Please fill out the application entirely and legibly. We need all information for insurance purposes. .

Name ______________________ **Nickname** ______________________

Address ______________________

City ______________ **State** ___ **Zip** ______________

Phone ______________________ **Email** ______________________

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth ______________________ **Social Security** ______________________

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse's Name ______________________ **Phone Number** ______________________

Your Occupation ______________________ **Retired?** YES NO

REVIEWOFSYMPTOMS

Please check all that apply

__ Foot Pain
__ Hand Pain
__ Low Back Pain
__ Neck Pain
__ Foot Numbness
__ Hand Numbness
__ Diabetes

__ High Cholesterol
__ High Blood Pressure
__ Pacemaker/ Defibrillator
__ Herniated Disc
__ Bulging Disc
__ Spinal Stenosis

__ Degenerative Disc
__ Vascular Problems
__ Leg Pain
__ Plantar Fasciitis
__ Morton's Neuroma

__ Cancer
__ Chemotherapy
__ Arthritis in Hands
__ Arthritis in Feet
__ Implanted Cord/ Bladder Stimulator
__ Sciatica
__ Pinched Nerve

__ Poor Circulation
__ Joint Replacement
__ Foot Surgery
__ Poor wound healing
__ Excessive thirst or urination

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected:

1) ______________________
2) ______________________
3) ______________________
4) ______________________

List approximately how long you have noticed these problems:

1) ______________________
2) ______________________
3) ______________________
4) ______________________

Is there a certain time of day any of these problems are better or worse? ____________________________

____
____
____

List the things you have used for these problems:
_Gabapentin _Neurontin _Lyrica _Cymbalta _Physical Therapy _Pain Medications _Aleve _Tylenol _Ibuprofen _Motrin _Chiropractic _Massage Therapy _Injections _Creams

Is your balance/walking ability affected? Yes or No

If yes, please describe ____________________________
____
____

What do you think is causing your problem?

____
____
____

Name of all doctors you have seen for these problems and treatment you received:

____

Have your symptoms: __Improved __Worsened __Stayed the same

List anything that makes your condition worse ____
____

List anything that makes your condition better ____
____

How would you describe the symptoms? Please check ALL that apply

__ Aching Pain __Numbness __Hot Sensation __Cramping
__Stabbing Pain __Tingling __ Throbbing Pain __ Swelling
__ Sharp Pain __Pins & Needles Pain __ Dead Feeling __ Burning
__Tiredness __ Heavy Feeling __ Cold Hands/Feet __ Electric Shocks

Is this condition interfering with any of the following?

__Sleep __Work __Daily Activities __Housework
__Recreational Activities __Walking __Standing __Shopping

SOCIAL HISTORY

Do you smoke? __YES __NO
If yes, how many cigarettes daily? _____

Do you drink? __YES __NO
If yes, how many drinks per week? _____

Do you exercise regularly? __YES __NO
If yes, please describe type & how often: ______________________

____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN — WORST PAIN POSSIBLE

0 1 2 3 4 5 6 7 8 9 10

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN — WORST PAIN POSSIBLE

0 1 2 3 4 5 6 7 8 9 10

PREVIOUS HEALTH HISTORY

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name ______________________________ **Signature** ______________________________

Please give name, address, and office phone number of your primary care physician.

Name ____________________ **Phone** ____________________ **Address** ______________________________

When were you last seen there? ______________________

May we send them updates on your treatment/condition? __YES __NO

List ALL allergies/sensitivities to medication, food, and other items here:

Item you react to:	*Reaction:*

List the prescription drugs you are currently taking (or you may attach a list):

Name	*Dose (mg or IU)*	*Times Dally*

List all nutritional supplements (vitamins, herbs, homeopathies, etc.) as above:

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHJ). These restrictions do not include the normal interchange of information necessary to provide you with office services. HJ PAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

I. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It may be necessary for the doctor and members of the staff to disclose your health information, examination and treatment records, and billing records in the event of a billing dispute or patient care discrepancy. The information disclosed will be limited to that necessary for quality control purposes and/or resolution of the matter in order to efficiently and effectively run our practice.

3. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

4. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

5. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

6. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

7. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

8. We agree to provide patients with access to their records in accordance with state and federal laws.

9. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.

I0. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

11. We may leave appointment reminder messages on your answering machine, voicemail, email, and text.

I, ______________________________________ **date** _____________ **do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

FINACIAL POLICY AND AGREEMENT

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to Tate Chiropractic, LLC located at 324 W 2nd St, Seymour, IN 47274. "Financial Policy" or "Agreement" shall refer to this document.

Authorization to Sign My Name on Payments. Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by [Name of Office])," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. I agree that any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments. I also agree that my account with your Office shall be construed as in "default" on the earlier of the following dates: (a) a Payer fails to pay any or all of the Charges in-full and directly to the Office upon receipt of those Charges within thirty (30) days or the period established by the earliest prompt pay deadline applicable to the Payer (whichever occurs later), (b) I do not pay any or all of the Charges in-full within fourteen (14) days of request, or (c) the Office attempts to charge my credit card in compliance with a written Payment Arrangement, but the charge is declined or not approved.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment'). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further agree to the terms of the Office's Auto / Work Comp Advance Beneficiary Notices as applicable. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can request copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers, not including in accident cases my health benefit plan or Medicare. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws to the extent permitted by law. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien", Health Insurance Election, and, if applicable, Auto/ Work Comp Advance Beneficiary Notices, and further agree to the terms and definitions set forth in these documents as applicable. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): Patient Signature: Date: __/__/

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): ____________________________________

Parent/Guardian Signature: ____ Date: __/__/_________

INFORMED CONSENT TO CHIROPRACTIC AND/ OR PHYSICAL MEDICINE SERVICES

1. I, the undersigned, authorize the chiropractic and medical staff, and associates or assistants as they may designate, to perform upon myself the following procedure(s):

CHIROPRACTIC ADJUSTMENTS	COLD INFRARED LASER THERAPY
EXAMINATION & X-RAYS	FLEXION/DISTRACTION THERAPY
REHABILITATIVE THERAPY	IASTM (GRASTON THERAPY)
TRACTION THERAPY	MASSAGE/CUPPING
DRY NEEDLING	THERAPEUTIC ULTRASOUND
KINESIO TAPING/STRAPPING	ELECTRICAL MUSCLE STIMULATION

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above-named doctor, associates or assistants, may consider necessary or advisable in the course of my health care.

3. The nature and purpose of the procedures, possible alternative mode of treatments, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above-named doctor.

4. I acknowledge that **NO GUARANTEE OR ASSURANCE** as to the results that may be obtained from the procedure has been given by the above-named doctor.

DO NOT SIGN THIS INFORMED CONSENT UNLESS YOU HAVE READ AND UNDERSTAND ALL PROVISONS INCLUDED HEREIN.

Date:______________________ Signed:____________________________

Signature of Patient

Time:_____________ A.M. P.M. Signed:____________________________

Signature of Consenting Party

Witness:_______________________ Relationship:________________________