PATIENT INFORMATION

Care Chiropractic

Date:_____

Name: _____ Social Security Number: _____

Birth date:_____ Age: _____ ☐ Male ☐ Female

Address: _____City:_____ State: _____ Zip:_____

Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Email:_____ Cell Carrier: _____

Preferred method of contact: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Text Message

Occupation/School:_____

Emergency Contact Name:_____ Phone: (_____)_____

Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Widowed

# of Children: _____Names/Ages:_____

Most patients are referred to us by a caring family member or friend. How or who referred you to us? _____

_____

Primary Insurance: _____ Secondary: _____

Were you recently involved in an auto accident? ☐ Yes ☐ No

Are you currently or could you be pregnant? ☐ Yes ☐ No

HEALTH CONCERNS

Please list your concerns in order of importance:

1. _____ 3. _____

2. _____ 4. _____

Since concern #1 started, it is: ☐ Same ☐ Getting Better ☐ Worse

What makes it better?_____

What makes it worse?_____

Does it interfere with: *(Check all that apply)* ☐ Leisure ☐ Work ☐ Sleep ☐ Sports ☐ Other

Please explain:_____

Have you seen other doctors for this condition? *(Check all that apply)* ☐ Chiropractor ☐ MD ☐ Other

Name/Address:_____

Please list all medications you are taking and why:_____

_____

Have you had any surgeries and/or hospitalizations? ☐Yes ☐No

If yes, please explain:_____

Auto and Work related injuries can cause serious spinal problems. Is this visit related to an accident or injury? ☐Yes ☐No
If yes, please explain:_____

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Headaches/Migraines	☐ Buzzing in ears	☐ Cold hands	☐ Mood swings
☐ Pins & needles in arms	☐ Ringing in ears	☐ Cold feet	☐ Loss of smell
☐ Pin & needles in legs	☐ Numbness in toes	☐ Fever	☐ Loss of taste
☐ Dizziness	☐ Depression	☐ Urinary problem	☐ Back pain
☐ Numbness in fingers	☐ Constipation	☐ Fainting	☐ Neck pain
☐ Fatigue	☐ Menstrual pain	☐ Stiff neck	☐ Cold sweats
☐ Sleeping problems	☐ Stiff joints	☐ Upset Stomach	☐ Diarrhea
☐ Tension	☐ Hot flashes	☐ Menstrual irregularity	
☐ Ulcers	☐ Irritability	☐ Sensitivity to bright lights	

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Bulimia	☐ Herniated Disc	☐ Rheumatoid Arthritis
☐ Anemia	☐ Cancer	☐ High Blood Pressure	☐ Stroke
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Thyroid Problems
☐ Arthritis	☐ Gout	☐ Multiple Sclerosis	☐ Other_____
☐ Asthma	☐ Heart Disease	☐ Osteoporosis	

Stress can cause or accelerate spinal damage. On a scale of 1 to 10 (1 = none, 10 = extreme), rate your stress levels in the past 90 days: Occupational _____ Personal _____

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

On a scale of 1 to 10 (1 = poor, 10 = excellent), please rate your habits regarding the following:

____Eating _____Body ____Weight _____Exercise _____Sleep _____Energy _____Digestion _____Overall Health

Do you have health goals? If so what are they? _____

DISCLOSURE & CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays on me (or the patient named below, for whom I am legally responsible) by Dr. Joshua Lecker (the "Doctor") and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now, or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor.

I understand chiropractic care contributes to my overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I understand that some of the risks to exam and treatment include, but are not limited to fractures, disc injuries, sprains, increased symptoms, pain, no improvement of symptoms or pain, and in extremely remote conditions strokes. I do wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based on the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

FINANCIAL POLICY AND AGREEMENT

Care Chiropractic, PLLC

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to Care Chiropractic, PLLC dba Dr. Joshua Lecker, located at 2106-A Trenton Road, Clarksville, TN 37040. "Financial Policy" or "Agreement" shall refer to this document.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by [Name of Office])," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. I agree that any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments. I also agree that my account with your Office shall be construed as in "default" on the earlier of the following dates: (a) a Payer fails to pay any or all of the Charges in-full and directly to the Office upon receipt of those Charges within thirty (30) days or the period established by the earliest prompt pay deadline applicable to the Payer (whichever occurs later), (b) I do not pay any or all of the Charges in-full within fourteen (14) days of request, or (c) the Office attempts to charge my credit card in compliance with a written Payment Arrangement, but the charge is declined or not approved.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further agree to the terms of the Office's Auto / Work Comp Advance Beneficiary Notices as applicable. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can request copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers, not including in accident

cases my health benefit plan or Medicare. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws to the extent permitted by law. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien", Health Insurance Election, and, if applicable, Auto / Work Comp Advance Beneficiary Notices, and further agree to the terms and definitions set forth in these documents as applicable. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Care Chiropractic, PLLC/ Dr. Joshua A. Lecker.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

I have read, understood, and agree to the terms of this Disclosure and Consent and Financial Agreement.

Patient Name (print): _____ Patient Signature: _____

Date: ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ____/____/_____