ALIGN HEALTH
AND HOLISTIC MEDICAL CENTER
Where Pain Relief Comes Naturally

Date:_____

Patient Information

Title: (Circle one) Mr. Mrs. Ms. Miss Dr. Other

First Name:_____ Middle Initial_____ Last Name:_____

Address:_____ City_____ State_____ Zip_____

Home/Cell: (_____)_____-_____ Email:_____

Date of Birth:_____/_____/_____ Sex: ☐ Male ☐ Female SS#_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other

Ethnicity: ☐ Hispanic ☐ Latino ☐ Non-Hispanic/ Non-Latino

Occupation: _____ Employer:_____

Emergency Contact

Name:_____
Phone#_____ Relationship to patient:_____

How did you hear about our practice?_____ Reason for Visit?_____

When did your symptoms appear?_____ How often do you have this pain?_____

Activities or movements that are painful to perform:_____

Accident Information

Is this visit due to an accident? ☐ YES ☐ NO If yes, what type? ☐ Auto ☐ Work ☐ Other

Has it been reported? ☐ YES ☐ NO If yes, to whom?_____

Insurance Information

Policy Holder Name:_____

Relationship to patient (if other than self):_____ Phone#_____

Do you have health insurance? ☐ YES ☐ NO Name of Carrier:_____

Do you have secondary insurance? ☐ YES ☐ NO Name of Carrier:_____

Assignment and Release (Insured Patient)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient Signature:_____

ALIGN HEALTH
AND HOLISTIC MEDICAL CENTER

2732 Hwy 411 S. Maryville, TN 37801
865-681-5277

Align Health and Holistic Medical Center Informed Consent for Treatment and Care

I hereby consent to the performance of medical services and procedures, and/or chiropractic adjustment and other chiropractic procedures, including but not limited to, various modes of physical therapy and diagnostic x-rays on me or on the patient below, for whom I am financially responsible by

☐ Dr. Eric Anderson, DC
☐ Dr. Daniel McMahan, DC
☐ Merry Roy, FNP-BC
☐ Kelly Warwick, PT

or other licensed providers who now or in the future treat me while employed by, working with, associate with, or serving as back-up for the selected providers, including those working at the clinic or office listed above.

I have had an opportunity to discuss with the provider listed above and/or with other office or clinic personnel the nature and purpose of medical procedures. I understand that results are not guaranteed.

I understand and am informed that, as in a practice of medicine, there are some risks to treatment. I do not expect the provider to be able to anticipate and explain all risks and complications. I wish to rely on the provider to exercise judgement during the course of the procedures that the provider feels at the time, based upon the facts then known, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its consent and, by signing below, I agree to the above consent. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date_____

Align Health and Holistic Medical Center
HIPAA Form

The patient understands and agrees to allow Align Health to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning these records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your health information, we encourage you to read the HIPAA notice that is available at http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf, before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient/Guardian Signature_____Date _____

Your provider 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 alternative treatments, or 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 voicemail or with the person answering the phone. If we send you an email, or you send us an email, the information that is sent to you is not encrypted. By signing this form, you are giving us the authorization to contact you with these reminders or communicate through our unencrypted email and to leave messages on your voicemail or with an individual at your home.

Patient/Guardian Signature _____Date _____

☐ *Please check the box if you do not wish to receive health information via email or a message be left by voicemail or with another individual.*

Only sign and date if you checked the box above.

Patient/Guardian Signature _____Date _____

Align Health and Holistic Medical Center
Patient Financial Policy

In order to reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policy. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Self-Pay Patients

Full payment is due at the time services are rendered. For you convenience, we accept cash, check, and most major credit cards.

Medical Insurance Coverage

Your insurance policy is a contract between you and your insurance company. Our billing specialist will verify your chiropractic coverage with your insurance and provide you with an estimate of your charges. If, for any reason, your insurance company does not pay the bill, you will be ultimately responsible. Please note that all health plans are not the same and do not cover the same services. In the event that your health plan determines a service or portion of the service "non-covered," you will be responsible for the complete charge and any balance due is your responsibility. Payment will be due upon receipt of statement from our office. If you should have any questions or concerns regarding your insurance or account, please ask the receptionist.

Co-payments, Deductibles, and Co-insurance

You will be required to pay the authorized co-payment at the time of service. Deductibles and co-insurance will be billed to insurance, but a portion will be payable at the time of service. Again, if you should have any questions or need to set up payment arrangements, please ask the receptionist.

