Date: ______________________________ Patient #: ________________________

Full Name: ___________________________________ Called Name: ____
Address: ____
City: _____________________________________ State: __________ Zip:_________________
Phone: (home)___________________ (work)____________________ (cell)_________________________
Email:____
☐ Male ☐ Female ☐ Single ☐ Married ☐ Coupled ☐ Divorced ☐ Widowed
Date of Birth: ______________ Age:________ Social Security # (Medicare only)______________________________
Occupation: ____ Employer: ____
How did you hear about our office? ☐Yelp ☐Google ☐East Nashvillian ☐Nashville Scene ☐EEC Website
☐Other_________________________________ ☐Referral____

Your Family
Spouse/Significant Other: ____
His/Her Occupation: ____________________________ His/Her Employer: ____
____
Emergency Contact: ___________________________________ Relation: ____
Phone: (home) ______________________ (work) ______________________ (cell) ___________________________

Primary Care Physician
Who is your primary care physician? ____
Address: ____
City: ______________________________ State: _________________ Zip: ____________________
Telephone: ____ Fax: ________________________________
When doctors work together, it benefits you. May we have permission to update your medical physician regarding your care in our office? Yes ______ No _____

Permission to take photo for patient file:
We have found it very helpful to have a photograph of each patient attached to their Electronic Health Record. This photo is never shared or transmitted in any way outside of our secure EHR system.
May we photograph you? ☐ Yes ☐ No

Accident Information
Is this condition due to an accident? ☐ Yes ☐ No
Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other ___________________________________
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Workers Compensation ☐ Other __________________________
Accident insurance company (Auto/Worker Compensation) ____
____
Claim Number: ________________________________
Claims Address: ____
____
Insurance Adjuster: ___________________________ Phone Number: ____
Fax Number : ____
Attorney Name (if applicable): ____

Health History

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy
☐Chiropractic Services ☐None ☐Other ____

Name and address of other doctor(s) who have treated you for your condition ______________________________
____

Date of last: Physical Exam _______________ Spinal X-Ray _______________
Spinal Exam _________________ MRI, CT-Scan, Bone Scan ________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Aids/ HIV	☐Yes	☐No	Gout	☐Yes	☐No	Pneumonia	☐Yes	☐No
Alcoholism	☐Yes	☐No	Heart Disease	☐Yes	☐No	Prostate Problems	☐Yes	☐No
Allergy Shots	☐Yes	☐No	Hepatitis	☐Yes	☐No	Prosthesis	☐Yes	☐No
Anemia	☐Yes	☐No	Hernia	☐Yes	☐No	Psychiatric Care	☐Yes	☐No
Anorexia	☐Yes	☐No	Herniated Disk	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Arthritis	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Asthma	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Sexually Transmitted Disease	☐Yes	☐No
Breast Lump	☐Yes	☐No	Liver Disease	☐Yes	☐No	Stroke	☐Yes	☐No
Bulimia	☐Yes	☐No	Migraine Headaches	☐Yes	☐No	Suicide Attempt	☐Yes	☐No
Cancer	☐Yes	☐No	Miscarriage	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Mononucleosis	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Diabetes	☐Yes	☐No	Multiple Sclerosis	☐Yes	☐No	Tumors, Growths	☐Yes	☐No
Emphysema	☐Yes	☐No	Mumps	☐Yes	☐No	Ulcers	☐Yes	☐No
Epilepsy	☐Yes	☐No	Osteoporosis	☐Yes	☐No	Vaginal Infections	☐Yes	☐No
Fractures	☐Yes	☐No	Pacemaker	☐Yes	☐No	Whooping Cough	☐Yes	☐No
Glaucoma	☐Yes	☐No	Parkinson's Disease	☐Yes	☐No	Other ______________________		
			Pinched Nerve	☐Yes	☐No	___________________________		
						___________________________		
						___________________________		

Exercise:	Work Activity:	Habits:	
☐None	☐Sitting	☐Smoking	Packs/Day ___________________
☐Moderate	☐Standing	☐Alcohol	Drinks/Week _________________
☐Daily	☐Light Labor	☐Coffee/Caffeine Drinks	Cups/Day_____________________
☐Heavy	☐Heavy Labor	☐High Stress Level	Reason ______________________

FEMALES: Are you pregnant or trying to get pregnant? ☐Yes ☐No Due Date __________________________
Date of onset of LAST menstrual period: ____________________ ☐ Not Applicable

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Injuries/Surgeries you have had:

	Description	Date
Head Injuries	________________________________	________________________
Broken Bones	________________________________	________________________
Dislocations	________________________________	________________________
Surgeries	________________________________	________________________

Current Medications and/or Nutritional Supplements:

______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Financial Policy
East End Chiropractic

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

Patients without insurance: We request that all of the charges be paid at the time of the visit unless other arrangements have been made and agreed upon on prior to service. A payment plan can be established in writing.

