Loudon Chiropractic
806 Mulberry Street, Loudon, TN. 37774
P: 865-657-9941 F: 865-657-9942

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle:_____
Gender: M F Date of Birth: ____ /____ /_____ Age: _____ SSN: _____ - _____ - _____
Home Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Work Phone: _____
Occupation: _____ Employer Name: _____
Employer Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____

Is anyone else responsible for the cost of your care? Insurance / Worker's Comp / Private Injury

SPOUSE OR GUARDIAN

Last Name: _____ First Name: _____ Middle:_____
Primary Phone: _____ Employer Name: _____
Date of Birth: ____ /____ /_____ SSN: _____ - _____ - _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____ Middle:_____
Primary Phone: _____ Relation to Patient: _____

MY PRIVACY

I have received, seen, or been offered a copy of the **Notice of Privacy Practices.** I understand that I have certain rights regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up care among the health providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

X _____ Date: _____
Signature of patient or persons acting on patient's behalf

MEDICAL HISTORY

Do you have, or have you had, any of the following?

If yes, please explain:

- ☐ Asthma/Breathing Problems_____
- ☐ Arthritis_____
- ☐ Bleeding/Clotting Disorder_____
- ☐ Blood Pressure Disorder_____
- ☐ Blood Transfusion
- ☐ Gastrointestinal Problems_____
- ☐ Cancer _____
- ☐ Cholesterol Disorder_____
- ☐ Diabetes_____
- ☐ Eye Disorder_____
  (i.e. Glaucoma, Cataracts, etc.)

If yes, please explain:

- ☐ Heart Disease/Disorder_____
- ☐ Lung Disorder_____
- ☐ Liver Disease
- ☐ Neurological Disorder_____
- ☐ Chronic Headaches
- ☐ Psychiatric Disorder_____
- ☐ Pulmonary Embolism/DVT
- ☐ Stroke
- ☐ Seizures or Epilepsy
- ☐ Thyroid Disorder_____
- ☐ Urinary/Kidney Disorder_____

New to Chiropractic? Y N Previous Chiropractor: _____
Please list any other medical conditions: _____
_____
Please list all past surgeries and hospitalizations with the approximate date: _____
_____
_____
Please list all current medications and doses: _____
_____
Do you currently smoke? Y N Do you drink alcohol? Y N Do you use recreational drugs? Y N

I certify that the information that I have given thus far is true and accurate to the best of my knowledge.

Signed: _____ **Date:** _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

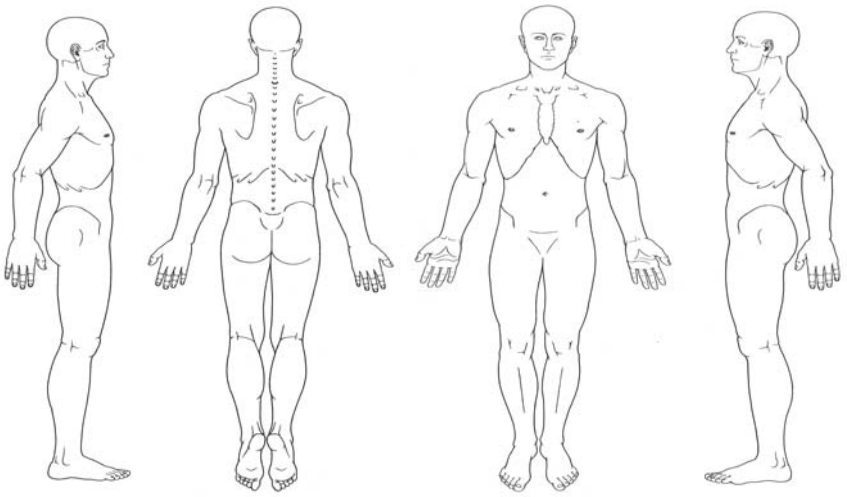
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

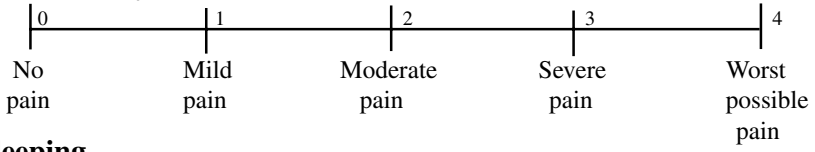
Patient Signature _____ **Date** _____

Functional Rating Index

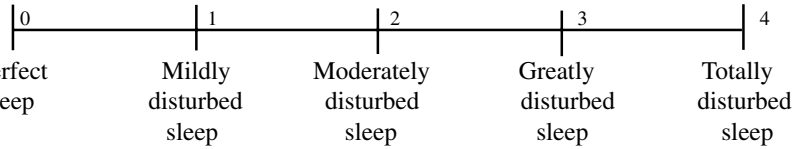
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

