TENNESSEE CENTER of Integrated Medicine

Patient Demographic Form

Patient Name: _____ Preferred Name: _____
Street Address: _____ Date of Birth: _____
City/State/Zip: _____ Cell Phone: _____
Email: _____ Home Phone: _____
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

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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 _____

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TENNESSEE CENTER of Integrated Medicine

FINANCIAL RESPONSIBILITY

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. This form confirms that you understand that the services provided are necessary and appropriate and explains your financial responsibility with respect to services received.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment.

You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, a payment plan may be available.

TENNESSEE CENTER of Integrated Medicine

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

You are responsible for understanding the limitations of your insurance policy, including:

• If a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient).

• What prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)

• Any co-payment, coinsurance or deductible that may apply

YOUR RESPONSIBILITIES

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility. All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance.

TENNESSEE CENTER of Integrated Medicine

We may add a finance charge of 1.33% of your outstanding account balance every month if you do not pay your account in full. If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made. No-shows. If you miss your appointment, you may be charged a $50.00 fee for a missed appointment. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance. Interpreter and Translation Services. If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least twenty four (24) hours prior to your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.

Thank you for choosing us as your healthcare provider!

Your signature below indicates understanding and acceptance of these policies.

_____ _____

Signature Date

TENNESSEE CENTER of Integrated Medicine

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:** _____

Do you have a secondary insurance? Yes / No

Insurance Company: _____

Insurance Guarantor/Sponsor Name: _____ Relationship to Patient: _____

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

****Address if different from patient:** _____

For Auto Accident/Workman's Compensation

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

TENNESSEE CENTER of Integrated Medicine

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 / OCCUPATIONAL THERAPY **Patient Initials_____**

I hereby request and consent to the performance of physical/occupational therapy examination and treatment including various modalities of physical/occupational therapy on me (or on the patient named below, for whom I am legally responsible) by the physical/occupational therapist and/or other licensed or qualified staff under the direction of physical/occupational therapist.

I will have an opportunity to discuss with the physical therapist 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 that, as in the practice of medicine, in the practice of physical / occupational therapy there are some risks to treatment, including but not limited to pain, soreness, bruising. I do not expect the therapist to be able to anticipate and explain all risks and complications, and I wish to rely upon the physical/occupational 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 _____

TENNESSEE CENTER of Integrated Medicine

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been offered and or 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.

You may release my information and or records to the following individuals:

_____

_____

_____

☐ I give permission to leave voicemail messages regarding appointments or patient care on my designated telephone.

_____ _____

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: _____