Welcome

Patient Information

Date _____

Social Security # _____

Patient Name _____

Address _____

City_____

State _____ Zip_____

E-mail_____

Sex Male Female Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single

☐ Separated ☐ Divorced ☐ Minor

Occupation _____

Patient Employer _____

Spouse's Name_____

Birthdate _____

Social Security _____

Spouse's Employer _____

Referred by _____

Insurance

Who is responsible for this account?_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Co.
Dr. Chad Upchurch, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from this date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Cell Phone (___)_____ Alt. Phone(___)_____
Cell Phone Provider _____ (to receive text)

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Phone (___)_____ Alt. Phone (___)_____

Accident Information

Is condition due to an automobile accident? ☐ Y ☐ N

Has auto insurance been contacted? ☐ Y ☐ N

Date of accident _____Claim #_____

Auto Ins. Responsible _____

Adjuster's Name _____

Patient Condition

Main complaint (be specific) _____

When did your symptom appear? _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Is it ☐ Constant or ☐ Come and Go

Other Health Goals _____

FIXX Regenerative Solutions

Daily Activities

Bending:	□ No Effect	□ Mild Painful (Can do)	□ Moderate Painful (Limited)	□ Severe Painful (Unable to do)
Care for Family:	□ No Effect	□ Mild	□ Moderate	□ Severe
Carry Groceries:	□ No Effect	□ Mild	□ Moderate	□ Severe
Change Position:	□ No Effect	□ Mild	□ Moderate	□ Severe
Climb Stairs:	□ No Effect	□ Mild	□ Moderate	□ Severe
Driving:	□ No Effect	□ Mild	□ Moderate	□ Severe
Computer Use:	□ No Effect	□ Mild	□ Moderate	□ Severe
Feeding:	□ No Effect	□ Mild	□ Moderate	□ Severe
House Chores:	□ No Effect	□ Mild	□ Moderate	□ Severe
Kneeling:	□ No Effect	□ Mild	□ Moderate	□ Severe
Lift Children:	□ No Effect	□ Mild	□ Moderate	□ Severe
Lifting:	□ No Effect	□ Mild	□ Moderate	□ Severe
Pet Care:	□ No Effect	□ Mild	□ Moderate	□ Severe
Reading:	□ No Effect	□ Mild	□ Moderate	□ Severe
Bathing:	□ No Effect	□ Mild	□ Moderate	□ Severe
Dressing:	□ No Effect	□ Mild	□ Moderate	□ Severe
Shaving:	□ No Effect	□ Mild	□ Moderate	□ Severe
Sleep:	□ No Effect	□ Mild	□ Moderate	□ Severe
Sitting in Chair:	□ No Effect	□ Mild	□ Moderate	□ Severe
Walking:	□ No Effect	□ Mild	□ Moderate	□ Severe
Yard Work:	□ No Effect	□ Mild	□ Moderate	□ Severe
Other_____	□ No Effect	□ Mild	□ Moderate	□ Severe

Medication

Are you currently taking any prescription medications? □ Yes □ No

List them _____

_____

_____

Pregnancy

Are you pregnant?

□ YES

□ No

Policy Agreement

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate any fees for professional services to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Consent to treat a minor: _____ Date: _____
Guardian or Spouse's

Signature of authorizing care: _____ Date: _____

Review of Systems (Please fill out all sections)

Constitutional: ☐ Does not apply to me
☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss

Eyes/Vision: ☐ Does not apply to me
☐ Blurred Vision ☐ Cataracts ☐ Change in Vision ☐ Double Vision ☐ Eye Pain ☐ Glaucoma

Ears, Nose, Throat: ☐ Does not apply to me
☐ Bleeding ☐ Difficulty Swallowing ☐ Discharge ☐ Dizziness ☐ Ear Drainage ☐ Ear Infection(s)
☐ Ear Pain ☐ Fainting ☐ Headaches ☐ Head Injury ☐ Hearing Loss ☐ Hoarseness
☐ Sinus Infections ☐ Sore Throats (frequent) ☐ Tinnitus (Ringing in Ears) ☐ TMJ Problems ☐ Loss of Smell

