Back and Neck Specialists
959 White Station Road South
Memphis, TN 38117
901-767-8824
901-767-8822 (fax)
www.901Chiro.com

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 #: _____

Referred by: _____

List any Medications you are taking: _____
_____
_____

Do you have any medication allergies: _____
_____

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

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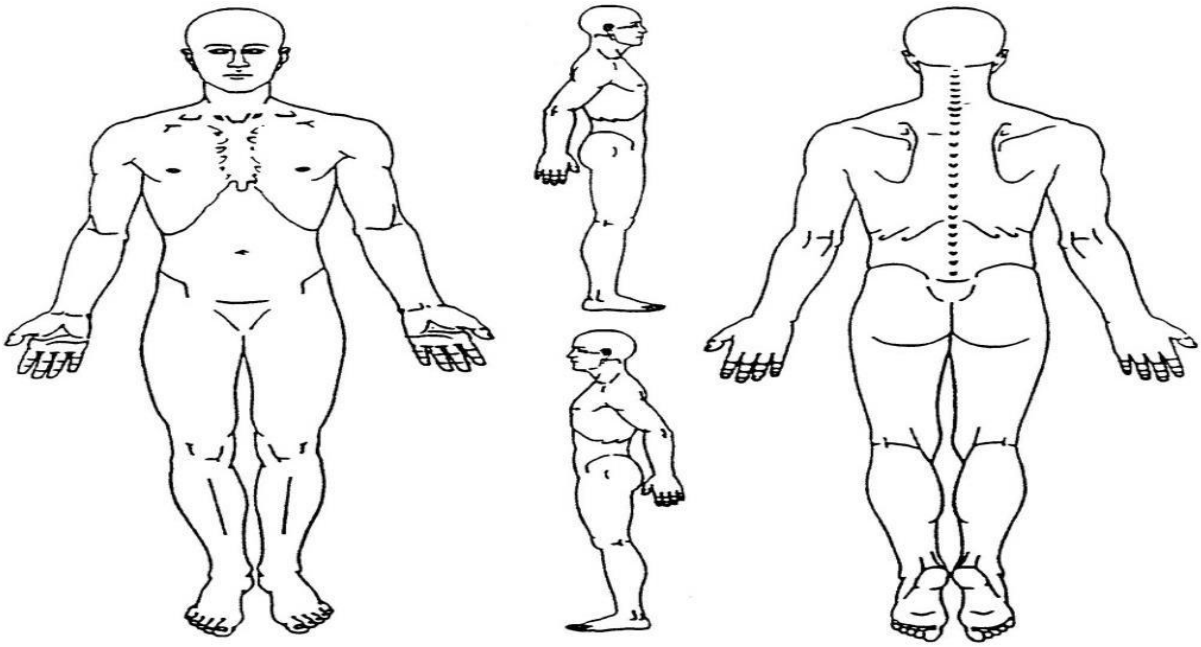
I hereby authorize medical benefits billed to my insurance to be paid to Back and Neck Specialists.
I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance.
I also accept responsibility for fees that exceed or are not covered by the payment made by my insurance.
I understand and take responsibility for the costs incurred for services rendered and that payment is expected at the time services are 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 of $50.00 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 Back and Neck Specialists.
I also hereby authorize Back and Neck Specialists 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

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



Problem #1

What brings you in today? _____

_____

_____

On a scale of 1 to 10, with 10 being the worst, how bad is it?
Circle one : 1 2 3 4 5 6 7 8 9 10
How does this affect your life? _____

_____

On a scale of 1 to 10, with 10 being the most, how committed are you to correcting this issue?
Circle one: 1 2 3 4 5 6 7 8 9 10

Problem #2

What brings you in today? _____

_____

_____

On a scale of 1 to 10 with 10 being the worst, how bad is it?
Circle one : 1 2 3 4 5 6 7 8 9 10
How does this affect your life? _____

_____

On a scale of 1 to 10, with 10 being the most, how committed are you to correcting this issue?
Circle one : 1 2 3 4 5 6 7 8 9 10

List any surgeries, accidents, injuries, implants, cancer, etc:

_____

_____

_____

What would you like to accomplish today? _____

_____

_____

Activities of Daily Living
Daily Activities: Effects of Current Condition on Performance

Please indentify how your current condition is affecting your ability to carry out activities that are routinely a part of your life (check one):

Bending	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Concentrating	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Recreation Activities	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Sleeping	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Carrying	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Dressing	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Lifting	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Sitting	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Standing	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Working	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Doing Chores	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Driving	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Sitting to Standing	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform
Walking	[ ] no effect	[ ] painful (can do)	[ ] painful (limits)	[ ] unable to perform

