

NAME \_\_\_\_\_ DATE \_\_\_\_\_

WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ AGE \_\_\_\_\_

PRESENT COMPLAINT? \_\_\_\_\_

WHEN DID THIS PROBLEM START? \_\_\_\_\_

DID YOU DO ANYTHING THAT BROUGHT THIS PROBLEM ON? \_\_\_\_\_

HOW DOES THE PROBLEM FOR WHICH YOU ARE SEEING THE DOCTOR TODAY  
AFFECT YOUR WORK OR DAILY ACTIVITIES? \_\_\_\_\_

HAVE YOU EVER HAD THIS PROBLEM BEFORE? \_\_\_\_\_ WHEN? \_\_\_\_\_

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? \_\_\_\_\_ WHO? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS? \_\_\_\_\_ FOR WHAT CONDITION?

DO YOU SUFFER FROM ANY SERIOUS SYSTEMIC DISEASES SUCH AS CANCER OR  
DIABETES? \_\_\_\_\_

WHAT OPERATIONS HAVE YOU HAD? \_\_\_\_\_

HAVE YOU HAD ANY BROKEN BONES? \_\_\_ NAME THEM \_\_\_\_\_

HAVE YOU HAD ANY BAD FALLS OR ACCIDENTS? \_\_\_\_\_

WHEN AND DESCRIBE \_\_\_\_\_

\*\*\*\*\*

WOMEN ONLY:

I AM NOT KNOWINGLY PREGNANT AT THIS TIME. \_\_\_\_\_

SIGNED

\*\*\*\*\*

CONFIDENTIAL CASE HISTORY

DATE \_\_\_\_\_

FULL NAME \_\_\_\_\_  
(FIRST) (MIDDLE) (LAST)

ADDRESS \_\_\_\_\_  
(STREET) (CITY/STATE) (ZIP)

PHONE NO \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

SEX \_\_\_\_\_ MARITAL STATUS M S W D NUMBER OF CHILDREN \_\_\_\_\_

SOCIAL SECURITY NO \_\_\_\_\_ LICENSE NO \_\_\_\_\_

OCCUPATION EMPLOYER \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ SPOUSE'S BIRTHDATE \_\_\_\_\_

SPOUSE'S OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_

NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_ PHONE \_\_\_\_\_

FOR APPOINTMENT REMINDERS:

EMAIL: \_\_\_\_\_ CELL #: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE? \_\_\_\_\_ YELLOW PAGES \_\_\_\_\_ NEWSPAPER

\_\_\_\_\_ RADIO \_\_\_\_\_ SPINAL SCREENING \_\_\_\_\_ REFERRAL WHO? \_\_\_\_\_

\*\*\*\*\*

PLEASE PRESENT A COPY OF YOUR INSURANCE CARD(S)

INSURANCE INFORMATION:

NAME OF PRIMARY INSURED: \_\_\_\_\_ D.O.B. \_\_\_\_\_

RELATIONSHIP TO INSURED: \_\_\_\_\_ D.O.B. \_\_\_\_\_

DO YOU HAVE ANY STATE ISSUED INSURANCE (MEDICAID)? IF YES: WHICH ONE?

WELLCARE PASSPORT HUMANA HEALTHY HORIZONS ANTHEM MEDICAID OTHER

IF RELATED TO AN ACCIDENT, PLEASE ANSWER THE QUESTIONS BELOW:

WERE YOU INJURED ON THE JOB? \_\_\_\_\_

WERE YOU INVOLVED IN AN AUTOMOBILE ACCIDENT? \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that TINUS CHIROPRACTIC CENTER 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 TINUS CHIROPRACTIC CENTER will be credited to my account on receipt. However, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

\_\_\_\_\_  
SIGNED

# TELL US WHERE YOU HURT

Name \_\_\_\_\_

Date \_\_\_\_\_

## Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols listed below.

