Dr. James Moore - Harpeth Chiropractic Center

To our valued patient,

We are truly sorry for the circumstances that have brought you to our office today. Our focus is providing you the best possible care so that you can recover as quickly as possible. To properly handle the billing of your case, it is essential you complete the forms attached and we have the following documents to proceed:

- Driver's License
- Your Auto Insurance Card and Declaration Page listing coverage
- At-Fault Party Insurance Information
- Attorney Information (if any)
- Accident/Incident Report

BMW Case Management will be handling your Personal Injury file. They are contracted by our office to ensure all documentation and necessary items are in place. They are also contracted to be patient advocates to ensure that you are educated and walked through this process. Your health is very important to us and we want to make sure you are taken care of.

PLEASE MAKE SURE YOU COMPLETELY ANSWER EVERY QUESTION, FILL IN EVERY BLANK AND BE SURE TO SIGN OR INITIAL EVERY SPACE THAT ITS REQUIRED. THESE FORMS ARE GOING TO BE ESSENTIAL WHEN IT COMES TIME TO SETTLE YOUR CASE OR IF YOU NEED TO OBTAIN AN ATTORNEY.

As you leave the office you will be given an information packet from BMW Case Management. Please contact their office within 24 hours of your first visit.

Thank you,

Dr. James Moore and Staff

6.08.16

Dr. James Moore - Harpeth Chiropractic Center

PERSONAL INJURY/AUTOMOBILE ACCIDENT FINANCIAL POLICY

Our Personal Injury/Automobile Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your auto insurance carrier on your behalf. Please remember, however, that you are ultimately responsible for payment of all services rendered to you regardless of insurance coverage or settlement status. Termination of care prior to your doctor's release will result in all balances being due immediately. Please notify us if you are using an attorney.

(initial) _____

MEDICAL PAYMENTS

"Medical Payments" or "Med-Pay" is part of your own auto insurance policy which will immediately cover the costs of your medical expenses given by a licensed health care provider and those of any passengers in your car, up to a certain limit, regardless of fault. Senate Bill 08-011, effective January 01, 2009, made Med-Pay benefits mandatory on all auto insurance policies unless specifically rejected in writing or declined during the application process. If payment is made by this method, and you are not at fault, your insurance premiums will not be increased, and you will not have to repay any benefits. Med-Pay is primary for services rendered to personal injury patients when available. We require you to use your "Med-Pay" if it is available on your policy.

(initial) _____

THIRD PARTY

Tennessee is currently an "at-fault" state regarding payment of claims resulting from an automobile accident or personal injury. This means the responsible party, or his or her insurance, should cover the cost of medically necessary treatment given by a licensed health care provider. Such claims are considered for payment when all treatment is complete and a settlement is reached with the third party. We will accept a doctor's lien.

(initial) _____

HEALTH INSURANCE

We will ***NOT*** bill your personal health insurance for personal injury. We will bill the primary which will be Med-Pay and/or third party insurance. Workers' Compensation will be billed directly. We do ask to have the information on record for continued care after you have been released.

(initial) _____

RESPONSIBILITY

I, _____ understand that I am primarily responsible for all medical bills and that in consideration for treatment from the motor vehicle accident, Dr. James Moore agrees not to demand payment at the time of service, and I agree to pay Dr. James Moore from the proceeds of any motor vehicle accident; and should I, my insurance company, third party insurance company or attorney fail to pay Dr. James Moore from the proceeds, I agree to pay all court costs, collection costs and attorney fees associated with the delinquent account.

(initial) _____

I have read and understand the personal injury/automobile accident financial policy of Harpeth Chiropractic Center. I understand that I am ultimately responsible for any services rendered to me by Harpeth Chiropractic Center. I understand that if I terminate care outside my doctor's recommendations, any balances will be due immediately.

_____

Patient Name

_____ _____

Patient or Guardian Signature Date

Doctor's Lien

Dr. James Moore - Harpeth Chiropractic Center

Patient's Name: _____ Date of Birth: _____

I do hereby authorize Dr. James Moore to furnish to you with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct my insurance company, responsible party's insurance company and/or my attorney to pay directly to said doctor such sums as may be due and owing him for medical service rendered to me both by reason of settlement, judgment, or verdict as may be necessary to adequately protect said doctor. I hereby further give a LIEN on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to my attorney, or directly to said doctor as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

(initial) _____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, third-party settlement, judgement, or verdict as may be necessary to adequately protect said doctor above named.

(initial) _____

By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, reasonable attorney fees, court costs, and all other costs related to the collection of debt.

(initial) _____

If my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Patient's Name: _____

Patient or Guardian's Signature: _____ Date: _____

_____

Address City St Zip

The undersigned being attorney of record for the above patient do hereby agree to observe all the terms of the above and agrees to withhold such sums form any settlement, third-party settlement, judgment or verdict as may be necessary to adequately protect said doctor named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS AND PROCEEDS OF CLAIM

I am seeking treatment from Dr. James Moore ("the Doctor") for injuries I suffered in a vehicle accident. In consideration of receiving such treatment, I hereby assign to the Doctor the following monies to which I am or may become entitled.

