Advanced Rehab & Medical/ Back Pain Relief Clinic/ 45 Urgent Care

New Patient Information

Name ______________________ ☐ Female ☐ Male Date ______________

What you prefer to be called ______________________ Age ________ Date of birth ______________

Preferred Language ☐ English ☐ Other __________ Race: ☐ White ☐ African American ☐ Other __________

Address ______________________ City ______________ State _____ Zip ________

Home Phone ______________________ Cell Phone ______________________

Do you Have an Email? ( )Yes/ ( ) NO

Email Address ______________________ SS# ______________

Employer ______________ Occupation ______________ Work Phone ______________

Emergency Contact ______________ Relation ______________ Phone ______________

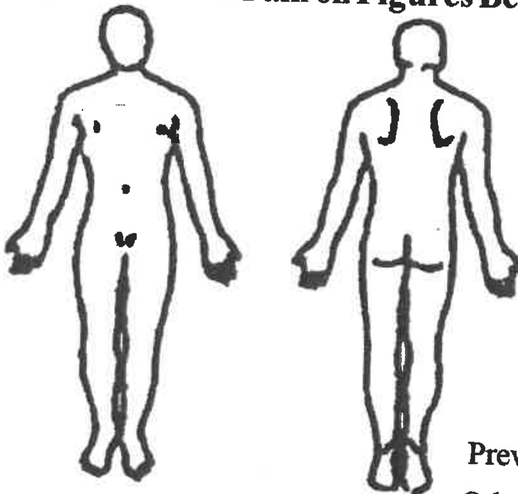
How did you hear about our office? ______________________

When did your condition begin? ______________________

Other Doctors seen for this condition? ______________________

Have you had the same or similar symptoms before? ☐ Yes ☐ No Date of prior condition ______________

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity:

(1) ______________________

(2) ______________________

(3) ______________________

Have you had chiropractic care before? ☐ Yes ☐ No

Family Physician/ PCP ______________________

May we forward our findings to your doctor? ☐ Yes ☐ No

Allergies (Medicine, Food, Environment)

____

____

Previous Surgeries ______________________

Other serious illnesses ______________________

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F	Condition
☐	☐	☐	Heart Disease
☐	☐	☐	anemia
☐	☐	☐	arthritis
☐	☐	☐	asthma
☐	☐	☐	diabetes
☐	☐	☐	scarlet fever
☐	☐	☐	Stroke
☐	☐	☐	muscular dystrophy

S	M	F	Condition
☐	☐	☐	polio
☐	☐	☐	epilepsy
☐	☐	☐	tuberculosis
☐	☐	☐	headaches
☐	☐	☐	rheumatism
☐	☐	☐	multiple sclerosis
☐	☐	☐	high blood pressure

S	M	F	Condition
☐	☐	☐	hepatitis
☐	☐	☐	cancer
☐	☐	☐	kidney disorder
☐	☐	☐	rheumatic fever
☐	☐	☐	HIV/ARC

Other serious illness: ______________________

For women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Social History

Do you smoke? Yes ____ No ____ If yes, how much? ____________________

Have you ever smoked? Yes _____ NO ______ If yes, how much? __________

Do you drink alcohol? Yes ____ No ____ If yes, how often? ______________

Do you or have you taken illicit drugs? Yes ____ No ____ If yes, describe ________________________

Health Insuarnce:

Policyholder Name_______________________________Date of Birth ________________

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Advanced Rehab and Medical/ Back Pain Relief Clinic/ 45 Urgent Care (Shannon Bone, DC; Mark Fowler, MD; Meagan vonHoltz, DC; Adam Copeskey, DC; Elena Jamscek, PA-C; Lisa Medlin, DNP; Jarrod Beachum, PA-C; Chad Zawacki, PA-C) and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Advanced Rehab and Medical/ Back Pain Relief Clinic/ 45 Urgent Care for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relation-ship.

Patient's or Guardian's Signature_______________________________Date ________________

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being__________________________, age______, do hereby authorize, request & direct Advanced Rehab and Medical/ Back Pain Relief Clinic/ 45 Urgent Care, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature ______________________ Date Signed ______________

Witness ______________________________________ ______________________

PATIENT NAME:______________________ TODAY'S DATE:______________________

DATE OF BIRTH:______________________

PLEASE CIRCLE YES IF YOU HAVE ANY OF THESE CONDITIONS CURRENTLY
IF YOU HAVE NOT HAD A SPECIFIC CONDITION PLEASE CIRCLE NO