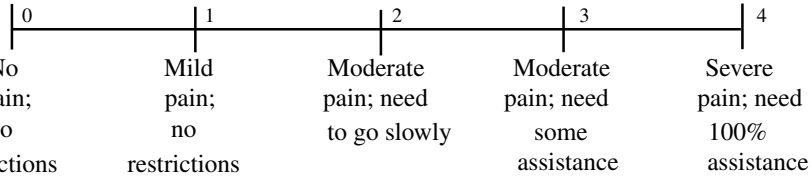
1. Pain Intensity



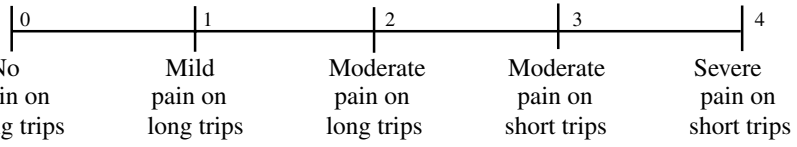
2. Sleeping



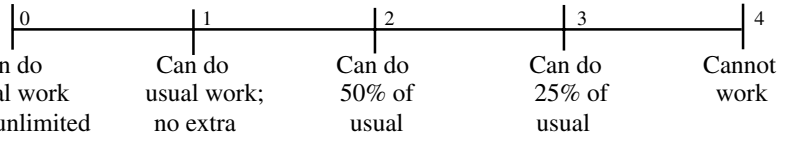
3. Personal Care (washing, dressing, etc.)



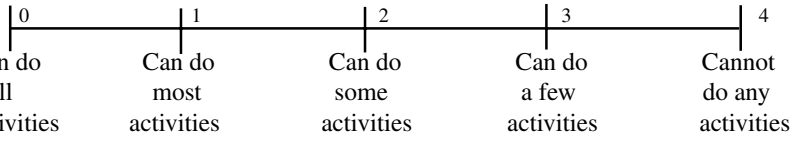
4. Travel (driving, etc.)



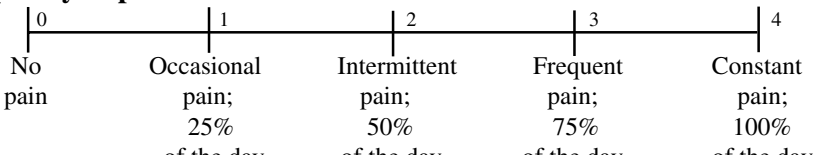
5. Work



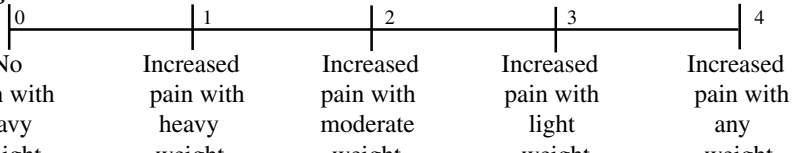
6. Recreation



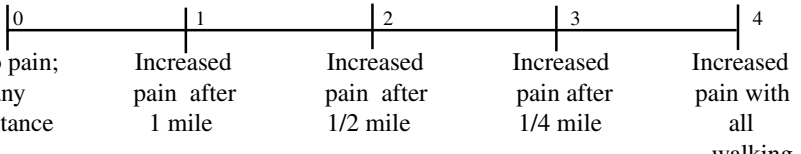
7. Frequency of pain



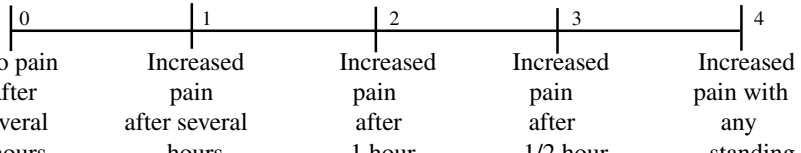
8. Lifting



9. Walking



10. Standing



Total: **(/4, x10) = Functional Rating Score:** **%**

Treating Doctor Signature **Date**

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www.chiroevidence.com

Loudon Chiropractic
Drs. Christopher & Stephanie Estes
806 Mulberry St. Loudon, TN 37774
P: 865-657-9941

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Please **CIRCLE** the number that best describes the question being asked.
Indicate your pain level **RIGHT NOW**, your **AVERAGE** pain, and your pain at **ITS BEST AND WORST.**

1) What is your pain level **RIGHT NOW**?
No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

2) What is your **TYPICAL** or **AVERAGE** pain?
No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

3) What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?
No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

4) What is your pain level **AT ITS WORST** (How close to "1-" does your pain get at its worst)?
No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____
_____
_____

Consent for Treatment
And
Authorization to Perform X-rays

In the chance that diagnostic x-rays are advisable, please read and sign the consent below.