Ache AAAA  
AAAA

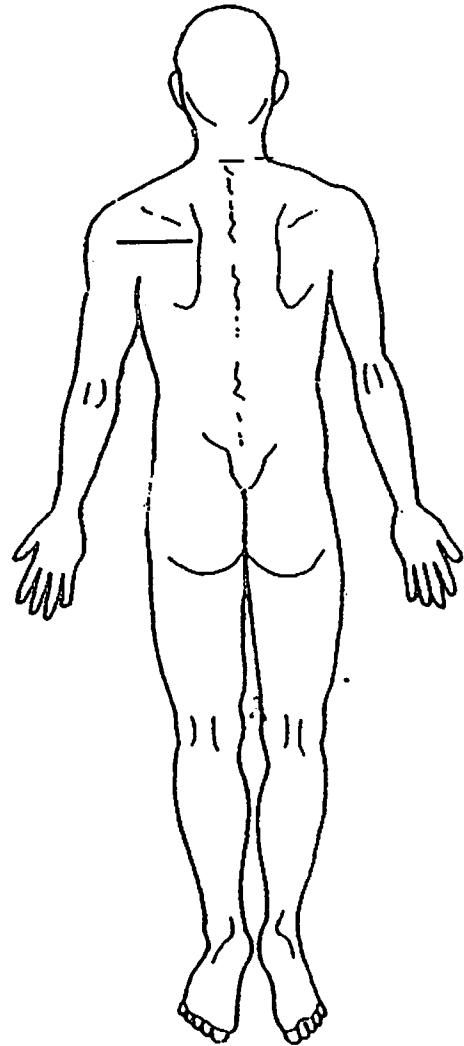
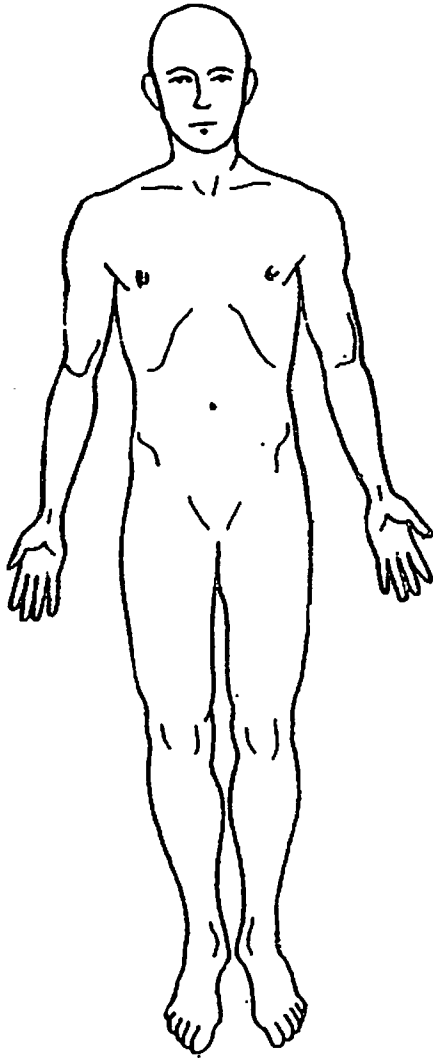
Numbness NNNN  
NNNN

Pins and Needles PPPP  
PPPP

Burning BBBB  
BBBB

Stabbing SSSS  
SSSS

Throbbing TTTT  
TTTT



Please mark on the line to indicate how severe your pain has been.

NO PAIN \_\_\_\_\_

SEVERE PAIN

# STATEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Tinius Chiropractic Center appreciates the confidence you have shown in choosing us to provide for your chiropractic needs. The service you have elected to participate in implies financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and for any deductible/coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you elect to continue treatment past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting your unpaid balance will be your responsibility. For your convenience, we accept cash, checks, and most major credit cards. Payment is expected at time of service. If we bill you, payment is expected by the due date on your Monthly Patient Statement. Payments can be made in person at the office, mailed to the address on your statement, or by calling the office @ 270-926-8042.

By signing you agree that: I have read and understand the above policy regarding my financial responsibility to Tinius Chiropractic Center for providing chiropractic services to the above-named patient or me. I certify that the insurance information I have provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay benefits directly to Tinius Chiropractic Center. I agree to pay Tinius Chiropractic Center the full and entire amount of all my bills incurred by me of the above-named patient, if applicable, any amount due after payment has been made by my insurance carrier.

You further agree that in order for us to collect any amounts you may owe, we may contact you by any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by text message or email, using any email address you provide us with.