Please circle if you have had any of the following:

Headaches
Scarlet Fever
Bleeding Disorders
Vaginal Infections
Whooping Cough
Anemia
STD
Bronchitis
Cancer
Breast lump
Disc Degeneration
Heart Attack
Hepatitis
High Blood Pressure
High Cholesterol
Miscarriage
Ulcers
Loss of Balance
Prostate Problems

Allergy Shots
Tuberculosis
Typhoid Fever
Cataracts
Liver Disease
Alcoholism
Tension
Kidney Disease
Bulimia
Diabetes
Hand or Wrist Pain
Numbness
Heart Disease
Deep Vein Thrombosis
Measles
Osteoporosis
Parkinson's Disease
Pneumonia
Rheumatic Fever

Stroke
Neck Pain
Tumors
Vascular Disease
Back Pain
AIDS/HIV
Asthma
Anorexia
Chicken Pox
Epilepsy
Goiter
Gout
Shingles
Dizziness
Thyroid Problems
Ringing in Ears
Pacemaker
RA
Constipation

Suicide Attempt
Tonsillitis
Stiff Neck
TMJ
Emphysema
Blood Clots
Arthritis
Hernia
Prosthesis
MS
Glaucoma
Pinched Nerve
Migraine
Psychiatric Care
Mono
Mumps
Polio

FOR OFFICE USE ONLY:

_____ Height _____ Weight _____ BP _____ O2

_____Pulse

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, healthcare 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:____

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*

Patient Reminder

We will be happy to send you a reminder of your appointment. Please initial if you authorize us to do so:

_____

We use a program that will send you text messages to your cell phone. 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 a text 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.

_____ _____

Signature Date

Office Financial Policy

This policy was developed to help our Office staff and patients have a clear understanding of the financial policy of our office.

SELF PAY- All services are expected to be paid for at the time services are rendered unless other arrangements have been made in writing.

HEALTH INSURANCE- Policies vary with each company. We will verify your benefits for Chiropractic care prior to treatment. You will be responsible for the portion outlined in your Explanation of Benefits from your insurance carrier.

MEDICARE- We do not accept assignment from Medicare. The patient is expected to pay at the time services are rendered. We will file all claims to Medicare on the patient's behalf. Medicare does not cover patient exams, X-rays or therapies. Medicare does not cover maintenance care. Any visits denied by Medicare will be the responsibility of the patient.

PERSONAL INJURY- All claims will be filed with personal auto or third party insurance. Any unpaid claims will be the responsibility of the patient. If an attorney is representing the patient, we will require a signed lien by both patient and attorney.

_____ _____

Signature Date

Patient Fee Schedule

New Patient Exam- $100.00

Cervical X-ray Series (three)- $100.00

Lumbar X-ray Series (two)- $100.00

Thoracic X-ray (one)- $60.00

Spinal Manipulation, 1-2 regions- $50.00

Spinal Manipulation, 3-4 regions- $70.00

Extremity Adjustment- $40.00

Muscle Stimulation- $35.00

Traction- $30.00

Therapeutic Exercise- $40.00

Manual Therapy- $40.00

Dry Needling- $50.00/ $55.00 (not covered by insurance)

Radiological Consult- $50.00 (not covered by insurance)

These are the charges that will be billed to your insurance company if the services are provided. Your actual cost will vary depending on the coverage of your particular plan.

If you are self-pay or Medicare, your charges will vary.

_____ _____

Signature Date

Back and Neck Specialists

NO SHOW POLICY

We schedule our appointments so that each patient receives the right amount of time to be seen by us for their Chiropractic appointment. That is why it is very important that you keep your scheduled appointment and arrive on time.

As a courtesy, and to help patients remember their scheduled Chiropractic appointments, Back and Neck Specialists provides a reminder phone call and/or text message 24 hours prior to the scheduled appointment.

If your schedule changes and you cannot keep the appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with us, we request as much notice as possible.

If you do not cancel or reschedule your Chiropractic appointment, we may assess a $10.00 "no show" service charge to your account. This "no show charge" is not reimbursable by your insurance company. You will be billed directly for it.

I understand the "NO SHOW" policy of Back and Neck Specialists and understand that I will be billed $10.00 for any no-show fee of a scheduled chiropractic appointment. I understand that I must cancel or reschedule any Chiropractic appointment in advance in order to avoid a potential no show charge. (NOTE: Massage cancellation and no show is covered under a separate policy)

_____

Name

_____

Date