Group or individual insurance: When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

"On The Job" Injury (Workers Compensation): If you are injured on the job, your employer must be informed of the accident and you will need to obtain the name and address of the carrier of their workers compensation insurance, as well as any information regarding your claim. If you do not provide us with this information, if a settlement has not been made within six months, or if you suspend or terminate care, any fees for services are due by you immediately.

Personal Injury or Automobile Accidents: Please notify your auto insurance carrier of your visit to our office immediately. Notify East End Chiropractic if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any outstanding fees for services are due by you immediately.

Medicare: We do not accept assignment from Medicare. You are responsible for payment of the Medicare-priced services at time of service and Medicare will reimburse you, the patient, directly. The only chiropractic service Medicare will cover is manual manipulation of the spine. Our office completes and files the claim forms for Medicare at no charge to you.

AGREEMENT TO PAY

I acknowledge and agree that I am responsible for all charges for items or services and treatment provided to me at East End Chiropractic. I understand that I can request additional information about charges for procedures or can obtain a non-binding estimate prior, or subsequent, to signing this agreement.

I understand that my insurance is an arrangement between myself and my insurance, NOT between Dr. John P. Olsen or Dr. Lauren Calabra and my insurance company. I also understand that if my insurance does not respond or if I suspend my schedule of care as prescribed by Dr. John P. Olsen or Dr. Lauren Calabra, that fees will be due and payable immediately.

I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Signature of Patient: ____ Date: ________________

Signature of Guardian:____ Date:________________

Summary of East End Chiropractic, PLLC Privacy Policy

Your protected health information may be used and disclosed to carry out treatment, payment or health care operations. You may revoke this consent at any time by notifying East End Chiropractic, PLLC in writing, except to the extent East End Chiropractic, PLLC has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosure that East End Chiropractic, PLLC may use your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request East End Chiropractic, PLLC to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health operations. East End Chiropractic, PLLC is not required to agree to the requested restrictions. If East End Chiropractic, PLLC agrees to the requested restriction, East End Chiropractic will honor the request and it will be binding on the office.

I hereby authorize the use and disclosure of my protected health information by East End Chiropractic, PLLC, its workforce, and its business associates, for the purposes of treatment, payment and health care operations.

I understand that the specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other information including history, treatment records, diagnosis, prognosis, narrative reports, and billing records.

Signature of Patient: ____ Date: ________________

Signature of Guardian:____ Date:________________

REQUEST FOR ASSIGNMENT OF
BENEFITS TO HEALTH CARE PROVIDER

Name of Patient: ______________________________

Name of Insured
(if different
from patient): ______________________________

Insurance Company: ______________________________

Health Care Provider: ______________________________

I am entitled to benefits under a policy of insurance written by the above insurance company. I have received treatment for an injury from the above health care provider.

As allowed by TCA §56-7-120, I hereby assign to the above health care provider, from the benefits to which I am entitled, a sum of money sufficient to cover the charges of that health care provider for the services I have received. I hereby request that the above insurance company pay that money directly to the health care provider.

I understand that the amount which is paid to the above health care provider may be limited by the amounts owed to other health care providers who have provided services to me for the same injury and by the amount of medical benefits to which I am entitled under the policy. I also understand that the amount paid to the above health care provider may be deducted from any “bodily injury” award I may receive.

If the above insurance company does not permit the assignment of benefits, I hereby request that the company disburse the sums to which I am entitled in the form of a check issued in the names of the insured and the above health care provider as joint payees and sent to the office of that provider.

I understand that if the benefits available to me under the policy are insufficient to cover the charges of the above health care provider, I am responsible for paying that portion of the provider’s charges not covered by insurance.

I agree to give a 30 day notification in writing to the above health care provider before changing this assignment of benefits in any way.

____
Patient

Date: ______________________________

____
Witness