

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

Phone # (H) _____ (W) _____ (Other) _____

Can we call you at work? Yes No

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: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

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: _____ D.O.B.: _____

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: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

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.

SIGNATURE (X) _____ DATE _____

Form 2

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ | |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking (Be sure to include dosage and frequency) _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

- | | |
|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ |
| | <input type="checkbox"/> Other _____ |

Do you exercise: Never Daily Weekly Walks Runs Swims

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ DATE _____

NEUROLOGICAL/MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please include details.

- | | | |
|--|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do our legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Do have frequent falls or find that you trip over your feet while walking?
Comment: _____ | NO | YES |
| 12. Have you tried any medications such as anti-inflammatory?
If yes, what kind of medication? | NO | YES |
| 13. Have you tried any Physical Therapy or Chiropractic treatments before?
If yes: When? For how long? What kind? | NO | YES |
| 14. Have you had an MRI?
If yes: When? Who ordered it? What was it ordered for? | NO | YES |
| 15. Have you used any splint or braces or other prescribed treatment by an MD?
If yes: When? What kind? Who ordered it? | NO | YES |
| 16. If you have tried any treatment or medications, did this make your problem better?
Comment: _____ | NO | YES |

For any yes answer, rule in/out the diagnosis with these two tests:

A) NCU/EMG tests Upper Lower Indicated Not Indicated (circle one)

B) Vascular Test Indicated Not Indicated (circle one)

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Patient's Signature

Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of _____ and will expire seven years after the date on
Date
which you last received services from us.

Patient Initials

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient's Signature

Date

PATIENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I reviewed the Notice of Privacy Practices of Core Healthcare & Physical Medicine.
(Please initial one of the following options & sign below.)

_____ I wish to receive paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____ @ _____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

PLEASE INITIAL ALL BELOW:

_____ I acknowledge that it is the policy of Core Healthcare & Physical Medicine to call and/or leave messages on my answering machine at home and/or with any person in my home or on my mobile phone, I may make a request of an alternative means of communication in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

Signature of Patient/Guardian

Date

Witness (Office Staff)

Date

PATIENT MISSED APPOINTMENT POLICY

DEFINITIONS

POLICY- a way of managing affairs so as to achieve some purpose.

APPOINTMENT- a meeting with someone at a certain time and place.

MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because **Treatments** will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. **All cancelled or missed appointments must be rescheduled and made up within one week.**
6. There is a \$5.00 service charge for no call/no show appointments.
7. There is also a \$20.00 charge for missing an appointment with the medical doctor.

I have read, understand, and agree to follow the above policy.

Patient's Name: _____

Signature: _____

Staff Witness: _____

Financial Office Policies

Core HealthCare & Physical Medicine PC

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts MasterCard, Visa, Discover Card, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation in this matter.

I have read and fully understand the financial office policy and agree to abide by these terms.

Patient Signature or Responsible Party

Core HealthCare & Physical Medicine PC
438 N First Street Ste. A
Pulaski, TN 38478
(931) 292-6356

Office HIPAA Form

*THIS NOTICE PERTAINS TO PRIVACY MEASURES TO ALL DOCTORS OPERATING AT 438
N. First St., Ste. A. Pulaski, TN 38478*

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for the Doctor (the Practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the following address/phone number/fax number/e-mail address:

The Practice may communicate confidential information about me to the following individual(s):

Patient/Patient Representative

Date