Date: _____ Time: _____ am/pm

I have been informed, by Dr. Estes, that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem or illness. I authorize Dr. Estes to perform such a radiographic examination. To the best of my knowledge, I am not pregnant as this procedure could cause harm to an un-born child.

Signed: _____

Witness/Staff: _____

Loudon Chiropractic

FINANCIAL POLICY

Dr. Christopher Estes D.C.
Dr. Stephanie Estes D.C.

806 Mulberry Street | Loudon | TN 37774 | p: 865.657.9941 | f: 865.657.9942

Patient's Name: _____ DOB: _____

_____ (initial) **INSURANCE**: It is the patient's responsibility to provide us with current insurance information. **Please have your insurance card every time you come to the office.** You are responsible for notifying us of any changes in your insurance coverage. If you fail to do so in a timely manner, you will be responsible for the balance.

_____ (initial) Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, copayments/coinsurances, non-covered charges and "usual and customary" charges. We will supply information as necessary. You are ultimately responsible for the timely payment of your account.

_____ (initial) **CO-PAYS / CO-INSURANCES**: Co-payments / Co-insurances are due at the time of service. You may be asked to pay this at the time of check in, **PRIOR** to being seen by the Doctor. You may also be asked to make a payment on any balance you may have from previous services.

_____ (initial) **UN-PAID BALANCES**: If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due. You are responsible for payment in full upon receipt of statement. We accept cash, checks, Visa, MasterCard, Discover and Amex. If legal action is necessary to collect unpaid balances, all fees associated with that process will be added to the patient's account balance.

_____ (initial) **NOTIFICATION**: It is our policy that patients be sent **3** statements. After three attempts to reach you, your account will be placed in the Overdue/Bad debt category. This will need to be resolved before we will schedule any further appointments. (It is important that you keep your address and phone number updated so that we may reach you.)

_____ (initial) **ANY OVERDUE BALANCES**: may be considered for further collection activity. If your account is turned over to collections, you will be released from care and a **minimum $50** collection fee will be added to your account balance. If legal action is necessary to collect, all fees associated will be your responsibility.

_____ (initial) **RETURNED CHECKS**: The charge for a returned check is **$25** payable by cash or credit card. This will be applied to your account in addition to your insufficient funds amount. You will be placed on a "Cash Only" basis following any returned check.

_____ (initial) **MINORS**: The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

_____ (initial) **MEDICAL RECORD / FMLA AND / OR SHORT-TERM DISABILITY**: If you want a copy of your records, you will be charged a **$20** copying fee. We will forward your records free of charge to another physician with a signed medical records release. There is also a fee of $**10-$25** for completion of FMLA and /or short-term disability paperwork depending on form complexity. All fees are due at time paperwork is received from patient. Please allow **7-10 days** for completion of forms.

_____ (initial) **APPOINTMENT REMINDERS**: I authorize Loudon Chiropractic to send appointment reminders and other reminders electronically via phone or text message to the phone number provided by me at the time of registration and to any family member/dependant associated with the phone number. I understand that this service is offered free of charge. **However, standard text messaging rates from my mobile carrier may apply.**

_____ (initial) **AUTHORIZATION TO RELEASE INFORMATION**: I authorize Loudon Chiropractic to release my information as necessary to my insurance provider, attorney, or adjuster in order to process claims for reimbursement of charges incurred by me as a result of professional services.

_____ (initial) **NOTICE OF ASSIGNMENT**: I authorize Loudon Chiropractic to receive direct payment of any expense benefits allowable as payment toward the total charges for professional services rendered to me. This payment will not exceed my indebtedness to the assignee. I agree that a photo static copy of this agreement shall serve as the original.

I have read and agree with Loudon Chiropractic's Financial Policy.

Patient Signature: _____ Date: _____

No Show / Late cancelation Policy

Effective 1/1/24, Loudon chiropractic/Kingston Chiropractic will implement the following policy regarding no show/late cancellation appointments.

Our policy is no different than most other medical offices' policies and is now a requirement to begin/continue care with us. For most, this will not affect anything regarding your appointments but sadly the abuse of a few patients has made this policy necessary.

A no show/late cancellation appointment is defined as a patient appointment that has not been attended with no communication or rescheduled with a notice of at least 24 hours of the original appointment time. We make every attempt to notify you of upcoming appointments via appointment cards, and/or automated reminders via email, text, or phone. lf you do not get the reminders, please check with us regarding your preferences to ensure you receive the notifications. We are aware things happen unexpectedly and therefore will offer a free forgiveness on one appointment that is missed or rescheduled with less than a 24 hour notice. Any future no show/late cancellations will incur a non-billable $25 fee that must be paid before receiving your next service.

Patient Signature _____

Date _____ / _____/ _____