Signature: \_\_\_\_\_

Relationship to patient (circle one): self spouse parent/guardian Date: \_\_\_\_\_

## BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT CARE

There may be times when it is necessary for an individual directly involved in your care to call the office to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Tinius Chiropractic Center to disclose my health information that is directly related to my current treatment at Tinius Chiropractic Center to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

# ASSINGMENT OF BENEFITS FORM

## Assignment of Benefits

\_\_\_\_\_  
Initial

I hereby assign all benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance, auto or any other health/medical plan, to issue payment check(s) directly to TINIUS CHIROPRACTIC CENTER PLLC, for medical services rendered to myself and/ or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

## Authorization to Release Information

\_\_\_\_\_  
Initial

I hereby authorize TINIUS CHIROPRACTIC CENTER PLLC to 1) release any information necessary to insurance carriers regarding my treatments and condition; (2) process insurance claims generated in the course of examination of treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

## Designation of Authorized Representative

There may be times when it is necessary for our staff to file disputes and/or appeals on your behalf in order for us to recover payments that should be made for services provided to you. We do this as a courtesy to you if your insurance fails to provide adequate payment. In order to provide this service, we must have permission to be your designated authorized representative.

\_\_\_\_\_  
Initial

You hereby appoint as your designated representative, and assign TINIUS CHIROPRACTIC CENTER all rights, title, and interest in and to, relating to the recovery of, any and all health care benefits otherwise payable to me or to which I am entitled for medical treatment rendered by provider. I also specifically authorize TINIUS CHIROPRACTIC CENTER to do the following on my behalf.

- 1.) File and prosecute any required appeal or grievance with my health plan and/ or health insurer for payment of medical claims submitted by or on behalf of my authorized representative including filing litigation or arbitration on my behalf of my designated authorized representative.
- 2.) File any required complaint, appeal or grievance with the state insurance department, Department of Labor, or any other regulatory agency for payment of medical claims submitted by on behalf of my authorized representative.
- 3.) Discuss my personal health information with my health plan and/or health insurer, and obtain a summary plan description, insurance policy and/or other plan documents.

This order will remain in effect until revoked by me in writing.

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

## Patient Acknowledgment of Privacy Notice

To Be Maintained with Patient's Chart

This is to acknowledge that I (print name) \_\_\_\_\_, have been given the opportunity to review Tinius Chiropractic Center's Notice of Privacy Practices. I understand that I have the right to request a personal copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Name of Patient or Guardian

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

Name \_\_\_\_\_ Date \_\_\_\_\_

### CURRENT MEDICAL COMPLAINTS

#### NECK PAIN

My pain began:           ( ) gradually   ( ) suddenly

I have pain:             ( ) sometimes   ( ) all of the time

My pain goes into my: ( ) right arm   ( ) left arm   ( ) both   ( ) none

I have tingling and/  
Or numbness in my: ( ) right arm   ( ) left arm   ( ) both   ( ) none

My pain is worse when I:

cough or sneeze	( ) yes	( ) no
bend forward	( ) yes	( ) no
lift	( ) yes	( ) no
push	( ) yes	( ) no
pull	( ) yes	( ) no
turn my head	( ) yes	( ) no

My pain wakes me up in the middle of the night: ( ) yes ( ) no

Changes in the weather affect my pain: ( ) yes ( ) no

The pain is:           ( ) sharp pain   ( ) stinging/burning   ( ) throbbing  
                  ( ) stiffness   ( ) aching           ( ) catching

I have headaches:           ( ) yes           ( ) no

If I do get headaches, they occur: ( ) sometime ( ) all of the time

#### UPPER BACK PAIN

My pain began:           ( ) gradually   ( ) suddenly

The pain is:             ( ) sharp   ( ) dull   ( ) stinging/burning   ( ) throbbing

I have pain:             ( ) sometimes   ( ) all of the time

The pain goes into my: ( ) ribs           ( ) shoulders   ( ) chest

The pain is aggravated  
by movement:           ( ) yes           ( ) no

Does rest lessen pain: ( ) yes           ( ) no

UPPER BACK PAIN cont.

