Oak Ridge Chiropractic
550 Oak Ridge Turnpike
Oak Ridge, TN 37830
Phone: (865) 481-8989
Website: www.OakRidgeChiropractors.com
Dr. Blake Hardin **Dr. Autumn Hardin**

AUTOMOBILE ACCIDENT PAPERWORK

PATIENT INFORMATION

Patient's Full Name _____ Date: _____/_____/_____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

☐ Male ☐ Female Age:_____ Date of Birth:_____/____/_____ Social Security # _____ - _____ - _____

Mailing Address: _____ City:_____ State:_____ Zip:_____

Occupation:_____ Hours/Week:_____ Employer:_____

Work Phone: _____ Ext: _____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children: _____

Emergency Contact:_____ Relationship:_____ Phone: _____

Primary Care Doctor's Name: _____ City: _____ State: _____

Driver's license: _____ State licensed in: _____

Are you using an Attorney for your Automobile Accident Case? ☐ Yes ☐ No

Attorney Name : _____ Attorney Phone Number: _____

Attorney Address: _____ City: _____ State: _____ Zip: _____

Do you have Automobile Insurance? ☐ Yes ☐ No Name of Insurance Company: _____

Automobile Insurance Policy Number: _____ Coverage Effective Date: _____

Insurance Company Phone number: _____ Name on the policy: _____

Policyholders SSN: _____ Policyholders Employer: _____

Policyholders Birthdate: _____

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, office name:_____

How did you hear about our office?

☐ Existing Patient (Name_____)
☐ Health Fair / Local Event
☐ Friend / Family
☐ Internet Advertisement
☐ Our Website
☐ Phone Book
☐ Newspaper
☐ Health Lecture
☐ Your Doctor
☐ Your Insurance Company
☐ Local Sponsorship
☐ Mailing
☐ Sign
☐ Your Attorney
☐ Other _____

Have you had any testing done (X-Rays, MRIs, Nerve Tests) for the complaint you are seeking treatment for today? If so please list type of test and at what facility you had them performed. _____

EXPLANATION OF ACCIDENT

Date of Accident: _____ Time of Day: _____ Number of people in car: _____

Where were you in the car? (Driver, Passenger, Front Seat, Back Seat):_____

Were you wearing your seat belt? _____ What direction were you struck from? _____

What direction were you headed? (North, South, East, West) on (Street name) _____

What direction was the other Vehicle headed? (North, South, East, West) on (Street name) _____

Approximate speed of your car _____ mph. Approximate speed of other car _____ mph.

Were you knocked unconscious? ☐ Yes ☐ No If you were knocked unconscious, for how long? _____

Were the police notified? ☐ Yes ☐ No Were there any witnesses? ☐ Yes ☐ No

Witness Name(s) _____

In your own words, please describe the accident: _____

_____

_____

Please list your **MAJOR COMPLAINTS** in the order of their severity:

1.) _____

2.) _____

3.) _____

Please describe how you felt:

A.) During the accident _____

B.) Immediately After the accident: _____

C.) Later that day: _____

D.) The next day: _____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ☐ Yes ☐ No

If yes, please list the doctor's name and phone number: _____

What type of treatment/testing did you receive? _____

Since this injury occurred, are your symptoms (Improving, Getting worse, Same) _____

Check all of the symptoms that you have noticed since the accident occurred:

- ☐ Headache
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Sleeping Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Head Seems to Heavy
- ☐ Pins and Needles in Arms
- ☐ Fainting
- ☐ Pins and needles in Legs
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Depression
- ☐ Light bothers eyes
- ☐ Loss of Memory
- ☐ Ringing in the ears
- ☐ Face Flushed
- ☐ Fainting
- ☐ Buzzing in Ears
- ☐ Loss of smell
- ☐ Loss of balance
- ☐ Loss of taste
- ☐ Diarrhea
- ☐ Cold Feet
- ☐ Cold Hands

Have you had to miss work as a result of this accident? ☐ Yes ☐ No If you have, please complete the following:

Last day worked: _____

Type of Employment: _____

Present Salary: _____ Are you being compensated for your time lost from work? ☐ Yes ☐ No

Have you noticed any restrictions in activity as a result of this injury? ☐ Yes ☐ No

If yes, describe in detail: _____

_____

Did you have any physical complaints BEFORE the accident? ☐ Yes ☐ No

If yes, please in detail: _____

_____

Do you have any congenital (from birth) factors that relate to this problem? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever been involved in an auto accident before? ☐ Yes ☐ No

If yes, please explain, including date(s) and type(s) of accidents as well as any injuries that might have occurred.