Respiration: ☐ Does not apply to me
☐Asthma ☐ Cough ☐ Coughing Up Blood ☐Shortness of Breath ☐ Sputum Production ☐ Wheezing

Cardiovascular: ☐ Does not apply to me
☐ Angina (chest pain or discomfort) ☐ Chest Pain ☐ Claudication (leg pain or achiness) ☐ Heart Murmur
☐ Heart Problems ☐ Difficulty breathing while lying down ☐ Palpitations
☐Waking at night with shortness of breath ☐ Shortness of breath with Exertion or Exercise ☐ Ulcers
☐ Swelling of Legs ☐ Varicose Veins

Gastrointestinal: ☐ Does not apply to me
☐ Abdominal Pain ☐ Belching ☐ Black, Tarry Stools ☐ Constipation ☐ Diarrhea
☐ Difficulty Swallowing ☐ Heartburn ☐ Hemorrhoids ☐ Indigestion ☐ Jaundice (yellowing of the skin)
☐ Nausea ☐ Rectal Bleeding ☐ Abnormal Stool Color ☐ Vomiting

Female: ☐ Does not apply to me
☐ Birth Control Therapy ☐ Breast Lumps/Pain ☐ Burning Urination ☐ Cramps ☐ Frequent Urination
☐ Hormone Therapy ☐ Irregular Menstruation ☐Urine Retention ☐ Vaginal Bleeding ☐ Vaginal Discharge

Male: ☐ Does not apply to me
☐ Burning Urination ☐ Frequent Urination ☐ Hesitancy/Dribbling ☐ Prostate Problems ☐ Urine Retention

Endocrine: ☐ Does not apply to me
☐ Cold Intolerance ☐ Diabetes ☐ Excessive Appetite ☐ Excessive Hunger ☐ Excessive Thirst
☐ Frequent Urination ☐Goiter ☐ Hair Loss ☐ Heat Intolerance ☐ Unusual Hair Growth

Nervous System: ☐ Does not apply to me
☐ Dizziness ☐ Facial Weakness ☐ Headaches ☐ Limb Weakness ☐ Loss of Consciousness
☐ Loss of Memory ☐ Numbness ☐ Seizures ☐ Sleep Disturbance ☐ Slurred Speech
☐ Stress ☐ Strokes ☐ Tremors

Past Health History- Please fill out carefully as these problems can affect your overall course of care.
Childhood Illness: ☐ Does not apply to me
☐ ADD ☐ Allergies/Hayfever ☐ Asthma ☐ Atopic Dermatitis (Eczema) ☐ Cerebral Palsy
☐ Chicken Pox ☐ Diabetes ☐ Ear Infections ☐Fetal Drug Exposure ☐ Food Allergies
☐ Headaches ☐ Hepatitis ☐ Measles ☐ Mumps ☐ Rash
☐ Scoliosis ☐ Seizure Disorder ☐ Sickle Cell Anemia ☐ Other (please describe)

Adult Illness: ☐ Does not apply to me
☐ Alzheimers ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Chicken Pox ☐ Crohn's/Colitis
☐CRPS (RSD) ☐ CVA (stroke) ☐ Cystic Kidney Disease ☐ Depression ☐ Diabetes (Non insulin) ☐ Ear Infections
☐ Emphysema ☐ Eye Problems ☐ Fibromyalgia ☐ Hear Disease ☐ Hepatitis ☐ HIV ☐ Hypertension
☐ Influenzal Pneumonia ☐ Liver Disease ☐ Lung Disease ☐ Lupus Erythema (discoid) ☐ Lupus Erythema
☐ Multiple Sclerosis ☐ Parkinson's Disease ☐ Pleurisy ☐ Pneumonia ☐ Scoliosis ☐ Seizure Disorder
☐ Shingles ☐ STD's ☐ Thyroid Problems
Other Illness (please be specific):_____