Therapeutic Treatments

Due to our office policy, we do not bill therapeutic treatment(s) to insurance. Patient is responsible for any therapies they receive at the time services are rendered. If you have any questions, please ask the receptionist.

☐ PLEASE CHECK THE BOX IF YOU DO NOT WANT THERAPIES

Motor Vehicle Accidents

If you have been involved in an auto accident and are submitting claims through a form of auto insurance, please be sure to have the following information available: *Insurance Company, adjuster's name, claim number, and contact phone number*. We will directly contact the company paying for your services. If you have an attorney, please provide us with the *name, address, phone number, and fax number*. You will also be asked to sign an attorney lien letter at your initial visit.

Medicare Patients

Medicare will only pay for the services they deem "medically necessary." If Medicare determines that your treatment was not medically necessary, they will deny payment for that service. If Medicare denies any services, your secondary insurance will not pay the expenses. We can only bill a chiropractic adjustment to Medicare, non-covered services are the responsibility of the patient and a required ABN will be completed and placed in your file. Current Medicare regulations will not reimburse for any of the following services billed from a chiropractic office: exams, therapy, and rehab. All non-covered services will be charged directly to the patient at a discounted rate. Charges for these services can be discussed with you ahead of time to ensure you know exactly what to expect.

I have read and understand Align Health and Holistic Medical Center's Financial Policy as outlined above.

Patient Signature _____ Date _____

Align Health and Holistic Medical Center
Medical Release Form

Patient Name: _____ Date of Birth: ____/____/_____

Patient Authorization to Receive Health Information

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization authorized to make the disclosure: (***Office Use Only***)
   _____
   _____
   _____

3. This information may be disclosed to and used by the following:

   Align Health and Holistic Medical Center
   2732 US Highway 411 S
   Maryville, TN 37801

4. The type and amount of information to be used or disclosed is as follows: (***Include Dates Where Appropriate***)

Problem List	Medical List	List of Allergies
Immunization Record	Laboratory Results	X-Ray/Imaging Reports
Office Visit Notes	All Records	Other: _____

5. I understand the information in my health record is requested and may be used for following reasons:

Continuing Care	Legal Documentation	Other: _____

6. I understand that the information in my health record may include information relating to sexually transmitted disease, *Acquired Immunodeficiency Syndrome* (AIDS) or *Human Immunodeficiency Virus* (HIV.) I may also include information about behavioral or mental services and treatment for alcohol and drug abuse.

7. I have the right to revoke the authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Align Health. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law profiles my insurer with the right to contact a claim under my policy, unless otherwise revoked.

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If you have questions about the disclosure of my health information, please inform the front desk.

_____ _____ _____
Patient/Guardian Signature Relationship to Patient Date

_____ _____
Signature of Staff Date

Align Health and Holistic Medical Center

Name: _____ Date: _____

Complaint 1: _____

Symptoms started on _____

How did symptoms start? (What were you doing?) _____

What is pain scale 1-10? _____ Frequency of pain: ☐ Constant ☐ Frequent ☐ Occasional

Are your symptoms getting: ☐ Better ☐ Worse ☐ Not changing

Describe your feeling: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing ☐ Burning ☐ Numb ☐ Tingling

Actions affecting complaint:
☐ Morning ☐ Afternoon ☐ Bending Backwards ☐ Bending forwards ☐ Bending Left ☐ Bending Right
☐ Twisting Left ☐ Twisting Right ☐ Sitting ☐ Standing ☐ Lying down ☐ Coughing ☐ Lifting ☐ Rest
☐ Cold ☐ Heat ☐ Medications

Pain radiates to:
☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Hip ☐ Leg ☐ Foot

Complaint 2: _____

Symptoms started on _____

How did symptoms start? (What were you doing?) _____

What is pain scale 1-10? _____ Frequency of pain: ☐ Constant ☐ Frequent ☐ Occasional

Are your symptoms getting: ☐ Better ☐ Worse ☐ Not changing

Describe your feeling: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing ☐ Burning ☐ Numb ☐ Tingling

Actions affecting complaint:
☐ Morning ☐ Afternoon ☐ Bending Backwards ☐ Bending forwards ☐ Bending Left ☐ Bending Right
☐ Twisting Left ☐ Twisting Right ☐ Sitting ☐ Standing ☐ Lying down ☐ Coughing ☐ Lifting ☐ Rest
☐ Cold ☐ Heat ☐ Medications