_____

_____

Any other pertinent information that may help us better serve you: _____

_____

_____

_____

_____

Please read and sign:

I hereby state that all information that I have provided Oak Ridge Chiropractic is complete and truthful and that I fully disclosed my health history.

PRINT NAME:_____

PATIENT SIGNATURE: _____ Date_____

PAST MEDICAL HISTORY

SYSTEMS REVIEW QUESTIONS:

Do you or have you ever had any problems with the following areas? (Please mark **Y** for yes or **N** for no in each of the following:)

1. _____ Eyes
2. _____ Ears, Nose, Mouth, Throat
3. _____ Heart
4. _____ Lungs/ Breathing
5. _____ Intestines/Bowels
6. _____ Urinary
7. _____ Muscles
8. _____ Nerves
9. _____ Joints/Bones
10. _____ Skin
11. _____ Internal Organs
12. _____ Blood
13. _____ Allergies
14. _____ Psychological/Emotional

Females only:

15. _____ Gynecological/Menstrual/Breast

Males Only:

16. _____ Prostate/Testicular

Please explain any above **Yes** answers: _____

_____

1. Has your current complaints lead to or been associated with any of the following:
   ☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion problems ☐ Cardiac/Respiratory problems ☐ Dizziness
2. Have you ever experienced your present problem before: ☐ Yes ☐ No If yes, When:_____
   Was treatment provided: ☐ Yes ☐ No If yes, By whom:_____ Outcome:_____
3. Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, when: _____
4. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No
   If yes, explain:_____
5. Have you **ever** had any **diagnosed conditions, illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries?**
   ☐ Yes ☐ No If yes, please explain below.

Date	Conditions / Injury / Fracture / Illness / Surgeries	Treatment	Results

6. Are you presently taking any **prescription drugs, over-the-counter drugs, vitamins, or supplements?** ☐ Yes ☐ No If yes, explain below.

Product/Drug	Reason	Dosage	Frequency

FAMILY HISTORY AND HEALTH STATUS: List any known diseases, disorders, or major illnesses in your family. If deceased, from what?

1. Mother: _____
2. Father: _____
3. Sisters: _____
4. Brothers:_____

SOCIAL HISTORY

☐ Current **every day** smoker ☐ Current **some day** smoker ☐ Former Smoker ☐ Never Smoker

Yes No

☐ ☐ Do you use other forms of tobacco? What/How much per day? _____

☐ ☐ Do you exercise? _____ Times per week_____ Type of exercise?_____

☐ ☐ Do you consume alcohol? How many drinks per week? _____

☐ ☐ Do you use recreational drugs? If yes, explain: _____

Please read and sign:

I hereby state that all information that I have provided Oak Ridge Chiropractic is complete and truthful and that I fully disclosed my health history.

PRINT NAME:_____

PATIENT SIGNATURE: _____ Date_____

DOCTOR SIGNATURE:_____ Date_____

HISTORY OF PROBLEM

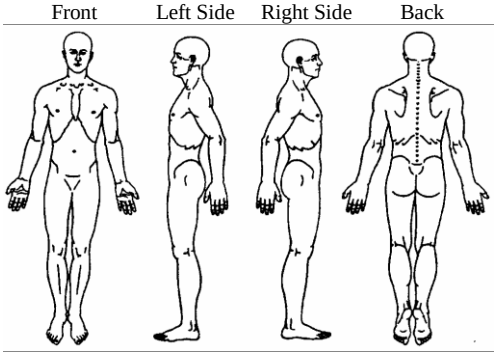
(***Important**: Please fill out one "History of Problem" form per problem area/region. If you need another form, please ask office staff.)