GASTROINTESTINAL			***HEENT***			***NEUROLOGICAL***		
Nausea	NO	YES	Sore Throat	NO	YES	SEIZURES	NO	YES
Vomiting	NO	YES	Hoarseness	NO	YES	HEADACHES	NO	YES
Heartburn	NO	YES	Ear Pain	NO	YES	Dizziness	NO	YES
Painful Swallowing	NO	YES	***CARDIOVASCULAR***			***DERMATOLOGY***		
Vomiting Blood	NO	YES	Abnormal Heart Beat	NO	YES	Rash	NO	YES
Black Stool	NO	YES	Chest Pain	NO	YES	Itching	NO	YES
Red Blood in Stool	NO	YES	Palpitations	NO	YES	Wounds	NO	YES
Abdominal Pain	NO	YES	Swelling Feet	NO	YES	***Musculoskeletal***		
Constipation	NO	YES	***RESPIRATORY***			Joint Pain	NO	YES
Diarrhea	NO	YES	Cough	NO	YES	Arthritis	NO	YES
Loss of Appetite	NO	YES	Shortness of Breath	NO	YES	Weakness	NO	YES
Bloating	NO	YES	Wheezing	NO	YES	***Psychiatric***		
			Phlegm	NO	YES	Depression	NO	YES
						Anxiety	NO	YES
						Bipolar	NO	YES

CONSTITUTIONAL			***GENITOURINARY***		
Recent Weight Gain	NO	YES	Frequent Urination	NO	YES
# of Pounds ________			Kidney Failure OR Dialysis	NO	YES
Recent Weight Loss	NO	YES			
# of Pounds ________			Painful Urination	NO	YES
Fever	NO	YES	Date of Last Menstrual Period ______________		
Fatigue	NO	YES			
Chills	NO	YES			

() By checking this box, I agree that only the problems I am currently having and seeking attention for are marked YES!

PATIENT SIGNATURE: ____

Please list all medications, vitamins and nutritional supplements that you are currently taking:

Medication/Vitamin/Supplement	Dosage	Reason for Taking

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health. I certify that I, or my dependent(s), have insurance coverage with ______________ and assign directly to Advanced Rehab and Medical/Back Pain Relief Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all submissions. The above-named doctor may use my health care information to above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____

Signature of Patient or Guardian

____

Date

Advanced Rehab and Medical/ Back Pain Relief Clinic
45 Urgent Care
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

By signing, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By signing, I acknowledge that Advanced Rehab and Medical/ 45 Urgent Care may call my name out loud in the public reception area. I also understand that I have the right to ask for privacy while discussing my medical history. I also acknowledge that Advanced Rehab and Medical is an open adjusting and therapy treatment area. I understand that I have the right to request a private treatment area if desired.

Advanced Rehab and Medical/Back Pain Relief Clinic/45 Urgent Care request to send your clinical outcome assessment with your primary care provider/dentist. If "no" is not explicitly expressed, it is up to the discretion of our clinic to release your outcome assessment to your PCP/dentist for continuation of care.

Do you give us permission to share this information with your Primary Care Physician/Dentist?

____YES ____NO

______________________________ ______________________

Patient Name (please print) Date

____

Parent, Guardian or Patient's legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Please list below the names and relationships of people to whom you authorize the Practice to release PHI.

______________________ ______________________

Name Relationship

______________________ ______________________

Name Relationship

______________________ ______________________

Name Relationship

Advanced Rehab and Medical/ Back Pain Relief Clinic/ 45 Urgent Care

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize Advanced Rehab and Medical/ Back Pain Relief Clinic/ 45 Urgent Care to obtain a copy of my patient records or x-rays containing protected health information. This authorization is given pursuant to Tennessee Statutes and HIPAA regulations. I authorize that any third party to whom records are disclosed should not be further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

______________________________ Printed Name of Patient

______________________________ Patient's Date of Birth

______________________________ Signature of Patient or Legal Guardian

______________________________ Patient Phone Number

______________________________ Date Signed

Specific description of information to be disclosed:

____ Xrays
____ MRI of ______________________
____ NCV/EMG of ______________________
____ Lab/ Lab Report
____ Office Notes
____ Other ______________________________________

KEEP

Advanced Rehab and Medical/ Back Pain Relief Clinic/ 45 Urgent Care

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care.

This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

(b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Practice may also use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations –

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
(h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
(i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
(j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
(k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
(l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
(m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
(n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
(o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
(p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice:
a) A postcard or letter mailed to you at the address provided by you; and/or a text message
b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:
(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.
(b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and obtain a copy of your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

(e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy).

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Receive notice of any breach of confidentiality of your PHI by the Practice.

(i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

(j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(k) Request copies of your PHI in electronic format.

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Sherri Bone, at 731-664-6998 or via email at sherri@advancedrehabandmedical.com.

PRACTICE'S REQUIREMENTS

The Practice:

- is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- is required to abide by the terms of this Privacy Notice.
- reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- will distribute any revised Privacy Notice to you prior to implementation.
- will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below that is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer is Sherri Bone.

You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE

This Notice is in effect as of the date you sign the HIPAA release form and will be in effect for 5 years prior to signature.

Date ___________________________