Appointment Date/Time: _____

Whom may we thank for referring you to this office? _____

APPLICATION FOR CARE AT EDC Family Chiropractic

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #: _____ Insurance Policy Holders Name & DOB: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

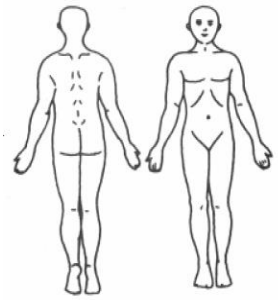
How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

LIST RESTRICTED ACTIVITY:	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes,** how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____
☐Adopted

I hereby authorize payment to be made directly to EDC Family Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to EDC Family Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME: _____ HR#: _____ Date: _____

X-rays are one way of looking inside a person's body. Chiropractors use X-ray analysis as one of the tools that help tell if your body is properly balanced and if your vertebrae and other skeletal structures are in proper alignment. This helps us determine your plan of care.

Long-standing nerve stress (subluxations) may cause a condition of inflammation of the bone and related structures and premature aging called spinal degeneration. An X-ray can tell us if you have this condition.

X-rays are a form of electromagnetic radiation and may have adverse effects on body tissue, especially rapidly dividing cells. For that reason it is best to avoid X-rays when pregnant. Please sign below so we may be able to proceed.

I, _____„in signing this form, state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

Patient's signature_____Date_____

If you are pregnant or suspect you may be pregnant we will perform a full physical exam and nerve scan.

Patient's signature_____Date_____

Doctor's signature_____Date_____

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 subluxations (structural and nervous system stress) in your body.

A subluxation is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. Subluxations can cause dis-ease or loss of proper body function.

Chiropractors spend years studying how to locate and correct this destructive condition, first by analyzing your structural system (especially your spine) using various methods. Secondly, we correct or adjust your subluxations by using specialized techniques (adjustments). When your structural system, spine and nervous system are free from the deep stress of subluxations you function more efficiently and your natural healing ability, your inner healer, will better communicate through your body.

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, you always need a body free from subluxations.

If, during the course of our chiropractic examination, we encounter unusual findings, we will let you know. You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. We will cooperate with you and with them in your goals.

To summarize: the purpose of chiropractic care is not to treat diseases or conditions, nor to suppress symptoms, nor to perform surgery, but rather to make your body function better by removing structural nerve stress (subluxations). Therefore, we do not prescribe surgery or medications. If you wish to decrease or stop medications, you should discuss that with your MD.

Our objective is to eliminate a major interference to the expression of your physical/emotional health and healing-subluxations-so that your natural healing ability and your inner healer may function without this severe form of stress.

I,_____, have read and fully understand the above statements.

Date_____

Assignment of Benefits Form

Financial Responsibility

I have requested services from EDC Family Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. I understand that insurance coverage is a supplement to help pay for care, not a sole means of achieving it. Regardless of what my insurance policy says they will pay, all services/products rendered are my responsibility. I understand that payments paid are applied first to any products/care not covered by insurance then to any deductible, co-pays, etc. Balances greater than 90 days past due may be sent to collections and a collection agency fee (minimum of 50% of the balance) will be added to the balance due.

Authorization of Release Information

You, EDC Family Chiropractic, and Dr. Jeremy Book, are authorized by me to release any information you deem appropriate concerning my care to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred at EDC Family Chiropractic by me. I also request payment of government benefits either to myself or to the party who accepts assignment on the HFCA-1500 form used to file my insurance.

Assignment of Benefits

I authorize payment of medical benefits to the physician or supplier listed on the HFCA-1500 form used by EDC Family Chiropractic for services described on the said HFCA-1500 form.
I authorize and assign the direct payment to EDC Family Chiropractic of any sum I now or hereafter owe you by any insurance company obligated to reimburse me for the charges for your services. I give assignment and lien against any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.

Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

EDC Family Chiropractic

1011 W. Broadway
Dr. Jeremy M. Book

Maryville, TN

Phone: 865-983-3333

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Watts Chiropractic we may use or disclose personal and health related information about you in the following ways:

*Your protected health information, including your health records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, ifthey are, or may be responsible for the payment of services provided.

*Your name, address, phone number and your health records may be used to contact you regarding appointment reminders, information about alternatives to your present care or other health related information that may of interest.

You have a right to request restrictions on our use of your protected information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, phone number, email address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home a message will be left on an answering machine or voicemail. You have a right to confidential communications and to request restrictions relative to such contacts.

You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

* If we provide health services to you in an emergency

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care for you.

*If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release you have a right to revoke at a later date.

Information that we use or disclose based on this privacy notice may be subject to disclosure by the person whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide health information to you in person at the time you receive chiropractic from us. We may also mail information to you regarding your care or the status of your account. If you would like to receive a mailed copy please let the front desk staff know.

account. If you would like to receive information at an address other than your home, please advise us in writing to your preferences.

We are required by state and federal law to maintain the privacy of your file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to amend or alter the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible in writing.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

Jeremy M. Book, DC

865-983-3333

drjeremy@edcfamilychiro.com

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This office utilizes an "open adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, examinations or report of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience more efficient and productive as well as to enhance your access to quality health care and information. If you choose not to be adjusted in an open-adjusting setting then other arrangements will be made for you.

This notice is effective as of_____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (printed)_____ Signature_____ Date_____

If you are a minor, or represented by another party

Personal Representative (Printed)_____ Date_____

Personal Representative (Signature)_____

Description of the authority to act on behalf of the patient.

_____