Number of Children: _____ Ages: _____ E-mail: _____

Occupation: _____ Employer: _____ How long? _____

Who may we thank for referring you? _____

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

Current Problem

The reason for this visit is the result of (please circle): New injury Chronic Auto Work Sports Other: _____

If accident related, has the injury been reported? Y N N/A To Whom: _____

List area of pain	Circle One	Circle One	Rate Pain 10=Worst
#1 _____	Constant Comes & Goes	Mild Moderate Severe	1 2 3 4 5 6 7 8 9 10
#2 _____	Constant Comes & Goes	Mild Moderate Severe	1 2 3 4 5 6 7 8 9 10
#3 _____	Constant Comes & Goes	Mild Moderate Severe	1 2 3 4 5 6 7 8 9 10

For your MAJOR complaint: Date condition began: / / How? _____

What activities are difficult to perform? (Circle) All movement Bending Lifting Walking Sitting Standing Lying

What makes it better? (Circle) Rest Ice Heat Pain relievers Exercise Other: _____

Is it interfering with: (Circle) Sleep Work Daily Activities Other: _____ Have you had this before? Yes No

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

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: _____

Are you taking any of the following medications (please circle): Insulin Blood thinners Tranquilizers Pain killers

For High Blood Pressure Anti-inflammatories Muscle relaxants Stimulants Nerve pills Other: _____

Do you smoke? Y N #____Packs/Day How long? _____ Drink alcohol? Y N #____Drinks/Week

Do you exercise? Y N If so, type? _____ Special diet? If so, type? _____

Do you take supplements? Y N If so, what kind? _____ Date of last physical exam: / /

Any family history of (Please circle): High Blood Pressure High Cholesterol Diabetes Stroke Heart Disease Cancer

Are you having any trouble with any of the following area(s): (Please circle)

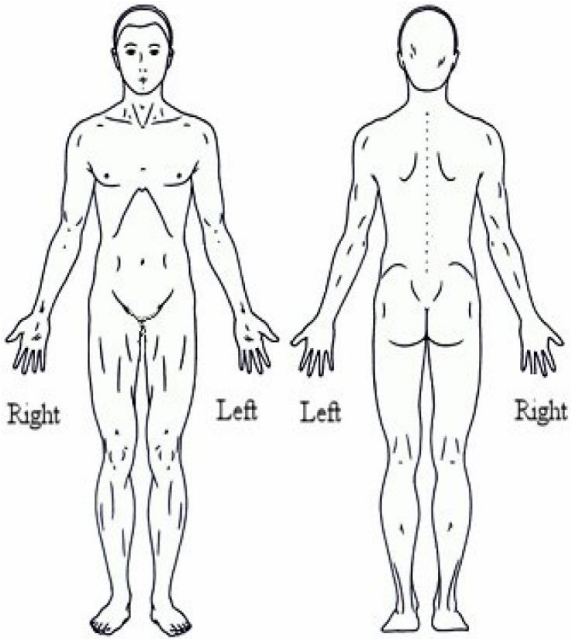
L/R Shoulder L/R Elbow L/R Wrist L/R Hand L/R Hip L/R Knee L/R Ankle L/R Foot

Women Only: (Circle if applies) Pregnant Nursing Birth Control Pill Irregular Cycle Hot flashes Lump in Breast

Please mark (**C**) for **C**urrent or (**P**) for **P**ast if you have or ever had any of the following conditions or diseases.

☐ High/Low Blood Pressure	☐ Hepatitis	☐ Shingles
☐ High Cholesterol	☐ Liver Problems	☐ Unexplained Weight Loss
☐ Heart Disease/Stroke	☐ Thyroid Problems	☐ Pain at Night
☐ Heart Surgery/Pacemaker	☐ Gall Bladder Problems	☐ Headaches/Migraines
☐ Heart Murmur/Defect	☐ Ulcers/Colitis	☐ Double Vision
☐ Diabetes	☐ Acid Reflux	☐ Dizziness
☐ Kidney Problems	☐ Constipation/Diarrhea	☐ Pain w/ Bowel Movements
☐ Blood in Urine	☐ Black/Bloody Stool	☐ Frequent Urination
☐ Loss of Bowel/ Bladder	☐ Irritable Bowel Syndrome	☐ Excessive Hunger/Thirst
☐ Difficulty with Urination	☐ Anemia	☐ Seasonal Allergies
☐ HIV+/AIDS	☐ Cancer: _____	☐ Sinus Problems
☐ Alcohol/Drug Abuse	☐ Arthritis	☐ Asthma
☐ Depression	☐ Emphysema	☐ Difficulty with Breathing
☐ Fainting/Seizures/Epilepsy	☐ Weak Muscles	☐ Swelling of Ankles

Show Us Where It Hurts



Please mark area(s) of injury or discomfort on the diagram.

Description→	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol-----→	NNNN	PPPP	BBBB	AAAA	SSSS

O Circle any area of pain not represented by a symbol.

In the Event of an Emergency: Who should we contact?

Name:_____

Relation:_____

Phone # ( )_____

Work # ( ) _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly mutual understanding between provider and patient. Our policy requires payment in full at time of service, unless other arrangements have been made with the office manager. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also 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

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

CONSENT FOR TREATMENT

When we accept you as a patient into our practice, **it is important** that you understand **the objectives of our care.**

Chiropractors provide a unique service that other healthcare providers do not offer: the location and correction of vertebral subluxations (misalignments) in your spine.

A vertebral subluxation is a misalignment in the spine that causes disruption in the communication between your brain and all your bodily functions. Nerves exit between each vertebrae which are carrying vital information from the brain to all your muscles, organs and tissues. If that nerve gets "pinched" or irritated, the information becomes impaired causing symptoms in your body.

Chiropractors spend years studying how to locate and correct this destructive condition, first by analyzing the structure of your spine by taking x-rays. Second, they correct or adjust your subluxations by using specialized techniques (spinal adjustment). When your spine and nervous system are free from nerve interference; your body's ability to heal, repair, and restore is optimized. We do not medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptom(s) your body is expressing.

If, during the course of our chiropractic spinal examination, we encounter unusual findings, we will let you know of them. If you need to be referred to another specialist we will let you know at that time.

To summarize: the purpose of chiropractic care is not to treat disease or conditions, nor to suppress symptoms, but rather to make your body function better by realigning the spine. Therefore, we do not prescribe surgery or medications. <u>If you wish to decrease or stop medications you should discuss that with your medical doctor.</u>

Consent for treatment: I hereby authorize Bennett Chiropractic and whoever they may designate as their assistants to perform examinations, radiographs, therapy, and adjustments to improve my spinal health. By signing, that certifies I understand and agree to the above statements.

_____ _____

Patient (or Guardian) Signature Date