Complaint:_____ Date of Onset: _____

What caused the pain:_____

Mark Your Area of Pain For This Problem

Front Left Side Right Side Back



Severity of pain. Circle the number that best fits complaint.

0 1 2 3 4 5 6 7 8 9 10

(no pain) (unbearable)

Onset of complaint started:

☐ Gradually ☐ Suddenly

Since onset, complaint has become:

☐ Worse ☐ Better

☐ Stayed the same ☐ Other _____

Describe the quality of the complaint/pain:

☐ Sharp ☐ Dull ache ☐ Throbbing

☐ Tingling ☐ Numbness ☐ Burning

☐ Stiffness ☐ Tightness ☐ Other:_____

Describe if pain is in a single spot or does the pain spread out:

☐ Single Spot

☐ Radiates Down into:

☐ Left shoulder	☐ Right shoulder
☐ Left arm	☐ Right arm
☐ Entire left hand	☐ Entire right hand
☐ Left thumb	☐ Right thumb
☐ Left pinky	☐ Right pinky
☐ Left buttock region	☐ Right buttock region
☐ Left groin	☐ Right groin
☐ Front of left thigh	☐ Front of right thigh
☐ Back of left thigh	☐ Back of right thigh
☐ Front of left leg	☐ Front of right leg
☐ Back of left leg	☐ Back of right leg
☐ Side of left leg	☐ Side of right leg
☐ Left foot	☐ Right foot

☐ Other _____

☐ Intermittent (0-25% of time when awake)

☐ Occasional (26-50% of time when awake)

☐ Frequent (51-75% of time when awake)

☐ Constant (76-100% of time when awake)

My symptoms bother me:

☐ Constantly or Everyday ☐ 3-6 times/days a week

☐ 1-2 times/day(s) a week ☐ 3-4 times/days a month

☐ 1-2 times/day(s) a month ☐ Every couple of months

☐ Other_____

When are your symptoms more severe?

☐ When I first wake up

☐ Later in the day

☐ After I get off of work

☐ When trying to sleep

☐ Symptoms are constant and do not change

☐ No specific pattern

☐ Other _____

Does any of the following make the pain worse:

☐ Driving	☐ Sitting	☐ Pulling
☐ Walking	☐ Running	☐ Pushing
☐ Standing	☐ Cough	☐ Bending
☐ Sneeze	☐ Bowel movement	☐ Lifting

☐ Other:_____

Does any of the following make it better:

☐ Rest/laying down	☐ Sitting
☐ Walking	☐ Exercise
☐ Stretching	☐ Chiropractic treatments
☐ Massage	☐ Muscle relaxant
☐ Ice	☐ Prescription pain med.
☐ Heat	☐ Over-the-counter pain med.

☐ Other:_____

Does it interfere with your daily activities:

☐ Minimal (annoyance, no impairment)

☐ Slight (tolerated, some impairment)

☐ Moderate (marked impairment)

☐ Marked (preclude any activity)

Print Name: _____

Patient Signature: _____

Date_____

_____

_____

_____

_____

_____

_____

Doctor Signature_____ Date_____

HISTORY OF PROBLEM

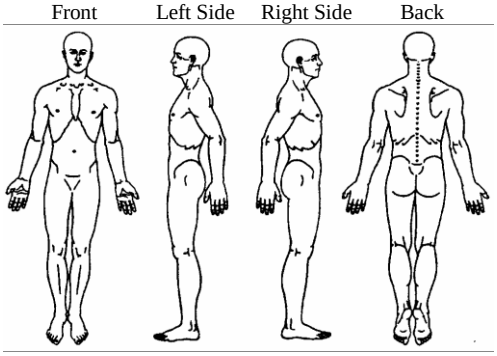
(***Important**: Please fill out one "History of Problem" form per problem area/region. If you need another form, please ask office staff.)

