Confidential Patient Health Patient _____ File # _____ Date _____

How did you hear about us? □ Patient _____ □ Dr. _____ □ Internet/Website
□ Yellow pages □ Sign/Drive by □ Hospital □ Insurance plan □ Pro-Adjuster □ TV □ Radio □ Friend/Co-Worker

□ Dr. □ Mr. □ Ms □ Mrs First: _____ Mid Initial: _____ Last _____

Birth Date: ___/___/___ Age: _____ Sex: Male / Female

Email Address: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: (___) _____ Work Phone: (___) _____ ext _____

Cell Phone: (___) _____ Fax # (___) _____

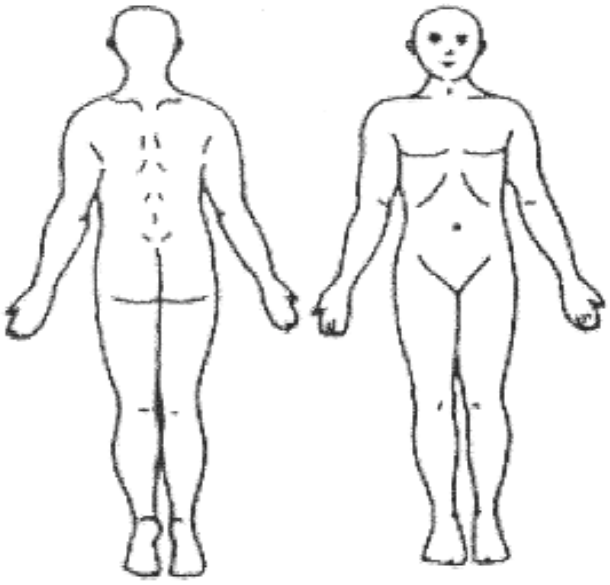
□Single □Married □Widowed □Divorced □Separated Spouse's Name: _____
Emergency Contact Name: _____ Relationship: _____
Phone: _____

INSURANCE INFORMATION

Who is responsible for your bill? YOU and. . .(mark appropriate box(es)) □ Myself ONLY □ Spouse
□ Worker's Comp □ Auto Insurance □ Medicare □ Health Ins: _____
□ Other: _____
Personal Health Insurance Carrier: _____ Member/ID Card# _____
Policy Holder's Name: _____ Group # _____
Policy Holder's Date of Birth: ___/___/___ Primary Care Physician: _____

CURRENT HEALTH CONDITION

PLEASE LABEL THE DIAGRAM, AREA OF SYMPTOM:
Mark on figure below area of pain/numbness/burning.
Use Letters BELOW to indicate **TYPE & LOCATION**
A=Ache B=Burning N=Numbness P=Pins&Needles S=Stabbing



Unwanted Condition/Pain (Why are you here today?):
_____

I currently have: □ PAIN □ STIFFNESS □ NUMBNESS □ WEAKNESS

Condition/Pain STARTED on what date? _____
Has it ever occurred before? Yes / No When? _____
Is this condition: □ Auto Related □ Job Related □ Home Injury
□ Slip or Fall □ Lifting □ Slept Wrong □ Unknown Cause □ Other

EXPLAIN in your own words how the injury/pain/condition happened:
_____
_____
_____

If caused by an Accident: Date _____ Time: _____

List **any other** Condition/Pain related or unrelated to the one listed above that you are experiencing: _____
_____

Please rate your overall pain/unwanted condition/discomfort/stiffness on a scale of 0 to 10:
0 (none) 1 2 3 4 5 6 7 8 9 10 (I should be in the ER right now)

Name: _____ File # _____ Date: _____

PRIOR TESTS	Date	Area	Location/Facility
☐ X-RAY		☐ Head ☐ Neck ☐ Mid back ☐ Low Back ☐ Other	
☐ MRI		☐ Head ☐ Neck ☐ Mid back ☐ Low Back ☐ Other	
☐ CT SCAN		☐ Head ☐ Neck ☐ Mid back ☐ Low Back ☐ Other	
☐ NCV			
☐ EMG			
☐ OTHER			

MEDICATIONS: Are you taking now or have you been taking. . .

