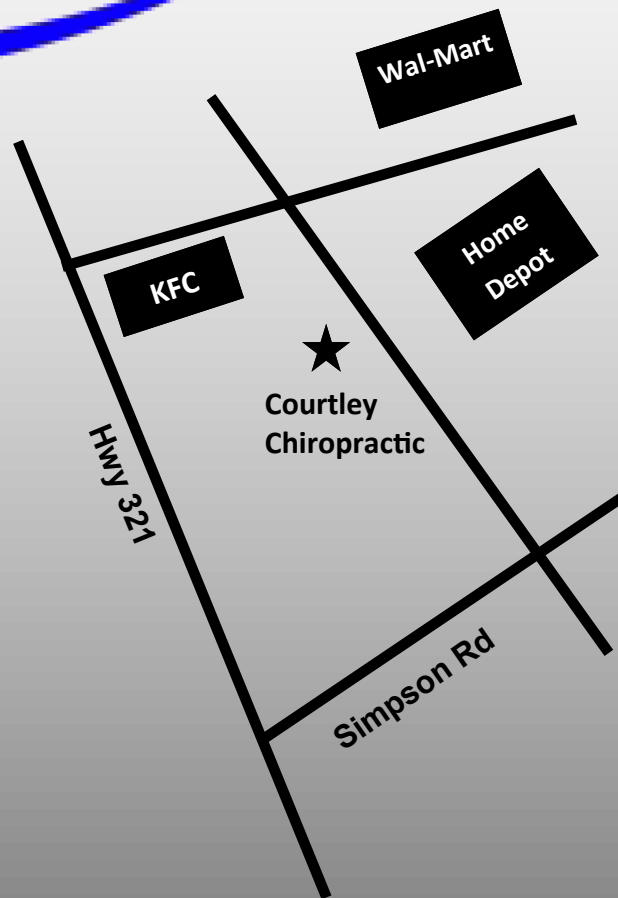


courtley **CHIROPRACTIC**



DR. SCOTT COURTLEY

149 KELSEY DRIVE

SUITE 102

LENOIR CITY, TN 37772

WWW.COURTLEYCHIROPRACTIC.COM

986.8088

Today's Date _____

Information About You

Account Number* _____ Birthday _____ Sex *M/ F* SSN _____

Last Name _____ First Name _____ Middle Initial _____

Marital Status: *S M D W* Occupation _____ Nickname _____

Address _____ Email _____

Address II _____ Phone H _____

City _____ Phone W _____

State _____ ZIP _____ Phone C _____

Referred By _____

Emergency Contact Name _____ Phone Number: _____

Number of Children ____ Names and Ages _____

Method of Payment: *Insurance, Self Pay, Care Credit, Med-pay, Other* _____

Have you ever had chiropractic care before? _____

For what problem and were the results satisfactory? _____

When is the last time you had x-rays? _____ Females: Are you pregnant? Y/ N/ I don't know



Any Surgeries	Trauma History	Social History	Diet History	Exercise	Current Meds
_____	Car Accidents	Drugs	Do you take Supplements?	Do you exercise?	_____
Implants	_____	_____	_____	What kind?	_____
_____	Serious Illnesses	Smoker Y/ N	Vitamins	How Often?	_____
Broken Bones	_____	Caffeine Y/ N	_____	Other Hobbies	_____
_____	_____	Alcohol Y/ N	Other	_____	_____
_____	_____	_____	_____	_____	_____

Family History: Did your mother or father have any of the following:
High blood pressure, Heart Attack, Emphysema, Seizures– Convulsions, Asthma, Diabetes, Kidney disease, pace maker, ulcers, digestive trouble, stroke, arthritis, Mental illness, thyroid, Cancer, Osteoporosis
Anything else you would like to discuss with us or let us know? _____



Initials _____

**Please Fill Out the Information Below, and circle all that apply to the problems you experience
(If you need help please ask the front desk)**



Main Health Concern 1)

Onset Date	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
_____	Trauma Repetitive Unknown	Pain Numb Swelling	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating,			Cerv Mid Back Lumbar L/R Leg L/R Arm Other	Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling /10
Flare Up/ Made Worse	Post Surgical Work Auto Insidious	Muscle Spasms Headach Tension Tingling	burning, Migraine, tension, hormonal, sinus, Other					

