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 #: _____

Person 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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Nashville, TN 37211
Date: ___/___/___

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
- _____ 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

Sweeney Chiropractic
201 Thompson Lane #103
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Date: ___/___/___

Patient Health History

Name: Last_____ First_____ Middle Initial____

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

Do you:

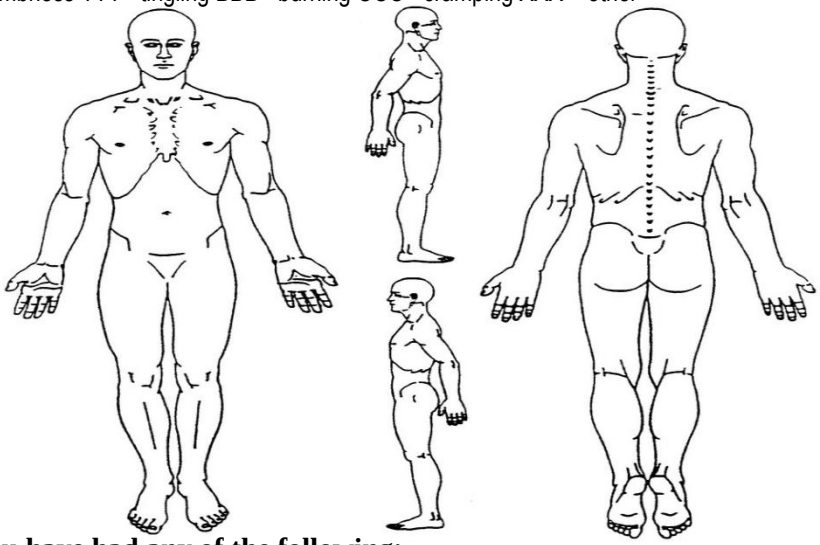
Smoke: [ ] Yes [ ] No **If so, how much? _____**
Drink Alcohol: [ ] Yes [ ] No **If so, how much? _____**
Exercise: [ ] Yes [ ] No **If so, how much? _____**
Allergies: [ ] Yes [ ] No **If yes, please list? _____**
Birth control: [ ] Yes [ ] No **If yes, please list? _____**

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**
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