1. **Insurance Benefits**. I have an automobile insurance policy issued by _____ insurance company. I hereby assign to the Doctor any benefits to which I am or may become entitled under that policy. The amount assigned to the Doctor shall be limited to the amount of the charges for medical services rendered to me by the Doctor as treatment for injuries I received in the accident.

2. **Proceeds of My Claim Against Another Party**. At this time it has not yet been determined which party caused the accident in which I was injured.

It may be determined at a later time, by a court through litigation or by settlement negotiations between the parties and/or their insurance company representatives, that another party caused the accident in which I was injured and that the other party is therefore responsible for paying damages to me in an amount sufficient to cover, in whole or in part, the medical expenses I have incurred as a result of the accident. If this determination is made through a settlement, the settlement agreement may provide that an amount of money shall be paid to me by the insurance company for the other party, even though the settlement agreement states that the payment shall be made without an admission of liability by the other party.

If the insurance company for the other party agrees to pay, or is ordered by a court to pay, a specified sum to me for bodily injuries I incurred in the accident, I hereby assign to the Doctor a portion of the monies I am entitled to receive from the other party's insurance company, limited to the amount of the charges for medical services rendered to me by the Doctor as treatment for injuries I received in the accident.

I understand that I am at this time making an assignment of the proceeds of a potential claim against the other party involved in the accident and that this assignment will be effective only after a determination, either by a court or by a settlement, that the other party's insurance company will pay a specified amount of money to me.

I understand that a copy of this Assignment must be provided to the insurance company for the other party before it will be binding on that company and that the Doctor must provide to that insurance company appropriate evidence of the services provided to me and the charges for those services.

By making this Assignment to the Doctor, I am directing _____insurance company for the other party and/or my attorney _____to pay the assigned amount directly to the Doctor.

Dr. James Moore - Harpeth Chiropractic Center
8122 Sawyer Brown Rd Ste 206
Nashville, TN 37221

I understand that if the insurance benefits and claim proceeds which are or become available to me are insufficient to cover the charges of the Doctor for the medical services provided to me, I am responsible for paying the balance of those charges.

I agree to notify the Doctor in writing at least thirty (30) days before changing this Assignment in any way.

_____ _____

Witness Print Patient Name

_____

Patient or Guardian Signature

Date: _____

Refer to judgement on Feb 5, 2015 by Supreme Court of Tennessee Action Chiropractic Clinic, LLC v. Prentice Delon Hyler, ER AL.;Case No. M2013-01468-SC-R11-CV.

6.08.16

ACTIVITIES OF DAILY LIFE

Patient's Name: _____ Date: _____

Carrying Groceries	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Sit to Stand	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Climbing Stairs	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Pet Care	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Driving	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Extended Computer Use	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Household Chores	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Lifting Children	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Reading/Concentration	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Dressing	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Shaving	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Sexual Activities	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Sleep	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Static Sitting	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Static Standing	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Yard Work	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Walking	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Washing/Bathing	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Sweeping/Vacuuming	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Dishes	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Laundry	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Garbage	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Bending	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Care for Family	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Kneeling	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Other:_____	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Other:_____	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Lifting (weight limit)	Circle one:	10lbs	20lbs	30lbs 40lbs 50lbs

Please mark **P** for "in the **Past**", **C** for "**Currently**" have and **N** for "**Never**"

___ Headache	___ Pregnant(now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds,Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun	___ Heartburn
___ Jaw Pain,TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Press.
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Press.
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot/Knee Problems	___ Hearing Loss	___ Menstrual Problems	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Prob	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis(A,B,C)

6.08.16

Dr. James Moore
Harpeth Chiropractic Center

PERSONAL INJURY/AUTOMOBILE ACCIDENT CLAIM INFORMATION FORM

For Office Use Only:

- ☐ Copy of Driver's License
- ☐ **Signed** Dr's Lien
- ☐ **Signed** Financial Policy
- ☐ **Signed** AOB/Settlement
- ☐ Copy of Personal Auto Insurance
- ☐ Copy of Per. Auto Declaration Page
- ☐ At-Fault Auto Info
- ☐ Attorney Info (if any)
- ☐ Accident Report
- ☐ BMW Business Card to Patient
- ☐ BMW Intro Letter to Patient

Verified by:_____ Date_____

Today's Date _____

Patient Name: _____

Guardian Name: _____

Your Auto Insurance Policy

Name of Insurance Company: _____

Telephone #:_____

Name on Policy: _____

Policy #:_____

Claim#:_____

Claims Representative Name: _____

Claims Representative Phone #:_____

Do you have Medical Payments Benefits on your policy?

