TLC CHIROPRACTIC, INC.

Appointment Date of Initial Exam: _______/_____/_____ TMH CRMC Other: ____________

Diagnostic Performed: MRI CT X-Ray None

CONFIDENTIAL PATIENT INFORMATION:

Patients Name: ______________________________ Chief Complaint: ___________________

Address:______________________________________ City:__________ State:_______ Zip:____

Cell Phone: ______________________________ Work Phone: ______________________

Employer's Name: ___________________________ Occupation: _______________________

SSN #: ____________________________________ Email: ___________________________

Date of Birth: _____/_____/_____Age: _________ Marital Status: Married Single Widowed Divorced

Primary Physician: ______________________ Name of Facility: ___________________ Ph.#: ______

Emergency Contact: __________________________ Phone #: _________________________

Is your Condition due to an: Sports injury Auto Accident Slip/Fall Work Related other:________________

□ **ChiroHealth USA [CHUSA]** Initial sign up and yearly renewal fee: $49.00
Initial Exam and Treatment: $75.00 Daily Office Visit: $35.00

□ **INSURANCE INFORMATION:**

Primary Health Ins. CO.________________________ Group #: __________ Member #: _____________
Name of Primary Insured: _____________________ Relationship to Insured? Self Spouse ______
Phone#:_______________ Address:______________City: _____________ State:_______ Zip:_______

What operations have you had? ____ When? _______________
____When? _______________
Serious Illness: ____ When? _______________
____ When? _______________
Please list any and all medications you are on: ____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

IN CONSIDERING THE AMOUNT OF MEDICAL EXPENSES TO BE INCURED, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to TLC Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.
I HEREBY convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.
THIS ASSIGNMENT WILL REMIAN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

PATIENT/ GUARDIAN SIGNATURE: ________________________________ **TODAY'S DATE:** ________

Terms Of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any question please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at TLC Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible $20 fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, ________________________________ being the parent or legal guardian of ______________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: __________________________Children: _________________________Others: ___________________

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

I, _______________________________, have read and fully understand the above statements.

HIPAA Acknowledgement

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. A copy will be provided to me upon my request.

Print Patient Name: ____

Signature: ____Date: ____________________________

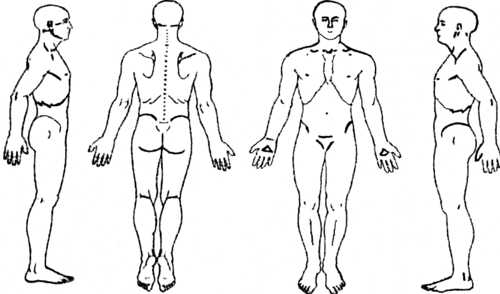
Patient Name: ______________________________________ Date: ____

MEDICAL HISTORY QUESTIONNAIRE

PRESENT ILLNESS

Today's Visit: Are you treating today for a new injury or symptom? ____________**Yes/ No** (circle one)

If yes, please explain: ____



Please mark in the space provided, where you are hurting today. If you are experiencing referred pain draw an arrow up ↑ or an arrow down ↓ to the areas affected. If the pain is broad, use ↔ this symbol to connect two points such as between the shoulders or across the beltline or bra-line.

PAST MEDICAL HISTORY

Have you ever injured: □ Neck □ Upper Back □ Mid Back □ Low Back □ Knee □ Shoulder

□ Other: ___________Please Explain: ____

Have you ever experienced pain in your: □ Neck □ Upper Back □ Mid Back □ Low Back □ Knee □ Shoulder

□ Other: ___________Please Explain: ____

Have you ever been in a motor vehicle accident before? **Yes/ No** If yes, approximate date: ________________________

Have you ever been involved in a slip and fall injury? **Yes /No** If yes, when: ___________________________________

Have you ever been involved in a work comp injury? **Yes/ No** If yes, when:___________________________________

Have you ever been involved in any other traumatic events? ____

Marital Status: (Please circle one) Married, Separated, Divorced, Single, Widowed

Do you have children? **Yes/No** If Yes, How Many _______________Ages: ____________________________________

Do you smoke cigarettes? **Yes/ No** ____________Do you drink? **Yes/ No** If yes, **social** or **moderate** Occupation:

__________________________Retired: Yes/ No_____ Disabled: **Yes/ No** ___________________________________

Which of the following conditions are you currently being treated or have been treated for in the past?