My pain is worse when I:

- cough or sneeze      ( ) yes
- sit                    ( ) yes
- bend                  ( ) yes
- walk                 ( ) yes
- lift                  ( ) yes
- push                 ( ) yes
- pull                 ( ) yes

The pain wakes me up in the middle of the night: ( ) yes ( ) no

Changes in the weather affect my pain:                    ( ) yes ( ) no

LOW BACK PAIN

My pain began:                    ( ) gradually      ( ) suddenly

The pain is:                    ( ) sharp ( ) dull ( ) stinging/burning ( ) throbbing

I have pain:                    ( ) sometimes      ( ) all of the time

Does the pain go into  
your legs:                    ( ) right leg      ( ) left leg      ( ) both      ( ) none

I have tingling and/  
or numbness in my: ( ) right leg ( ) left leg ( ) both ( ) none

Is the pain aggravated  
by movement:                    ( ) yes                    ( ) no

Does rest lessen pain: ( ) yes                    ( ) no

My pain is worse when I:

- cough or sneeze      ( ) yes                    ( ) no
- sit                    ( ) yes                    ( ) no
- bend                  ( ) yes                    ( ) no
- walk                 ( ) yes                    ( ) no
- lift                  ( ) yes                    ( ) no
- push                 ( ) yes                    ( ) no
- pull                 ( ) yes                    ( ) no

The pain wakes me up in the middle of the night: ( ) yes ( ) no

Changes in the weather affect my pain:                    ( ) yes ( ) no

Signature \_\_\_\_\_

INSURANCE QUESTIONNAIRE

NAME: \_\_\_\_\_ AGE : \_\_\_\_\_ SEX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_

TYPE OF ACCIDENT: ( ) AUTOMOBILE ( ) INDUSTRIAL ( ) FALL ( ) OTHER

WHERE AND WHEN DID ACCIDENT TAKE PLACE? \_\_\_\_\_

AREA OF BODY INJURED? ( ) NECK ( ) UPPER BACK ( ) MID-BACK ( ) LOW BACK

HAVE YOU EVER INJURED THIS AREA BEFORE? ( ) YES ( ) NO

STATE IN YOUR OWN WORDS HOW ACCIDENT HAPPENED AND DESCRIBE INJURIES RECIEVED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_

DID YOU NOTIFY YOUR EMPLOYER: \_\_\_\_\_

DOES YOUR PRESENT JOB AGGRIVATE YOUR CONDITION? ( ) YES ( ) NO

HAVE YOU MISSED WORK SINCE THE ACCIDENT? \_\_\_\_\_ DAYS \_\_\_\_\_ WEEKS \_\_\_\_\_ MONTHS

DATES OF TOTAL DISABILITY FROM \_\_\_\_\_ TO \_\_\_\_\_

DATES OF PARTIAL DISABILITY FROM \_\_\_\_\_ TO \_\_\_\_\_

HAVE YOU BEEN SEEN BY ANY OTHER DOCTOR FOR THIS INJURY? ( ) YES ( ) NO

NAME OF DOCTOR: \_\_\_\_\_

WHAT WAS HIS DIAGNOSIS? \_\_\_\_\_

WERE YOU HOSPITALIZED? ( ) YES ( ) NO

IF SO, NAME HOSPITAL \_\_\_\_\_ DATE OF HOSPITALIZATION: \_\_\_\_\_

SINCE THE ACCIDENT HAS YOUR CONDITION: ( ) IMPROVED ( ) STAYED SAME ( ) WORSENERD

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

# Tinius Chiropractic Center

1300 Tamarack Rd  
Owensboro, KY 42301  
Phone: 270-926-8042

Dr. Brian Tinius DC

Dr. Michael Greene DC

## Notice of Doctor's Lien

I do hereby authorize **Dr. Brian Tinius DC and/or Dr. Michael Greene DC of Tinius Chiropractic Center** to furnish you, my attorney, with a full report their examination, diagnosis, diagnoses, treatment, prognosis, etc.. of myself regarding the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I I have been treated in connection therewith. Said doctor's bills will be paid in full with no reduction in the amount of the bill regardless of the amount received in any settlement.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honors this lien as inherent to the settlement and enforceable upon the case as if it were executed by them.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by them for service rendered me and that this agreement is made solely for said doctor's addition protection and in consideration of their contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated: \_\_\_\_\_ Patient's signature: \_\_\_\_\_

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect said doctor named above. The attorney further agrees that in the event of this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated: \_\_\_\_\_ Attorney's signature: \_\_\_\_\_

Please date, sign, and return one copy to the doctor's office. Also keep one for your records.

