

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 TINIOUS 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 TINIOUS 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

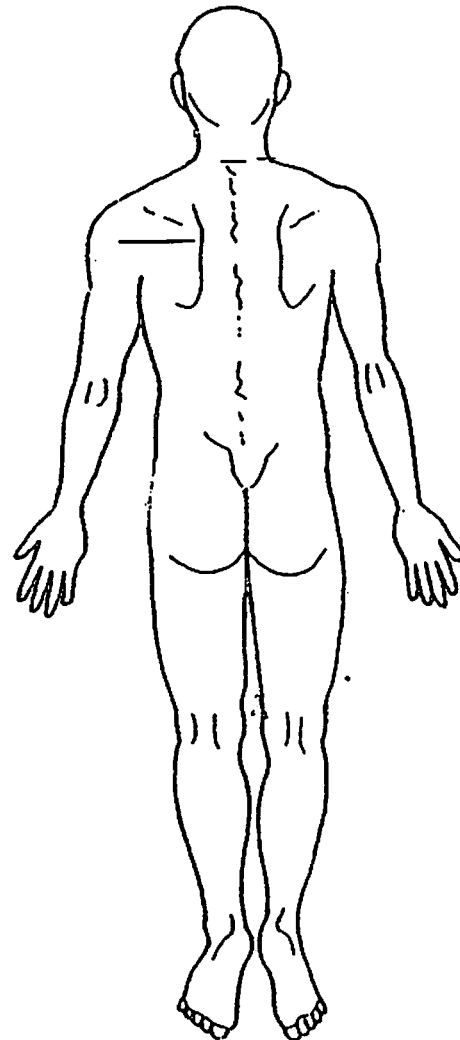
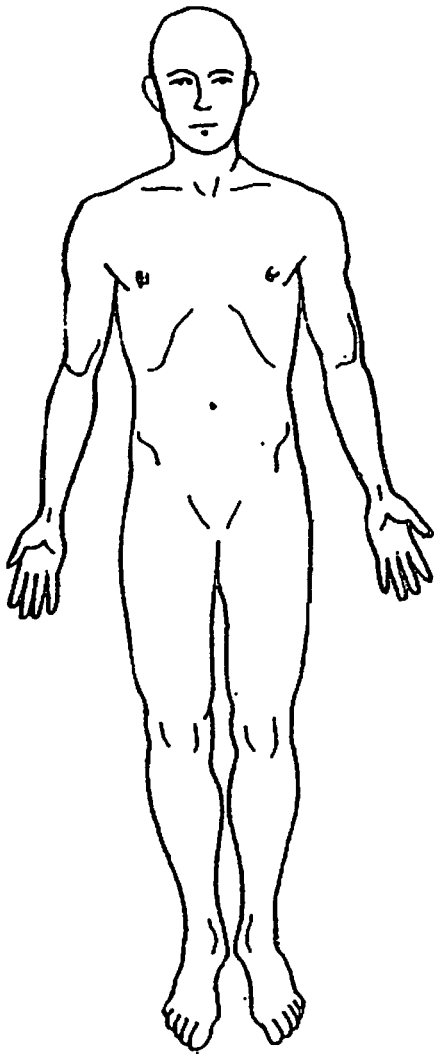
Numbness NNNN
NNNN

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