

Sweeney Chiropractic
201 Thompson Lane #103
Nashville, TN 37211
Date: ___/___/___

Patient Registration

Name: Last _____ First _____ Middle Initial _____
Address: _____ Apt/Unit: _____
City/State: _____ Zip: _____ Gender: Male Female
Date of Birth: _____ Marital Status: Married Single Widow Divorced
Home Phone: _____ Mobile (Cell) Phone: _____
Email: _____ Social Security #: _____
Occupation: _____ Employer: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____

Emergency Contact Information

Name: Last _____ First _____ Middle Initial _____
Address: _____ Apt/Unit: _____
City/State: _____ Zip: _____ Gender: Male Female
Phone #: _____

Personal Responsible for Account- Workers Compensation-Motor Vehicle Accident (PIP)

Is your injury due to a motor vehicle accident: Yes No Workman's Comp. Accident: Yes No

If Yes, please provide the following...

Name of Company responsible for your account? _____

Contact/Case Representative: _____ Phone: _____

Attorney: _____ Phone: _____

Primary Coverage: Insurance Name: _____
Name of Owner: _____

Secondary Coverage: Insurance Name: _____
Name of Owner: _____

I hereby authorize medical benefits billed to my insurance to be paid to Dr. Jim A Sweeney, DC.

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance.

I also accept responsibility for fees that exceed or are not covered by the payment made by my insurance.

I understand and take responsibility for the costs incurred for services rendered.

In the event of default in the payment of the amount due, and if this account is placed in the hands of a collection agency and/or attorney for collection or legal action, an additional charge equal to the cost of collection, including the collection agency, attorney fees, and any court costs incurred, will be paid by me.

I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered, unless other arrangements have been made by me and Dr. Jim A Sweeney, DC.

I also hereby authorize Dr. Jim A Sweeney, DC to leave information or a message regarding my care/treatment at my home phone number including voicemail or answering devices.

Signature of patient or Guardian

Date

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Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:

<http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf>

- 1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
- 2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
- 3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
- 4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
- 5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
- 6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial: _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial: _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payer.

Initial: _____

Non Disparagement

The patient consents to take no action which is intended, or would reasonably be expected, to harm Sweeney Chiropractic or their reputation or which would reasonably be expected to lead to unwanted or unfavorable publicity to Sweeney Chiropractic.

Initial: _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of the third party payers. This assignment is irrevocable. Failure to fill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payer necessary for reimbursement of charges incurred.

Initial: _____

Patient Printed Name

Patient Signature

Date

Witness Printed Name

Witness Signature

Date

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Patient Reminder

We have several different methods by which we can remind you of your up-coming appointments. We would greatly appreciate it if you please initial which methods you would prefer.

- _____ Phone Call Reminder
- _____ Email Reminder
- _____ Text Message Reminder
- _____ Email Reminder
- _____ All of the above

Email: _____

Cell Phone Number: _____

Cell Phone Carrier (Verizon, Sprint, etc): _____

We use a program that will send you texts that requires the cell phone carrier company in order to correctly deliver your texts. Also, please be advised that you **cannot respond to this service via text or email as we do not receive the messages**. Please, call the Office to reschedule or cancel your appointments. We have an answering system by which we receive messages if you need to call outside of office hours.

Our typical reminder program will send you an email, text, or phone call the day prior to your appointment. Please, if you are running late, or if you cannot make your appointment, **call the Office** so that we may be able to make sure you will be able to be seen. Certain types of appointments require specific therapy equipment that takes a specific amount of time per patient, per session. Being late for these appointments will result in an extended wait time, so as not to prevent another patient's treatment being delayed. We truly appreciate your help in this matter.

Print

Signature

Date

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Patient Health History

Name: Last _____ First _____ Middle Initial _____

List any medications (prescriptions and over-the-counter), vitamins and supplements you currently take:

Do you:

Smoke: Yes No If so, how much? _____

Drink Alcohol: Yes No If so, how much? _____

Exercise: Yes No If so, how much? _____

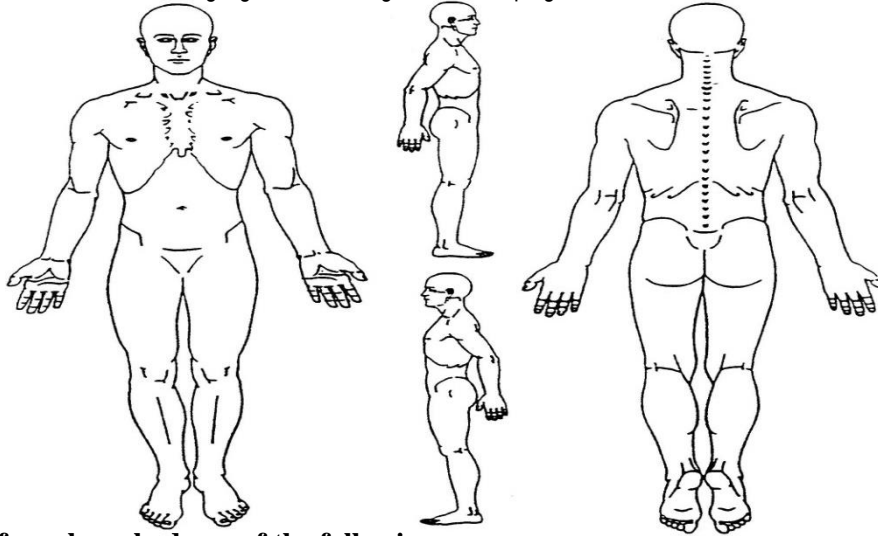
Allergies: Yes No If yes, please list? _____