Surgeries: ☐ Does not apply to me
☐ Angioplasty ☐ Appendectomy ☐ Caesarian Section ☐ Cardiac Catheterization ☐ Carpal Tunnel Repair
☐ Coronary Artery Bypass ☐ Cosmetic ☐ Gallbladder ☐Hernia Repair ☐ Hysterectomy ☐ Joint Replacement ☐ Laminectomy
☐ Mastectomy ☐ Pacemaker Insertion ☐ Rotator Cuff ☐ Spinal Fusion ☐ Tonsillectomy
☐ Other (please be specific): _____

Injuries: ☐ Does not apply to me
☐ Back Injury ☐ Broken Bones ☐ Severe Fall ☐ Fracture ☐ Disability ☐ Head Injury ☐ Industrial Accident
☐ Joint Injury ☐ Car Accident ☐ Mild/Moderate/Severe Soft Tissue Injury

491 Henslee Dr
Dickson, TN 37055
615-441-6115

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

Height: _____ Weight:_____ Blood Pressure:_____ /_____

Financial Policy

We are committed to providing you the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. Please ask if you have any questions about our fees, financial policy, or financial responsibilities.

Our office participates in several insurance plans. Each plan has its own set of rules and regulations. Our office participates in these programs to allow you (the patient) to reduce your health care cost in this office.

DEDUCTIBLES AND CO-PAYMENTS – By law we MUST collect your carriers designated co-payment at the time of service. Please be prepared to pay deductible or co-payment each visit.

NON-COVERED THERAPIES – In the event that your policy does not cover the cost for therapeutic modalities (i.e. manual therapy) you will be responsible for the cost of those services if they are needed for your care.

NON-COVERED X-RAYS – With some insurance policies x-rays or re-examination x-rays will not be covered. You will be responsible for any charges that are not covered by your insurance company.

We cannot guarantee payment as we are not the insurance carrier. However, as a courtesy we will confirm your coverage. Since we often are given misinformation it is our suggestion that you also confirm your chiropractic coverage. If claims are delayed by more than three months, we require you to reimburse our office in full for services rendered. **THE PATIENT IS LIABLE FOR ANY AND ALL EXPENSES INCURRED IN OUR OFFICE.**

PATIENTS WITHOUT INSURANCE COVERAGE – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE – We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the exam, x-rays, therapies, deductible and 20% co-insurance which can be billed to secondary insurance if you have one.

THIS POLICY APPLIES TO TODAY'S VISIT AND ALL FUTURE VISITS. OUR OFFICE ACCEPTS CASH, CHECKS, MASTERCARD, VISA AND CARE CREDIT.
There is a $25.00 service charge for all returned checks.
I understand that failure to pay outstanding balances or make payment arrangements within 90 days, the amount due will be considered delinquent and subject to legal action or assignment to a collection agency or attorney. I further agree to pay for reasonable collection and attorney fees.

SIGNED _____ **DATE** _____

Authorization Notice for the Use and Disclosure of the Patient's Protected Health Information

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law. We are required to abide by the terms of this policy. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your chiropractor to sign this consent/acknowledgements form. By signing the consent/acknowledgement form, your chiropractor, our office staff and others outside that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

1. I am authorizing FIXX Regenerative Solutions to use my name out loud in order to call me back to a room for chiropractic care.
2. I understand that in this practice open bay adjusting and open bay therapy are used. If at any time I need to speak with the doctor in private, I can make this request and set up a special consultation time with the receptionist.
3. I am authorizing FIXX Regenerative Solutions to use and/or disclose my protected health information (PHI) to insurance companies, lawyers and doctors for all health care delivery purposes, which are known as treatment, payment, and health care operations (TPO).
4. We may use your health information to call/text you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. We may mail appointment reminders, announcements or greeting cards to your home.
5. I understand that this office will not receive financial or in-kind compensation in exchange for using or disclosing any of my health information.
6. I understand that I may request a copy of this form at any time for any reason, and it will be provided for me.
7. This form and the Notice of Privacy Practices for Protected Health Information were completely read and filled in by me before I signed it. I certify that all my questions were answered to my satisfaction and that I understand this authorization form and its contents.
8. I further understand that this authorization is valid from today until I ask for a change in this policy in writing.

_____ _____

Name of Individual (Printed) **Date**

_____ _____

Signature of Individual **Date**

_____ _____

Printed Name of Parent/Guardian **Signature Parent/Guardian**