Pain radiates to:
☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Hip ☐ Leg ☐ Foot

What treatment have you already received for your condition? _____

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

Date of last: Physical Exam _____ Spinal X-Ray _____ Spinal X-Ray _____

Spinal Exam _____ Chest X-Ray _____ MRI/CT Scan _____

Place a mark in the box to indicate if you have had any of the following:

☐AIDS/HIV	☐Pinched Nerve	☐Heart Disease	☐Hernia	☐Herniated Disk
☐High Blood Pressure	☐High Cholesterol	☐Bleeding Disorders	☐Cancer	☐Chemical Dependency
☐Migraine	☐Psychiatric Care	☐Pacemaker	☐Epilepsy	☐Stroke
☐Suicide Attempt	☐Tumors/Growths	☐Ulcers		

☐Other _____

MEDICATIONS

_____

_____

_____

_____

_____

_____

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

	Date
Falls	
Head Injuries	
Broken Bones	
Dislocations	
Surgeries	

ALLERGIES

_____

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

_____

Review of Systems Questionnaire

Date: _____

Patient Name: _____ DOB: _____

PLEASE ANSWER EACH QUESTION:	YES	NO	COMMENTS
Constitutional:			
A. Recent weight change?	☐	☐	_____
B. Weakness, fatigue or chills?	☐	☐	_____
Eyes:			
A. Difficulty seeing?	☐	☐	_____
B. Contact Lenses?	☐	☐	_____
C. Temporary loss of vision?	☐	☐	_____
Ears, Nose and Throat:			
A. Allergies? (seasonal, environmental)	☐	☐	_____
B. Dentures?	☐	☐	_____
C. Problems with hearing?	☐	☐	_____
D. Hoarseness, sore throat, trouble swallowing?	☐	☐	_____
Cardiovascular:			
A. Chest pain (heart pain, angina)?	☐	☐	_____
B. Issues with swelling in legs or feet?	☐	☐	_____
C. Known heart rhythm problems?	☐	☐	_____
D. Leaky heart valves?	☐	☐	_____
E. Problems with circulation?	☐	☐	_____
F. High or low blood pressure?	☐	☐	_____
Respiratory:			
A. Chronic cough?	☐	☐	_____
B. Shortness of breath?	☐	☐	_____
C. Wheezing or asthma symptoms?	☐	☐	_____
GI:			
A. Constipation?	☐	☐	_____
B. History of jaundice?	☐	☐	_____
C. Recent change in appetite?	☐	☐	_____
D. Bloody Stool?	☐	☐	_____
E. Frequent heartburn or indigestion?	☐	☐	_____

REVIEW OF SYSTEMS page 2 of 3

Patient Name:_____

DOB:_____ Date:_____

	YES	NO	Comments
GU:			
A. Frequent bladder infections?	☐	☐	
B. Frequent nighttime urination?	☐	☐	
C. Incontinence?			
D. (MEN) Issues with stream?	☐	☐	
E. (MEN) BPH or enlarged prostate	☐	☐	
MS:			
A. Joint pain requiring medicine? (if yes, which joint?)	☐	☐	
B. Calf or leg pain with walking?	☐	☐	
C. Arthritis?	☐	☐	
Skin:			
A. Rashes?	☐	☐	
B. Skin Cancers?	☐	☐	
C. Other major skin problems?	☐	☐	
Neuro:			
A. Problems with memory?	☐	☐	
B. TIA's or minor stroke?	☐	☐	
C. Recent numbness or weakness?	☐	☐	
D. History of seizures?	☐	☐	
E. Problems with balance?	☐	☐	
Psych:			
A. Depression?	☐	☐	
B. Anxiety?	☐	☐	
C. Other psychiatric problems?	☐	☐	
Endocrine:			
A. History of high or low blood sugar?	☐	☐	
B. Thyroid problems?	☐	☐	
Heme/Lymph:			
A. Bleeding tendencies/bruising, Or frequent nose bleeds?	☐	☐	
B. Any history of anemia?	☐	☐	
C. Do you have sickle cell disease?	☐	☐	
Breasts:			
A. Pain?	☐	☐	
B. Discharge?	☐	☐	
C. Other changes or abnormalities?	☐	☐	

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

References

1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.