If you mark "YES" to a question, circle all that apply.	YES	NO
Communicable- HIV, AIDS, Hepatitis?		
Cardiovascular- Heart problems or hypertension? Low or high blood pressure?		
Respiratory- shortness of breath, COPD, asthma, sinus problems or cough?		
Immunological / Allergies- rheumatoid arthritis, lupus, allergies, seasonal allergies?		
Ocular- red, itchy, blurry, pain, glaucoma?		
Constitutional- fatigue, weight gain, weight loss?		
Gastrointestinal- acid reflux, nausea, bowel problems?		
Genitourinary- urinary tract infections, kidney stones?		
Females- Are you pregnant? Are you nursing?		
Ear, Nose, Throat- sinusitis, sore throat?		
Psychological- depression, anxiety?		
Dermatological- rashes, skin problems?		
Endocrine- Diabetes, thyroid disease?		
Other-		

Patient Signature: ________________________________ **Date**: ______________________________________

ASSIGNMENT

1. **Direct payment for medical services**. I hereby authorize that payments for medical services on my behalf be made directly to TLC CHIROPRACTIC, INC. (hereafter "TLC").

2. Assignment. I further assign to TLC my ability to ask, demand, sue for, collect, endorse, sign and receive any such insurance, insurance benefits, or insurance claim proceeds for the medical services performed by TLC on my behalf. TLC is not obligated or compelled to exercise this assignment power but has the assignment power to be used at his discretion.

3. Release of information. I hereby authorize the release of information necessary to collect insurance, insurance benefits, or insurance claim proceeds for the medical services performed by TLC on my behalf. This authorization allows TLC to allow the information to be released, copied, or examined as TLC deems appropriate. Information, as used in this paragraph, shall include, but is not limited to, medical records, medical reports, medical billing, medical testing, and insurance documentation.

4. Cooperation. I further agree to fully cooperate in the investigation and preparation of any case in which TLC asks, demands, sues for, collects, endorses, signs and receives any such insurance, insurance benefits, or insurance claim proceeds for the medical services performed by TLC on my behalf. In order to fully cooperate, I understand that I will be required to appear on reasonable notice for all conferences, depositions, and court appearances. I will also need to comply with all legal requests made by TLC or by his authorized legal representative in connection with collecting insurance, insurance benefits, or insurance claim proceeds for the medical services performed by TLC on my behalf.

5. Copies. I understand that a copy of this authorization for release of information document is sufficient authorization.

6. Unenforceability. I understand that the invalidity or unenforceability of any provision or provisions of
this agreement shall not affect the other provisions, and this agreement shall be construed in all respects as if any invalid or unenforceable provisions were omitted.

7. **Direct Payment or Assignment Prohibition**. If my insurance policy prohibits direct payment or assignment of benefits to TLC, then I hereby instruct and direct any insurance company whose policy provides benefits to make any payment directly payable to me and mail it to TLC at the following address: 487-3 E. Tennessee Street, Tallahasssee, FL 32301.

8. Due Upon Receipt. I recognize that payment for services rendered by TLC is due upon receipt of the services but that TLC has agreed to accept this assignment as an accommodation to me, and that TLC may revoke its right to collect for TLC's services.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, will remove that portion from this document (by striking, dating, and initialing the portion struck). Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

______________________________ ____________________

Patient's/Guardian's signature Date

______________________________ ____________________

Witness to patient's/guardian's signature Date