Main Health Concern 2)

Onset Date	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
_____	Trauma Repetitive Unknown	Pain Numb Swelling	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating,			Cerv Mid Back Lumbar L/R Leg L/R Arm Other	Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling /10
Flare Up/ Made Worse	Post Surgical Work Auto Insidious Other_____	Muscle Spasms Headach Tension Tingling	burning, Migraine, tension, hormonal, sinus, Other					

Main Health Concern 3)

Onset Date	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
_____	Trauma Repetitive Unknown	Pain Numb Swelling	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating,			Cerv Mid Back Lumbar L/R Leg L/R Arm Other	Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling /10
Flare Up/ Made Worse	Post Surgical Work Auto Insidious Other_____	Muscle Spasms Headach Tension Tingling	burning, Migraine, tension, hormonal, sinus, Other					

Activities of Daily Living: Circle which of the following are affected from your health issues and rate their severity.

- | | | |
|-------------------------------|------------------------------------|----------------------------------|
| Walking- Pain /10 ___% Ltd | Bending - Pain /10 ___% Ltd | Sitting - Pain /10 ___% Ltd |
| Standing - Pain /10 ___% Ltd | Sleeping - Pain /10 ___% Ltd | Lifting - Pain /10 ___% Ltd |
| Pushing - Pain /10 ___% Ltd | Driving - Pain /10 ___% Ltd | Dressing - Pain /10 ___% Ltd |
| Reading - Pain /10 ___% Ltd | Watching TV- Pain /10 ___% Ltd | Doing Chores - Pain /10 ___% Ltd |
| Gardening - Pain /10 ___% Ltd | Playing Sports - Pain /10 ___% Ltd | Working - Pain /10 ___% Ltd |
| Dancing - Pain /10 ___% Ltd | Sit to Stand - Pain /10 ___% Ltd | Rolling over - Pain /10 ___% Ltd |

Other Conditions: Please indicate with the letter **N** if you have these conditions now (within the past 6 months) or **P** if you ever had this conditions in the past.

- | | | | | |
|---------------|----------------------|-------------------|------------------------|----------------------|
| Headaches | Freq Loss of Balance | Arthritis | Upset Stomach | Shortness of Breath |
| Neck Pain | Loss of Smell | Feet Cold | Dry Skin | Depression |
| Stiff Neck | Loss of Taste | Hands Cold | High Blood Pressure | Difficulty Urinating |
| Wrist Pain | Ears Ring | Leg Cramps | High Cholesterol | Fatigue |
| Irritability | Sinus Problems | Hemorrhoids | Hard to Loose Weight | Numbness in Toes |
| Constipation | Diarrhea | Gall Bladder Pain | Cold/ Heat Intolerance | _____ |
| Low Back Pain | Chest Pains | Tension | Pins & Needles in Arms | _____ |
| Knee Pain | Foot Pain | Swelling Joints | Shoulder Pain | _____ |

TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to Courtley Chiropractic for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize Courtley Chiropractic to administer such care that is necessary for my particular case. This care may include a consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below. This includes those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are preexisting, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature _____ Date ____/____/____ (If under age 18) Parent's signature

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____/____/____

_____/____/____
Signature Date

Consent to x-ray:

I hereby grant Courtley Chiropractic, P.A. permission to perform an x-ray evaluation if needed of _____. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

_____/____/____
Signature (parent if minor) Date

Consent to evaluate and adjust a minor child

I, _____ being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____/____/____
Signature Date

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature _____ Date ____/____/____
(If under age 18) Parent's signature



Acknowledgement of Receipt of Notice of Privacy Practices

149 Kelsey Drive, Suite 1502
Lenoir City, TN 37772
865-986-8088

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Tennessee Chiropractic Association Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Tennessee Chiropractic Association (TCA). This disclosure will be made if we need the TCA's assistance to receive reimbursement for your services or, we need the TCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the TCA this information. You are also giving the TCA authorization to re-disclose your information to the party responsible for the payment of your services, the TCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to your. If this contact is made by phone and you are not at home, a message will be left on our answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature: _____

Date: _____

If not signed by the patient, please indicate relationship.

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: (Efforts to obtain/ Reasons for refusal)