Any Over The Counter meds? ☐ No ☐ Yes _____
Have you taken any of the following? ☐ Acetaminophen ☐ Tylenol ☐ Percocet ☐ Vicodin ☐ Lortab ☐ Excedrin
Any prescription pain meds? ☐ No ☐ Yes _____
Any prescription muscle relaxers? ☐ No ☐ Yes _____
Any other prescription meds? ☐ No ☐ Yes _____

MOTOR VEHICLE COLLISIONS

Have you been involved in any motor vehicle collisions? ☐ Yes ☐ No
Did you have a permanent injury or settlement? ☐ Yes ☐ No If yes, what injuries did you have?

EMPLOYMENT:

Occupation/Job Title: _____
Description of Work: _____
Work Activity Postures: ☐ Bending ☐ Climbing ☐ Kneeling ☐ Pulling ☐ Pushing
☐ Reaching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking

PAST CONDITIONS:

☐ Arthritis
☐ Asthma
☐ Bedwetting
☐ Cancer
☐ Chicken pox
☐ Crohn's/colitis
☐ CVA (stroke)
☐ Depression
☐ Diabetes (insulin dependent)
☐ Diabetes (non-insulin dependent)
☐ Ear infections
☐ Fibromyalgia
☐ Headaches
☐ Heart Disease
☐ Hepatitis
☐ HIV
☐ High Blood Pressure
☐ Multiple Sclerosis
☐ Parkinson's
☐ Pneumonia
☐ Scoliosis
☐ Seizures
☐ Shingles
☐ Spina bifida
☐ Vertigo
☐ Other _____
☐ _____
☐ _____

SURGERIES:

☐ Appendectomy
☐ C-section
☐ Cardiac Cath
☐ Carpal tunnel (Left / Right)
☐ Coronary artery bypass
☐ Cosmetic
☐ Gall bladder
☐ Hernia repair
☐ Hip replacement (Left / Right)
☐ Knee repair (Left / Right)
☐ Laminectomy Level? _____
☐ Pacemaker insertion
☐ Rotator cuff repair (Left / Right)
☐ Spinal fusion Level? _____
☐ Other _____

SOCIAL HISTORY:

Do you consume alcohol? ☐ Yes ☐ No If yes, how much/often? _____
Do you smoke? ☐ Yes ☐ No If yes, how much/often? _____

Is there any daily or recreational activity that you have had to stop or limit due to your pain/discomfort? ☐ Yes ☐ No
If yes, please list: _____

What activities would you love to perform/do again if you had no pain or worries about doing it? _____

Name: _____ File # _____ Date: _____

1 = I don't do this activity.
2 = NO PAIN I do this activity but I have no pain doing it.
3 = MILD PAIN I have mild pain while doing this activity.
4 = MODERATE PAIN I have moderate pain while doing this activity.
5 = SEVERE PAIN I have severe pain while doing this activity.

DAILY ACTIVITIES:

	1	2	3	4	5	HOW LONG CAN YOU DO THE FOLLOWING W/O PAIN?
BENDING	☐	☐	☐	☐	☐	
CARRYING GROCERIES	☐	☐	☐	☐	☐	
MOVEMENT SIT/STAND	☐	☐	☐	☐	☐	
CLIMB STAIRS	☐	☐	☐	☐	☐	
DRIVING	☐	☐	☐	☐	☐	
WORKING ON COMPUTER	☐	☐	☐	☐	☐	
HOUSEHOLD CHORES	☐	☐	☐	☐	☐	
KNEELING	☐	☐	☐	☐	☐	
LIFT CHILDREN	☐	☐	☐	☐	☐	
LIFTING	☐	☐	☐	☐	☐	
READING	☐	☐	☐	☐	☐	
SLEEP	☐	☐	☐	☐	☐	
STATIC SITTING	☐	☐	☐	☐	☐	
STATIC STANDING	☐	☐	☐	☐	☐	
WALKING	☐	☐	☐	☐	☐	
YARD WORK	☐	☐	☐	☐	☐	

RECREATIONAL: Please list some of your favorite activities in the space provided.

	1	2	3	4	5	HOW LONG CAN YOU DO THE FOLLOWING W/O PAIN?
CHURCH	☐	☐	☐	☐	☐	
COOKING	☐	☐	☐	☐	☐	
CRAFTS	☐	☐	☐	☐	☐	
CYCLING	☐	☐	☐	☐	☐	
DANCING	☐	☐	☐	☐	☐	
EXERCISE	☐	☐	☐	☐	☐	
FISHING	☐	☐	☐	☐	☐	
GOLF	☐	☐	☐	☐	☐	
PILATES	☐	☐	☐	☐	☐	
RUNNING	☐	☐	☐	☐	☐	
TENNIS	☐	☐	☐	☐	☐	
WALK FOR EXERCISE	☐	☐	☐	☐	☐	
WEIGHTLIFTING	☐	☐	☐	☐	☐	
YOGA	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient's Signature: _____ **Date:** _____

Or

(Guardian's Signature): _____ Date: _____

BILLING ACKNOWLEDGMENT

Explanation of insurance Benefits:
Many insurance policies do cover Chiropractic care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for Chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage and will bill your insurance in a timely manner as a courtesy to you.