Complaint:_____ Date of Onset: _____

What caused the pain:_____

Mark Your Area of Pain For This Problem

Front Left Side Right Side Back



Severity of pain. Circle the number that best fits complaint.

0 1 2 3 4 5 6 7 8 9 10

(no pain) (unbearable)

Onset of complaint started:

☐ Gradually ☐ Suddenly

Since onset, complaint has become:

☐ Worse ☐ Better

☐ Stayed the same ☐ Other _____

Describe the quality of the complaint/pain:

☐ Sharp ☐ Dull ache ☐ Throbbing

☐ Tingling ☐ Numbness ☐ Burning

☐ Stiffness ☐ Tightness ☐ Other:_____

Describe if pain is in a single spot or does the pain spread out:

☐ Single Spot

☐ Radiates Down into:

☐ Left shoulder	☐ Right shoulder
☐ Left arm	☐ Right arm
☐ Entire left hand	☐ Entire right hand
☐ Left thumb	☐ Right thumb
☐ Left pinky	☐ Right pinky
☐ Left buttock region	☐ Right buttock region
☐ Left groin	☐ Right groin
☐ Front of left thigh	☐ Front of right thigh
☐ Back of left thigh	☐ Back of right thigh
☐ Front of left leg	☐ Front of right leg
☐ Back of left leg	☐ Back of right leg
☐ Side of left leg	☐ Side of right leg
☐ Left foot	☐ Right foot

☐ Other _____

☐ Intermittent (0-25% of time when awake)

☐ Occasional (26-50% of time when awake)

☐ Frequent (51-75% of time when awake)

☐ Constant (76-100% of time when awake)

My symptoms bother me:

☐ Constantly or Everyday ☐ 3-6 times/days a week

☐ 1-2 times/day(s) a week ☐ 3-4 times/days a month

☐ 1-2 times/day(s) a month ☐ Every couple of months

☐ Other_____

When are your symptoms more severe?

☐ When I first wake up

☐ Later in the day

☐ After I get off of work

☐ When trying to sleep

☐ Symptoms are constant and do not change

☐ No specific pattern

☐ Other _____

Does any of the following make the pain worse:

☐ Driving	☐ Sitting	☐ Pulling
☐ Walking	☐ Running	☐ Pushing
☐ Standing	☐ Cough	☐ Bending
☐ Sneeze	☐ Bowel movement	☐ Lifting

☐ Other:_____

Does any of the following make it better:

☐ Rest/laying down	☐ Sitting
☐ Walking	☐ Exercise
☐ Stretching	☐ Chiropractic treatments
☐ Massage	☐ Muscle relaxant
☐ Ice	☐ Prescription pain med.
☐ Heat	☐ Over-the-counter pain med.

☐ Other:_____

Does it interfere with your daily activities:

☐ Minimal (annoyance, no impairment)

☐ Slight (tolerated, some impairment)

☐ Moderate (marked impairment)

☐ Marked (preclude any activity)

Print Name: _____

Patient Signature: _____

Date_____

_____

_____

_____

_____

_____

_____

Doctor Signature_____ Date_____

NECK INDEX

Disability Index Score _____ *Sum x 2

This questionnaire will give your provider information about how your **NECK PAIN** affects your everyday life. Please answer every section by marking the one statement that **BEST** applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Section 1-Pain Intensity

0.) I have no pain at the moment.

1.) The pain is mild at the moment.

2.) The pain comes and goes and is moderate.

3.) The pain is moderate and does not vary much.

4.) The pain is severe but comes and goes.

5.) The pain is severe and does not vary much.

Section 2-Personal Care

0.) I can look after myself without causing extra pain.

1.) I can look after myself normally but it causes extra pain.

2.) It is painful to look after myself and I am slow and careful.

3.) I need some help, but manage most of my personal care.

4.) I need help every day in most aspects of self-care.

5.) I do not get dressed; I wash with difficulty and stay in bed.

Section 3-Lifting

0.) I can lift heavy weights without extra pain.

1.) I can lift heavy weights, but it causes extra pain.

