Patient Demographic Form

Patient Name: ______________________________ Preferred Name: ____________________
Street Address: ______________________________ Date of Birth: ____________________
City/State/Zip: ______________________________ Cell Phone: ____________________
Email: ______________________________ Phone Carrier: ____________________
Patient SSN: ______________________________ Other Phone: ____________________

Marital Status (Please Circle) a. Married b. Single c. Widowed d. Divorced e. Separated

Appointment Reminder and Office Announcements Method (Please Circle) Text / Email

Would you like to receive our Health Newsletter via email? Yes / No

---

Emergency Contact Information:

Contact Name: ______________________________ Relationship: ____________________

Contact Phone: ______________________________

Medication List

	Name	Dose	Reason
1.			
2.			
3.			
4.			
5.			

Medication Allergies

1. ______________________________
2. ______________________________
3. ______________________________

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
Pacemaker	___	___	Epilepsy or Seizure Disorder	___	___	Take Blood Thinners	___	___
Heart Disease	___	___	Implanted Electrical Device	___	___	COPD	___	___
Cancer	___	___	Metal or Silicone Allergy	___	___			
Latex Allergy	___	___	Taking medication that may increase sensitivity to light				___	___
Diabetes	___	___	Have had a steroid shot in the last 7 days				___	___

FEMALE USE ONLY

I ATTEST THAT I AM NOT PREGNANT OR THINK I MAY BE PREGNANT. I UNDERSTAND THAT CERTAIN PASSIVE MODALITIES INCLUDING ULTRASOUND, ELECTRICAL STIMULATION, DRY NEEDLING AND LASER THERAPY COULD BE POTENTIALLY HARMFUL TO THE BABY.

IF YOU ARE PREGNANT, YOU HAVE MADE THE DOCTOR AWARE OF YOUR PREGNANCY.

Patient Signature ______________________________ Date ____________________

OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. If you are unable to pay when services are rendered, please inform our front desk and other arrangements will be made.
2. As a courtesy we will file the primary/secondary insurance. Patients are requested to please bring current insurance information for verification purposes, this will ensure an expedient disposition of the account balance.
3. MEDICARE & MANAGED CARE CONTRACTS: This facility is under contract with several Managed Care Companies, HMOs, PPOs and Medicare. If you are a participant in this type of insurance coverage, we request that you pay all co-payments and/or deductibles in full at the time services are rendered.
4. METHODS OF PAYMENT: For your convenience, we accept Visa, Mastercard, Discover, Cash, Money Order, Travelers Check, and Personal Check. **If you pay by personal check and the check is returned marked "Insufficient Funds", a Returned Check Charge of $15.00 will be applied to your account.
5. **MISSED APPOINTMENTS:** Appointments are scheduled specifically for each patient. We request that if you cannot keep an appointment that you cancel your appointment at least 24 hours prior to the appointment time. **If you have more than 3 missed appointments, we reserve the right to discharge you from care.**
6. The Medical Authorization and Assignment Release Form is required from each patient. The form will contain the names and titles of the professional medical staff providing services, authorization to disclose the patient's medical record to receive payment, and have payment sent directly to the medical facility.

I have read and understand the office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

__________________________ _______________________

Responsible party printed name | Relationship to patient

__________________________ _______________________

Responsible party signature | Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, __________________________, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operation such as quality assessments and accreditation.

I release my records to the following individuals: ____

__________________________ _______________________

Patient signature | Date

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- Please Specify: ____

Staff signature: ______________________________ Date: ____________________

Request for Assignment of Benefits to Health Care Provider

Patient Name: ____

Are you the primary insurance holder? Yes / No

Insurance Company: ____

Insurance Guarantor/Sponsor Name: _________________________ Relationship to Patient: ____________

Guarantor/Sponsor DOB: ____/___/_____ Sponsor Full SSN (Military): ______________

****Address if different from patient:** ____

Car/Work Comp Insurance Name: ________________________________ Claim Number: ________________

I am entitled to benefits under a policy of insurance written by the above insurance company. I am receiving treatment for an injury from the above health care provider. As allowed by Tennessee law, I hereby assign Tennessee Center of Integrated Medicine, from the benefits from which I am entitled, a sum of money sufficient to cover the charges of that health care provider for the services I have received. I hereby request that the above insurance company pay that money directly to the health care provider.

I understand that the amount which is paid to the above health care provider may be limited to the amounts owed to other health care providers who have provided services to me for the same injury and by the amount of medical benefits to which I am entitled under the policy. I also understand that the amount paid to the above health care provider may be deducted from any "bodily injury" award that I may receive.

If the above insurance company does not permit the assignment of benefits, I hereby request that the company disburse the sums to which I am entitled in the form of a check issued in the names of the insured and the above health care provider as joint payees and sent to the office provider. I understand that if the benefits available to me under the policy are insufficient to cover the charges of the above health care provider, I am responsible for paying that portion of the provider's charges not covered by insurance. I agree to verbally let the provider know before my insurance benefits change in any way.

Tennessee Center of Integrated Medicine collects payment as services are rendered.

Copay:

_____________________________________ ______________________________

Patient signature Date

INFORMED CONSENT

CHIROPRACTIC **Patient Initials________**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic.

I will have the opportunity to discuss the basic information regarding Laser Therapy with my provider. I am aware that increased soreness may occur after the first laser session, and that mild bruising may occur from the soft tissue manual therapy element of the treatment program.

I will have an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

PHYSICAL THERAPY **Patient Initials________**

I hereby request and consent to the performance of physical therapy examination and treatment including various modalities of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the physical therapist named below and/or other licensed physical therapists who now or in the future work at the clinic or office listed above or any other office or clinic.

I will have an opportunity to discuss with the physical therapist named below and/or with other office or clinic personnel the nature and purpose of physical therapy and other procedures. I understand that results are not guaranteed.

I understand and informed that, as in the practice of medicine, in the practice of physical therapy there are some risks to treatment, including but not limited to pain, soreness, bruising. I do not expect the physical therapist to be able to anticipate and explain all risks and complications, and I wish to rely upon the physical therapist to exercise judgement during the procedure which they feel at the time, based upon the facts then known to him or her, is in my best interest.

ACUPUNCTURE **Patient Initials________**

I hereby authorize the treatment of Acupuncture if appropriate for my condition. I am aware Acupuncture has a risk for pneumothorax, and post treatment soreness such as bruising.

FUNCTIONAL MEDICINE **Patient Initials________**

I hereby request nutritional consultations and functional medicine treatment. I understand that in the practice of functional medicine some treatments are considered "alternative" by the conventional medical community and that there are some risks to treatment. Specific diseases are not being treated but the dysfunctions of the human body are being addressed. I do not expect the doctor to be able to anticipate and explain *all* the risks and complications and I wish to rely on the doctor to exercise judgement during treatment based upon the facts then known and in my best interest.

Regarding Diet Recommendations and Nutritional / Herbal Supplements - We may make diet recommendations and recommendations regarding use of nutritional and herbal supplements to supply nutrition of the physiological and biomechanical process of the human body. Although these foods and products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all your healthcare providers fully informed about all medications and nutritional supplements, herbs or hormones you may be taking.

As a service to you, we make nutritional supplements available in our office. We purchase only top-quality products and only from manufacturers who have gained our confidence through considerable research and experience. You are under no obligation to purchase these in our office, but we cannot guarantee a similar quality from an outside source.

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

Patient Signature ________________________________ Date ____________________