Payment Arrangements:
If you have insurance, we will bill for you as a courtesy. Payment for deductibles, if it has not been met, is the responsibility of the patient as well as any co-payment or remaining balance after insurance payment. We do participate in many insurance plans that may allow nominal out of pocket expense. Your co-pay is due as services are rendered. You are also responsible for portions of your bill that exceed your insurance limits.

Assignment of benefits:
By signing this form, you are authorizing payment of medical benefits to be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However, if you pay for your visits in full, the assignment will not be reported by this provider and any payment will be sent directly to you.

Voluntary termination of care:
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you will ultimately be personally responsible for payment regardless of your insurance coverage.

I have read, acknowledged and agree to the above.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

The Movement Chiropractic & Manual Medicine
109 International Dr Ste 200
Franklin, TN 37067

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HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____

Printed Name of Patient or Representative

_____
Signature Date
Relationship to Patient
(if other than patient): _____

Witness: _____
Printed Name . Practice Representative

_____
Signature Date

INFORMED CONSENT TO
CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination test, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to; fractures, disc injuries, dislocations, muscle strains, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries in the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks of complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

The Movement Chiropractic & Manual Medicine
109 International Dr. Ste 200
Franklin, TN 37067
(615) 271-2757

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE

_____
Printed Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative (if minor or incapacitate) Date

_____ _____
Witness to Patient's Signature Date

_____ _____

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

MEMBER BILLING ACKNOWLEDGMENT

Chiropractic

For questions, please call ASH at 800.972.4226

IMPORTANT NOTICE: You may have additional coverage options for these services through your medical insurance benefits. ASH recommends that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I,_____, a member being treated by Dr. Davis / Treadway,
(Name of Patient/Member/Subscriber) (Chiropractor Name)

do hereby acknowledge that a certain portion of my care will not be covered by my insurance company, or health plan under the terms of my Benefit Plan with _____.
(Name of Health Plan)

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Date	Procedure	Charge
		$
	Unlisted Procedure: Graston,Cupping, Active Release	$ 25.00
	Supplies- Dry Needles	$ 5.00
	Supplies- Theraband	$ 5.00
		$
		$

Separately list each date of service on which non-covered services will be rendered and have the member initial the charge. Please attach additional Member Billing Acknowledgment form(s) for additional services.

This form is only to be used if an ASH member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member's health plan. Non-covered services may also include services determined by ASH to be maintenance-type services.

The ASH Contracted Chiropractor may not bill the member during the course of an ASH approved treatment program unless there is a copayment, deductible, coinsurance, or the member is receiving non-covered services.

The ASH Contracted Chiropractor may not bill the member for the difference between what the ASH Contracted Chiropractor bills and what the ASH Contracted Chiropractor agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Chiropractor agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill members for any services not reimbursed by ASH. Such use will render this agreement "void" and non-binding on the Member. This agreement may only be used to allow the member to agree to "self pay" for specific services **in advance**.

I acknowledge that I have reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, including non-covered services as described above, and agree to make financial arrangements with my chiropractor,

Dr. _____, to pay for these services myself.
(Chiropractor Name)

Dated at _____, _____ this _____ day of _____, 20_____.
(city) (state) (date) (month) (year)

Member Signature
(Guardian must sign for all members 17 years or younger)

Member Health Plan ID#

Practitioner Signature

Date

THE MOVEMENT
CHIROPRACTIC & MANUAL MEDICINE

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, The Movement Chiropractic & Manual Medicine reserves the right to charge a fee of $35 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not canceled within a 24-hour advance notice.

"No show" fees are billed to the patient. This fee is not covered by insurance, and will be paid via the credit card left on file. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy. You also agree to pay the no show fee via credit card that you will leave on file.

_____ _____
Printed Name Date

_____
Signature

Credit Card Type (MC, Visa, Etc): _____
Credit Card Number: _____
Expiration Date: _____
CVC: _____
Zip Code associated with card: _____

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