2.) Pain prevents me from lifting heavy weights off the floor.

3.) Pain prevents me from lifting heavy weights, but I can manage light to medium weights when on a table.

4.) I can lift very light weights.

5.) I cannot lift or carry anything at all.

Section 4-Reading

0.) I can read as much as I want to with no pain in my neck.

1.) I can read as much as I want with slight pain in my neck.

2.) I can read much as I want with moderate pain in my neck.

3.) I cannot read as much as I want because of moderate pain in my neck.

4.) I cannot read as much as I want because of severe pain in my neck.

5.) I cannot read at all because of pain in my neck.

Section 5 Headache

0.) I have no headaches at all.

1.). I have slight headaches which come infrequently.

2.) I have moderate headaches which come infrequently.

3.) I have moderate headaches which come frequently.

4.) I have severe headaches which come frequently.

5.) I have headaches almost all of the time.

Section 6-Concentration

0.) I can concentrate fully when I want to with no difficulty.

1.) I can concentrate fully when I want to with slight difficulty.

2.) I have a fair degree of difficulty concentrating when I want to.

3.) I have a lot of difficulty in concentrating when I want to.

4.) I have a great deal of difficulty concentrating when I want to.

5.) I cannot concentrate at all.

Section 7-Work

0.) I can do as much work as I want to.

1.) I can only do my usual work, but no more.

2.) I can do most of my usual work, but no more.

3.) I cannot do my usual work.

4.) I can hardly do any work at all.

5.) I cannot do any work at all.

Section 8-Driving

0.) I can drive my car without neck pain.

1.) I can drive my car as long as I want with only slight neck pain.

2.) I can drive my car as long as I want with moderate neck pain.

3.) I cannot drive my car as long as I want because of moderate neck pain.

4.) I can hardly drive my car at all because of severe neck pain.

5.) I cannot drive my car at all.

Section 9-Sleeping

0.) I have no trouble sleeping

1.) My sleep is slightly disturbed (less than 1 hour sleepless).

2.) My sleep is mildly disturbed (1-2 hours sleepless).

3.) My sleep is moderately disturbed (2-3 hours sleepless).

4.) My sleep is greatly disturbed (3-5 hours sleepless).

5.) My sleep is completely disturbed (5-7 hours sleepless).

Section 10-Recreation

0.) I am able to engage in recreational activities with no neck pain.

1.) I am able to engage in recreational activities with some neck pain.

2.) I am able to engage in most, but not all recreational activities because of neck pain.

3.) I am able to engage in only a few of my usual recreational activities because of pain in my neck.

4.) I can hardly do any recreational activities because of the pain in my neck.

5.) I cannot do any recreational activities at all.

Print Name _____ Date _____

BACK INDEX

Disability Index Score _____ *Sum x 2

This questionnaire will give your provider information about how your **BACK PAIN** affects your everyday life. Please answer every section by marking the one statement that **BEST** applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Section 1-Pain Intensity

0.) The pain comes and goes and is very mild.

1.) The pain is mild and does not vary much.

2.) The pain comes and goes and is moderate.

3.) The pain is moderate and does not vary much.

4.) The pain comes and goes and is very severe.

5.) The pain is very severe and does not vary much.

Section 2-Sleeping

0.) I get no pain in bed.

1.) I get pain in bed but it does not prevent me from sleeping well.

2.) Because of pain my normal sleep is reduced by less than 25%.

3.) Because of pain my normal sleep is reduced by less than 50%.

4.) Because of pain my normal sleep is reduced by less than 75%.

5.) Pain prevents me from sleeping at all.

Section 3-Sitting

0.) I can sit in any chair as long as I like.

1.) I can only sit in my favorite chair as long as I like.

2.) Pain prevents me from sitting more than one hour.

3.) Pain prevents me from sitting more than ½ an hour.

4.) Pain prevents me from sitting more than 10 minutes.

5.) I avoid sitting because it increases my pain immediately.

Section 4-Standing

0.) I can stand as long as I want without pain. .

1.) I have some pain while standing but it does not increase with time.

