WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two INSURANCE INFO

Primary Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

three ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____) _____

Payment method: ❑ Cash ❑ Check

_____ ____/____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

PLEASE CONTINUE ON BACK

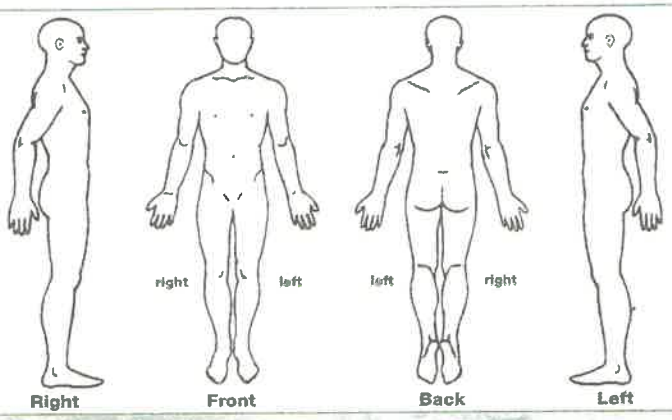
five 5 REASON FOR VISIT

Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness
Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity
When did your condition/accident occur? ___/___/___ Where did your injury occur? _____
Please explain what happened: _____
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.
Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: _____

Using the adjacent body charts, please circle all affected areas.
Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

Have you ever been treated by a Chiropractor? ❑Yes ❑No
Clinic or Dr's name: _____
Clinic phone#: _____



six 6 HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History: _____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes _____ hours per week
Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
For woman: Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)
Initials ___ Date ___/___/___
Comments
Initials ___ Date ___/___/___
Comments
Initials ___ Date ___/___/___
Comments

Consent Form
Reed Chiropractic

Patient Name: _____

Chart # _____

I hereby request and consent to the performance of chiropractic adjustments and other procedures including but not limited to various forms of manual therapy, physiological therapeutics, traction, modalities, exercises, physical therapy, diagnostic x rays or range of motion tests on myself (or the patient listed below for whom I am legally responsible) by the doctor of chiropractic, as an employee of Reed Chiropractic Associates and/or other licensed doctors of chiropractic now or in the future at this clinic.

I understand and have been informed that in the practice of chiropractic medicine there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations or sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications that could occur. I wish to rely upon the doctor to exercise prudent judgment during the course of any procedures which the doctor feels at the time, with the information given, is in my best interest.

I have read or had read to me the above consent. I have also been given the opportunity to ask questions about this consent. By signing below, I agree to the above named procedures. I intend this consent form to remain valid for the entire course of my treatment for my present condition or any future conditions for which I seek treatment. I understand that I have the right to revoke this consent in writing at any time for any and all future procedures with the understanding that any such revocation shall not apply to the extant that Reed Chiropractic Associates has already taken action in reliance on this consent.

Patient Signature: _____ *(Guardian's signature if the patient is under 18)*

Date: _____ Witness Signature: _____

Consent for Chiropractic X rays

Patient Name: _____ **Chart #** _____ **Date** _____

During your examination, the doctor may feel that x rays will be needed in order to diagnose your condition. You should be made aware that these x rays may be required in order to administer treatment. In order to perform x rays on any patient, our office requires the patient gives consent for such tests to be performed.

By signing below I agree and understand that the doctor may need x rays in order to properly diagnose my condition and I give permission for all such diagnostic tests.

I UNDERSTAND THAT IF I REFUSE TO HAVE X RAYS, THE DOCTOR RESERVES THE RIGHT TO REFUSE ANY TREATMENT

Patient Signature: _____ *(Guardian's signature if the patient is under 18)*

Date: _____

Females Only – I confirm that I am not pregnant. Patient Signature: _____

Reed Chiropractic Associates, P.C.
Dr. Jason T. Reed, DC CCEP
HIPPA Declaration

The Practice:

* Is required by federal law to maintain your privacy and to provide you with *this* privacy notice the practice's legal duties and privacy practices with respect to your personal health information.

* Under the Privacy Rule, the practice may be required by state law to grant greater access or maintain greater restrictions on the use or release of your personal health information than that which is provided for under federal law.

* Is required to abide by the terms of the privacy notice

* Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for all of your personal health information that is maintained.

* Will distribute any revised privacy notice to you prior to its implementation

* Will not retaliate against you in any way for filing a complaint

This notice is in effect as of April 6th 2009

The Patient:

By signing my name below, I acknowledge receipt of this privacy notice and declare my understanding and agreement to its terms.

Patient or Guardian's signature: _____ **Date:** _____

****

Email and Message Authorization

Email: I, _____(patient), do hereby give consent to Reed Chiropractic Associates, their employees and Dr. Jason T. Reed, DC to use my email address for possible future possible communication. I understand that I can be removed from the e-mail list at any time by providing a statement in writing.