Birth control: Yes No If yes, please list? _____

List any surgeries, accidents, injuries, implants, cancer, etc:

Please mark off the areas of your complaint on the diagram below with the following indicators:

PPP = pain NNN = numbness TTT= tingling BBB= burning CCC= cramping XXX = other



Please circle if you have had any of the following:

- | | | | | | |
|-------------|--------------------|---------------------|-------------------|---------------------|----------------------|
| Headaches | Allergy Shots | Stroke | Suicide Attempt | Scarlet Fever | Tuberculosis |
| Neck Pain | Bleeding Disorders | Tonsillitis | Typhoid Fever | Tumors | Vaginal Infections |
| Stiff Neck | Cataracts | Vascular Disease | Whooping Cough | TMJ | Liver Disease |
| Back Pain | Emphysema | Anemia | Alcoholism | AIDS/HIV | Blood Clots |
| Tension | STD | Asthma | Arthritis | Bronchitis | Kidney Disease |
| Anorexia | Hernia | Cancer | Bulimia | Chicken Pox | Anemia |
| Breast lump | Liver Disease | Disc Degeneration | Diabetes | Epilepsy | Hand or Wrist Pain |
| Epilepsy | MS | Goiter | Glaucoma | Heart Attack | Numbness |
| Gout | Pinched Nerve | Hepatitis | Heart Disease | High Blood Pressure | Deep Vein Thrombosis |
| Shingles | Psychiatric Care | Kidney Disease | High Cholesterol | Migraine | Dizziness |
| Measles | Thyroid Problems | Mono | Miscarriage | Osteoporosis | ringing in Ears |
| Mumps | Ulcers | Parkinson's Disease | Pacemaker | Polio | Loss of Balance |
| Pneumonia | RA | Prosthesis | Prostate Problems | Rheumatic Fever | Constipation |

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Patient History/Chief Complaint Form

Name: Last _____ First _____ Middle Initial _____
 Have you been to a chiropractor before: Yes No How was your experience? _____
 Have you seen anyone for this/these complaints? _____
 Who is your Primary Care Physician? _____ May we contact them? Y N
 Are you taking any medications for this/these complaints? _____
 Who referred you to our clinic? _____ How did you hear of us? _____

Primary Complaint/Please Describe:

Date when symptom started: _____ How did it start: _____
 Are you symptoms: Improving Getting Worse Same or Other: _____
 What increases your symptoms? _____
 What decreases your symptom? _____
 What activities are limited by your discomfort? Please Circle

Bending	Getting Up	Reading	Working
Bowel Movement	Lifting	Sitting	Walking
Coughing	Lying Down	Sleeping	Turning Head
Daily Routine	Pulling	Sneezing	Urination
Driving	Pushing	Standing	Running

Other: _____
 How often do you experience this symptom throughout the day? 100% 75% 50% 25% 10%
 Describe your pain: Sharp, Dull, Ache, Burn, Throbbing, Constant, Intermittent, Frequent
 Does it radiate into your: Arm Leg Head None Do you have numbness or tingling: Y N
 Please rate your pain/symptom on a scale of 1 to 10 (0 being no pain/symptom and 10 being extreme): ____/10
 Approximate date of your most recent (month/year): _____

Spinal X-ray	MRI	Blood Work
Physical Exam	CT Scan	Nerve Tests

Secondary Complaint/Please Describe:

Date when symptom started: _____ How did it start: _____
 Are you symptoms: Improving Getting Worse Same Other: _____
 What makes the symptom increase? _____
 What decreases your symptom? _____
 What activities are limited by your discomfort? Please Circle

Bending	Getting Up	Reading	Working
Bowel Movement	Lifting	Sitting	Walking
Coughing	Lying Down	Sleeping	Turning Head
Daily Routine	Pulling	Sneezing	Urination
Driving	Pushing	Standing	Running

Other: _____
 How often do you experience this symptom throughout the day? 100% 75% 50% 25% 10%
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 Please rate your pain/symptom on a scale of 1 to 10 (0 being no pain/symptom and 10 being extreme): ____/10
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 Signature of patient or Guardian

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