Today's Date _____

Information About You

Account Number* _____ **Birthday** _____ **Sex** M/F **SSN** _____

Last Name _____ **First Name** _____ **Middle Initial** _____

Marital Status: S M D W **Occupation:** _____ **Nickname** _____

Address _____ **Email** _____

Address II _____ **Phone H** _____

City _____ **Phone W** _____ **Phone C** _____

State _____ **ZIP** _____

Ethnicity (select one): ◯ Alaskan Native ◯ American Indian ◯ Asian ◯ Black/African American

◯ Native Hawaiian ◯ Other Pacific Islander ◯ White/Caucasian ◯ Other: _____

Preferred Language: ◯ English ◯ Spanish ◯ Other/ Specify: _____

Referred By _____

Emergency Contact Name _____ **Phone Number** _____

Number of Children _____ **Names and Ages** _____

Method of Payment: Insurance, Self Pay, Care Credit, Med-pay, other: _____

Have you ever had chiropractic care before? _____

For what problem and were the results satisfactory? _____

When is the last time you had x-rays? _____ **Females:** Are you pregnant? Y/N/Don't Know

Family History: Did your mother or father have many of the following:

High blood pressure, Heart attack, Emphysema, Seizures-Convulsions, Asthma, Diabetes, Kidney disease, pace maker, ulcers, digestive trouble, stroke, arthritis, Mental illness, thyroid, Cancer, osteoporosis

Anything else you would like to discuss with us or let us know? _____

_____

Allergies: ◯ None

Drug/Medications	Food	Others: (animals, pollen, latex, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking Status: (individuals age 13 and older):

- ○ Smoker – Daily
- ○ Smoker – Occasionally (not daily)
- ○ Former
- ○ Never
- ○ Smoker – Status Unknown

Current Prescription Medications

Name of Prescription:	Dose: *(mg, ml, etc)*	Form: *(tabs, caps, etc)*	Duration: *(times/day, wk, mo)*	*–or–*	*Chronic*	*Unknown*
_____	_____	_____	_____ x per	_____	_____	_____
_____	_____	_____	_____ x per	_____	_____	_____
_____	_____	_____	_____ x per	_____	_____	_____
_____	_____	_____	_____ x per	_____	_____	_____
_____	_____	_____	_____ x per	_____	_____	_____
_____	_____	_____	_____ x per	_____	_____	_____

Other Conditions: Please indicate with the letter **N** if you have any of these conditions now (within the past 6 months) or **P** if you have ever had this condition in the past.

Headaches	Diarrhea	High Blood Pressure
Neck Pain	Chest Pains	High Cholesterol
Stiff Neck	Foot Pain	Hard to Lose Weight
Wrist Pain	Arthritis	Cold/Heat Intolerance
Irritability	Feet Cold	Pins/Needles in Arms
Constipation	Hands Cold	Shoulder Pain
Low Back Pain	Leg Cramps	Shortness of Breath
Knee Pain	Hemorrhoids	Depressing
Freq Loss of Balance	Gall Bladder Pain	Difficulty Urinating
Loss of Smell	Tension	Fatigue
Loss of Taste	Swelling Joints	Numbness in Toes
Ears Ring	Upset Stomach	
Sinus Problems	Dry Skin	

Office Use: Vitals (age 2 years+)

Height: _____(inches) Weight _____ (lbs) Blood Pressure: _____/_____

Terms of Acceptance

When a person seeks chiropractic health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic Facility we have one main goal, to detect and correct/reduce the vertebral subluxations complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes altercation of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our only practice objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to Courtley Chiropractic for x-ray, is for the examination only and the x-rays will remain property of this office, being on file where they may be seen at any time while a patient of this office.

Consent to Care

I do hereby authorize Courtley Chiropractic to administer such care that is necessary for my particular case. This case may include a consultation, examination, spinal adjustment and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and am 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, disk 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at any time, based upon the facts then known, and is in my best interest. The doctor will not be held responsible for any health conditions or diagnoses which are preexisting, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the doctors specific recommendations at this clinic that I will receive the full benefit from the program offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, 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.

Signature _____ Date _____/_____/_____ (*if under 18, parents signature)*

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle: _____/_____/_____

Consent of x-ray:

I hereby grant Courtley Chiropractic, P.A. permission to perform an x-ray evaluation if needed of _____. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

_____ _____ /____/ _____
Signature (*parent if minor)* Date

Consent to Evaluate and Adjust a Minor Child

I, _____, being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____ / ____/ _____
Signature Date

Insurance Information

I clearly understand that all insurance coverage is an arrangement between my insurance carried and me. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand carriers may denied any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that had not been closed or finalized.

Signature _____ Date_____/_____/_____
(if under age 18, parent's signature)

Acknowledgement of Receipt of Notice of Privacy Practices

149 Kelsey Lane Suite 102, Lenoir City TN 37772

865-986-8088

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Tennessee Chiropractic Association Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Tennessee Chiropractic Association (TCA). This disclosure will be made if we need the TCA's assistance to receive reimbursement for your services, or we need the TCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the TCA this information. You are also giving the TCA authorization to re-disclose your information to the party responsible for the payment of your services, the TCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

_____ _____/ _____/ _____

Signature Date

If not signed by the patient, please indicate relationship.

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of decreased patient

_____

Name of Patient

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: (Efforts to obtain/Reasons for Refusal)

_____

_____

_____