2.) I cannot stand for longer than 1 hour without increasing pain.

3.) I cannot stand for longer than ½ an hour without increasing pain.

4.) I cannot stand for longer than 10 minutes without increasing pain.

5.) I avoid sitting because it increases pain immediately.

Section 5-Walking

0.) I have no pain while walking.

1.) I have some pain while walking but it doesn't increase with distance.

2.) I cannot walk more than 1 mile without increasing pain.

3.) I cannot walk more than ½ a mile without increasing pain.

4.) I cannot walk more than ¼ of a mile without increasing pain.

5.) I cannot walk at all without increasing pain.

Section 6-Personal Care

0.) I do not have to change my way of washing or dressing to avoid pain.

1.) I do not change my way of washing or dressing even though it causes pain.

2.) Washing and dressing increases pain but I manage not to change how I do it.

3.) Washing and dressing increases pain and I have to change the way I do it.

4.) Because of the pain I am unable to do some of the washing and dressing alone.

5.) Because of the pain I am unable to wash and dress myself without help.

Section7-Lifting

0.) I can lift heavy weight without extra pain.

1.) I can lift heavy weights but it causes extra pain.

2.) Pain prevents me from lifting heavy weights off the floor.

3.) Pain prevents me from lifting heavy weights, but I can manage if they are on a table.

4.) Pain prevents me from lifting heavy weights, but I can manage light to medium weights.

5.) I can only lift very light weights.

Section 8-Traveling

0.) I get no pain while traveling.

1.) I get some pain while traveling but none of my usual traveling makes it worse.

2.) I get extra pain while traveling but does not cause me to change travel plans.

3.) I get extra pain while traveling which causes me to change my travel plans.

4.) Pain restricts all forms of travel except that done while lying down.

5.) Pain restricts all forms of travel.

Section 9-Social Life

0.) My social life is normal and gives me no extra pain.

1.) My social life is normal but increases the degree of pain.

2.) Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.).

3.) Pain has restricted my social life and I do not go out very often.

4.) Pain has restricted my social life to my home.

5.) I hardly have a social life because of the pain.

Section 10-Changing degree of pain.

0.) My pain is rapidly getting better.

1.) My pain fluctuates but overall is definitely getting better.

2.) My pain seems to be getting better but improvement is slow.

3.) My pain is neither getting better or worse.

4.) My pain is gradually worsening.

5.) My pain is rapidly worsening.

Print Name _____ Date _____

Oak Ridge Chiropractic

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.
I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. I also understand that treatment will be provided or overseen by either Dr. Blake M. Hardin, or Dr. Autumn K. Hardin, chiropractic physicians.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasional bruising with the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I understand there is no guarantee that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the administering of these procedures by my doctor and such other person of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Print Name:_____

Patient Signature:_____ Date_____

Signature of Parent or Guardian (if a minor): _____

AUTHORIZATION AND ASSIGNMENT
Oak Ridge Chiropractic

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you , I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what was due, I personally owe you.

4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Tennessee

5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed Oak Ridge Chiropractic are paid in full.

Print Name: _____

Patient Signature_____ Date____/_____/_____

Signature of Parent or Guardian (if a minor)_____

OAK RIDGE CHIROPRACTIC FINANCIAL POLICY

1. ***INSURANCE*** We participate in most insurance plans, including Medicare. If you are not insured by a plan we are in contract with, payment in full is expected at each visit. If you are insured by a plan we are in contract with but do not have an up to date insurance card, payment in full is expected. Knowing and understanding ***YOUR*** insurance benefits is ***YOUR*** responsibility.

2. ***CO-PAYMENTS AND DEDUCTIBLES*** All co-payments and deductibles must be paid at the time of service. This arrangement is part of the contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

3. ***NON-COVERED SERVICES*** Please be aware that some and perhaps all of the services you receive may be non-covered or considered not reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

4. ***CLAIMS SUBMISSION*** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. ***IT IS YOUR RESPONSIBILITY*** **TO** ***COMPLY WITH THEIR REQUEST.*** Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not a party to that contract.