# TINIUS CHIROPRACTIC CENTER

## Auto Accident Information

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Your Auto Insurance Company:

\_\_\_\_\_

### Attorney Information

Name of Attorney: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Your Accident and/or PIP Claim Number:

\_\_\_\_\_

### Adjuster Information

Name: \_\_\_\_\_

Phone (with Ext) \_\_\_\_\_

Your Policy Number:

\_\_\_\_\_

E-mail: \_\_\_\_\_

**\*\*Please provide copy of police report if available.**

**Medical Information Release:** I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the auto injury for which I have sought treatment, and I consent to the release of this information or written material to the auto insurance company, other treating physicians, and my attorney (if applicable).

Signature \_\_\_\_\_

Date \_\_\_\_\_

I understand that charges for services rendered due to my injuries are customarily covered (paid) at 100% by the insurance company. In cases of auto accidents we do not bill medical insurance.

I further understand and agree that in the event any charges are not covered by my insurance carrier I will be responsible for payment of any unpaid balance.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Direction of Payment**

I am the injured person and an insured entitled to **Basic Reparation Benefits (PIP)** under the Kentucky Motor Vehicle Reparations Act.

Pursuant to **KRS 304.39-210**, I hereby **designate and direct** the above-named automobile insurance carrier to **pay medical expense benefits directly to the medical provider listed above** for reasonable and necessary treatment related to the motor vehicle accident referenced.

Further, pursuant to **KRS 304.39-241**, I direct the insurer to allocate PIP benefits to **medical expense benefits** for services rendered by the provider identified in this form, subject to statutory limits.

This direction applies to:

- All past medical services related to this accident
- All current medical services related to this accident
- All future medical services related to this accident

**Authorization & Acknowledgment**

- I understand that PIP benefits in Kentucky are limited (generally up to \$10,000 unless additional coverage applies).
- I understand that this form **does not assign liability coverage or third-party claims**, and applies only to PIP / no-fault benefits.
- I authorize the insurer to release information necessary to process PIP benefits related to this claim.
- I understand that I remain financially responsible for charges not paid or not covered by PIP.

**Signature**

By signing below, I knowingly and voluntarily direct payment of PIP medical benefits as stated above.

**Claimant Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Kentucky PIP Direction of Payment (Provider Designation)**

**Pursuant to KRS 304.39-210 and KRS 304.39-241**

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**Injured Person / Claimant Information**

- Full Name: \_\_\_\_\_
  - Date of Birth: \_\_\_\_\_
  - Address: \_\_\_\_\_
  - City / State / ZIP: \_\_\_\_\_
  - Phone: \_\_\_\_\_ Email: \_\_\_\_\_
- 

**Insurance / Claim Information**

- Auto Insurance Carrier (PIP): \_\_\_\_\_
  - Policy Number: \_\_\_\_\_
  - Claim Number (if known): \_\_\_\_\_
  - Date of Motor Vehicle Accident: \_\_\_\_\_
- 

**Medical Provider Information**

- **Tinius Chiropractic Center**
- **Mike Greene, D.C.**
- **1300 Tamarack Road**
- **Owensboro, KY 42301**
- **270-926-8042**
- **NPI: 1265892103**
- **Tax ID: 320104791**

**Direction of Payment**

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**Injured Person / Claimant Information**

- **Full Name:** \_\_\_\_\_
  - **Date of Birth:** \_\_\_\_\_
  - **Address:** \_\_\_\_\_
  - **City / State / ZIP:** \_\_\_\_\_
  - **Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_
- 

**Insurance / Claim Information**

- **Auto Insurance Carrier (PIP):** \_\_\_\_\_
  - **Policy Number:** \_\_\_\_\_
  - **Claim Number (if known):** \_\_\_\_\_
  - **Date of Motor Vehicle Accident:** \_\_\_\_\_
- 

**Medical Provider Information**

- **Tinius Chiropractic Center**
- **Brian Tinius, D.C.**
- **1300 Tamarack Road**
- **Owensboro, KY 42301**
- **270-926-8042**
- **NPI: 1194757203**
- **Tax ID: 320104791**