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**

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:_____ Business Phone_____

☐Married ☐ Single ☐Widowed ☐ Separated ☐ Divorced Number of Children_____

Emergency Contact:_____ Relationship:_____ Phone: _____

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

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
☐ Billboard
☐ Other _____

Is Today's Visit Due To An On the Job, Work Related Injury: ☐ Yes ☐ No

Is Today's Visit Due To An Auto Accident: ☐ Yes ☐ No

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. _____

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

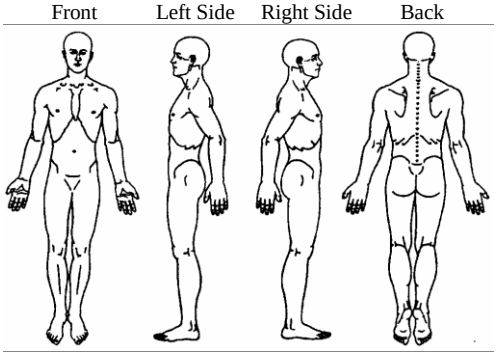
(***Important**: Please fill out one "History of Problem" form per problem area/region. If you need another form, please ask office staff.)

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_____

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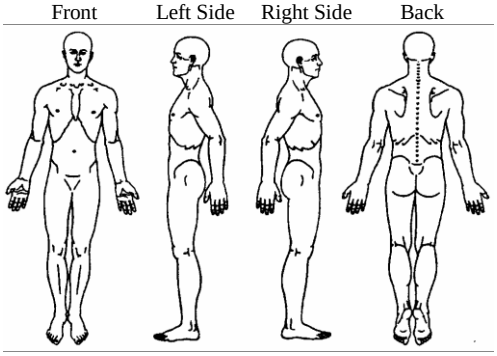

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☐ Other _____

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☐ Moderate (marked impairment)

☐ Marked (preclude any activity)

Print Name: _____

Patient Signature: _____

Date_____

_____

_____

_____

_____

_____

_____

Doctor Signature_____ 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_____

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:_____