5. ***COVERAGE CHANGES*** If your insurance changes, please notify us before your next appointment so we can make the appropriate changes. If your insurance does not pay for your claim in 60- days, the balance will automatically be billed to you.

6. ***NON PAYMENT*** If your account is over 90 days past due, we will turn your account over to our collection agency. The amount submitted is your unpaid balance PLUS collection fees. This may result in you being dismissed from our practice.

7. ***RETURNED CHECK*** If your bank returns your check due to insufficient funds you will be charged $30 plus the amount of the check. This total is to be paid in full immediately.

8. ***MISSED APPOINTMENTS*** You will be charged **$20** for missed office appointments not cancelled or rescheduled 24 hours in advance. You must pay this BEFORE we can schedule another appointment for you.

Do Not Sign below until you have read and you fully understand our Financial Policy.

Print Name: _____

Patient Signature: _____ Date_____

MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize Blake M. Hardin D.C. and/or Autumn K. Hardin, D.C., d.b.a. Oak Ridge Chiropractic LLC, to furnish you, my attorney, with a full report of him/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and assign the direct payment by you, my attorney, to said doctor such sums as may be due and owing him/her for medical service rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctors. And I hereby further give a Lien on my case to said doctors against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, as the result of the injuries for which I have been treated or injuries in connection therewith.

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 honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said doctors for all medical bills submitted by him/her for service rendered me and that this agreement is made solely for said doctors' additional protection and in consideration of him/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I waiver the Statute of Limitations regarding my doctor's right to recover.

Please acknowledge this letter by signing below. I have been advised that if my attorney does not wish to cooperate in protecting the doctors' interest, the doctors will not await payment but will require me to make payments on a current basis.

Patient Signature_____ Date_____

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, judgment, or verdict, as may be necessary to adequately protect said doctor above-named.

Attorney Signature_____ Date_____

OAK RIDGE CHIROPRACTIC
Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

Privacy Officer: Dr. Autumn K. Hardin, D.C.
Security Officer: Dr. Autumn K. Hardin, D.C.
Complaint Officer: Dr. Autumn K. Hardin, D.C.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions. There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an “open therapy bay” in which several people may be a getting therapy at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to have your therapy in a private room, please let us know and we will do our best to accommodate your wishes. Some therapies may not be moved to another location and in this case we would not be able to perform your therapy in a private room

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health

care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to
PRIVACY OFFICER, 550 Oak Ridge Turnpike Oak Ridge, TN 37830.

I have read or had read to me the above explanation of HIPAA Regulations. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS FORM. I have made my decision voluntarily and freely.

Patient Signature:_____ Date:_____

REQUEST FOR ASSIGNMENT OF
BENEFITS TO HEALTH CARE PROVIDER

Name of Patient: _____

Name of insured
(if different
from patient): _____

Insurance Company: _____

Health Care Provider: _____

I am entitled to benefits under a policy of insurance written by the above insurance company. I have received treatment for an injury from the above health care provider.

As allowed by T.C.A. 56-7-120, 1 hereby assign to the above health care provider, from the benefits to which I am entitled, a sum of money sufficient to cover the charges of that health care provider for the services I have received. I hereby request that the above insurance company pay that money directly to the health care provider.

I understand that the amount which is paid to the above health care provider may be limited by the amounts owed to other health care providers who have provided services to me for the same injury and by the amount of medical benefits to which I am entitled under the policy. I also understand that the amount paid to the above health care provider may be deducted from any "bodily injury" award that I may receive.

If the above insurance company does not permit the assignment of benefits, I hereby request that the company disburse the sums to which I am entitled in the form of a check issued in the names of the insured and the above health care provider as joint payees and sent to the office of the provider.

I understand that if the benefits available to me under the policy are insufficient to cover the charges of the above health care provider, I am responsible for paying that portion of the provider's charges not covered by insurance.

I agree to give a 30 day notification in writing to the above health care provider before changing this assignment of benefits in any way.

_____
Patient

_____
Date

_____
Witness