- ☐ Yes, Amount: _____
- ☐ No
- ☐ I don't know

Third Party Insurance Policy

Third Party's Name: _____

Name of Insurance Company: _____

Telephone #:_____

Name on Policy: _____

Policy #:_____

Claim#:_____

Claims Representative Name: _____

Claims Representative Phone #:_____

Attorney (it is not always necessary to have an attorney for PI claims)

Name of Law Firm: _____

Name of Attorney: _____

Phone #:_____

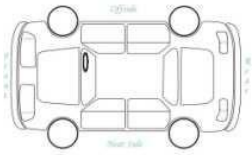
Patient / Guardian Signature: _____

6.08.16

Dr. James Moore
Harpeth Chiropractic Center
ACCIDENT HISTORY QUESTIONNAIRE

Patient Name_____Date _____

1. Date of Accident:_____2. Time:_____AM/PM
3. Driver of Car: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year & model of your car: _____
   Year & model of other car: _____
7. What was the approximate damage done to your car? $_____
8. Visibility at time of accident ☐Poor ☐Fair ☐Good ☐Other: _____
9. Road conditions at the time of accident: ☐ Icy ☐ Rainy ☐ Wet ☐Clear ☐Dark
   ☐ Other (describe) _____
10. Where was your car struck?

FRONT  BACK

In your own words, please describe accident: _____

_____

_____

_____

_____

11. Type of Accident: ☐ Head-on collision ☐ Broad-side collision ☐ Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car:

_____

_____

13. Did you see the accident coming? ☐ Yes ☐ No
14. Did you brace for impact? ☐ Yes ☐ No
15. Were seat belts worn? ☐ Yes ☐ No
16. Where shoulder harnesses worn? ☐ Yes ☐ No
17. Does your car have headrests? ☐ Yes ☐ No If yes, what was the position of those headrests compared to your head before the accident?
    ☐ Top of headrest even with bottom of head
    ☐ Top of headrest even with top of head
    ☐ Top of headrest even with middle of neck
18. Was your car braking? ☐ Yes ☐ No
19. Was your car moving at the time of the accident? ☐ Yes ☐ No
20. If yes, how fast would you estimate you were going?_____mph
21. How fast would you estimate the other car was going?_____mph
22. Head/body position at the time of impact
    ☐ Head turned left/right ☐ Body straight in sitting position
    ☐ Head looking back ☐ Body rotated right/left
    ☐ Head straight forward ☐ Other: _____
23. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock
    ☐ Dazed, circumstances vague ☐ Other: _____
24. How was the shoulder harness adjusted? ☐ Loose ☐ Snug

25. Were you wearing a hat or glasses? ☐ Yes ☐ No
26. Could you move all parts of your body normally or as you could before the accident? ☐ Yes ☐ No
27. If no, what parts couldn't you move and why? _____

_____

28. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
29. If no, why not? _____
30. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____
31. Did you get any bruises? ☐ Yes ☐ No If yes, where? _____
32. Please describe how you felt:
    Immediately after the accident: _____
    Later that day: _____
    The next day: _____
33. Check symptoms apparent since the accident:

☐ Headache	☐ Neck pain/Stiffness	☐ Mid back pain
☐ Eyes Light Sensitive	☐ Pain Behind Eyes	☐ Dizziness
☐ Fainting	☐ Sleeping Problems	☐ Numbness in Fingers
☐ Numbness in Toes	☐ Loss of Smell	☐ Loss of Taste
☐ Loss of Memory	☐ Fatigue	☐ Breath Shortness
☐ Irritability	☐ Depression	☐ Ringing/Buzzing
☐ Loss of Balance	☐ Tension	☐ Cold Hands
☐ Cold Feet	☐ Diarrhea	☐ Constipation
☐ Chest Pain	☐ Nervousness	☐ Cold Sweats
☐ Anxious	☐ Facial Pain	☐ Clicking or Popping Jaw
☐ Low Back Pain	☐ Other _____	

34. Occupation: _____
35. Employer: _____
36. Have you missed time from work? ☐ Yes ☐ No
37. If yes, full time off work: _____ to _____
38. If yes, part time off work: _____ to _____
39. Did you seek medical help immediately after the accident? ☐ Yes ☐ No
    ☐ If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone Else Drove Me
    ☐ Drove Own Car ☐ Other: _____
40. Doctor #1: Name: _____
41. First visit date: _____
42. Were you examined? ☐ Yes ☐ No
43. Were X-rays taken? ☐ Yes ☐ No
44. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
45. If yes, what kind of treatment did you receive? _____
46. What benefits did you receive from the treatment? _____
47. Date of last treatment? _____
48. Doctor #2: Name: _____
49. First visit date: _____
50. Were you examined? ☐ Yes ☐ No
51. Were X-rays taken? ☐ Yes ☐ No
52. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
53. If yes, what kind of treatment did you receive? _____

_____ _____

Patient / Guardian Signature Date

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

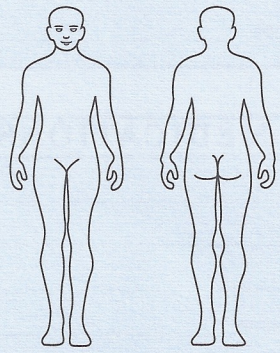
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (_____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very 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 your health care information.

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

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change 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 any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with 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. *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.*

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date