Messaging: I, _____(patient), do hereby give consent to Reed Chiropractic Associates, its employees and Dr. Jason T. Reed, DC to leave detailed messages on my voicemail or with the following individuals. I also give permission for my accounting information, insurance information and/or medical records to be disclosed and discussed with the following individuals.

Names: _____ _____

_____ _____

Patient Signature: _____ (Guardians' signature if the patient is under 18)

Date: _____

Witness Signature: _____ **Date:** _____

Reed Chiropractic
Financial Policies

Thank you for choosing Reed Chiropractic as part of your health care team. We are committed to providing the best possible care for you. In order to achieve this goal, we need your help in understanding our financial policies. Please understand that proper payment of your bills is considered part of your treatment plan. Please read and initial after each section.

It is the policy of Reed Chiropractic to collect payment for any deductibles, co pays, co insurance and non covered charges at the time of service. We accept cash, check, VISA, Mastercard, Discover and Care Credit as methods of payment. If you need to discuss alternative payment arrangements, you must do so **BEFORE** you receive care. There is a $35 collection charge on any returned checks. **Initial:** _____

Health Insurance: Reed Chiropractic is happy to file your medical insurance for all services rendered. It is important that you understand that your health insurance is an agreement between you and your insurance company. Our office is not responsible for what your insurance will or will not pay. It is your responsibility to know and understand the Chiropractic benefits listed in your policy as well as any limitations that may apply. It is your responsibility to provide our office with the most up to date copies of both primary and/or secondary insurance cards before services are rendered. As a courtesy our office will attempt to contact your insurance company to verify benefits but this in NOT A GUARANTEE OF COVERAGE. Our office will do its best to estimate as closely as possible what your portion of the bill will be. The final amount due can only be known after your insurance company has processed the claim. If that amount is different from the good faith estimate, you will be responsible for the additional cost. If there is an overage, the amount will be held in your account and used as a credit toward future visit. There will be no refund. **Initial:** _____

Non Covered Expenses: Our office is committed to providing the best treatment for our patients and we charge usual and customary charges for Chiropractic care. The goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, not on what your insurance coverage may be. You are responsible for payment of charges your insurance company reduces or denies. Any claim that your insurance company refuses to process is your responsibility. **Initial:** _____

Collections: Any account that is over 90 days past due is subject to being turned over to a collection agency. You will receive notice in the mail with fair warning before this occurs. If you have provided a credit card number to keep on file, the amount will be charged to that card before the account goes to collections, Reed Chiropractic is not responsible for any mail that you do not receive due to a bad address that was not updated by you to our office. There will be additional fees added by the collection agency that will be your responsibility as well. You will not receive treatment again until the bill is paid in full. **Initial:** _____

Special Forms: The completion of FMLA, disability or other special request forms is a time consuming process and requires up to 14 days to complete. There is a $30 charge for the completion of such forms and that amount is not covered by any medical insurance. **Initial:** _____

Medical Records Requests: If we referred you to another physician for consultation or continued care we will forward your records to that physician directly if necessary at no cost. If you request copies of your records for any other reason, there is $1.00 per page charge. If you need your x rays burned on a disk, there is a $7 charge. There is a 3 day turn around time on either request. **Initial:** _____

Missed Appointment Charge: Attending your scheduled appointments is crucial to successful treatment of your condition. If you need to cancel or reschedule an appointment, please allow us the courtesy of a 24 hour notice so that we may schedule someone else in need at that time. If you fail to give notice or do not show up there will be charged a $30 charge. This charge is not covered by any insurance company. **Initial** _____

Authorization for the Release of Medical Records

Patient Name: _____ **Date of Birth:** _____

I hereby request and authorize:

Reed Chiropractic Associates, P.C.
Jason T. Reed, DC CCEP
1531 Lindsay Ln S
Athens, AL 35613
Phone # 256-206-9722 Fax # 256-206-9725

_____ To Disclose Information to: _____ To receive information from:

Provider _____

Address _____

City/State/Zip _____

Phone # _____ Fax # _____

Information to be disclosed include copies of:

____ Entire medical record ____ X Ray Films & Reports

____ MRI Images & reports ____ CT Scans & reports

_____ Daily chart notes _____ Progress Reports

Other, specify: _____

This authorization will be effective until such time that it is canceled in writing by the patient or guardian. I understand that the cancellation will have no effect on any information released or obtained prior to receiving the cancellation notice. A copy of the authorization is as valid as the original.

Signature of Patient or Guardian: _____ Date: _____

Notice to recipient of information: This information has been disclosed to you from confidential records which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the express written consent of the patient or legal representative.