Gatlin Chiropractic & Wellness
1800 St. John Ave - Dyersburg, TN 38024-1949
Phone: (731) 288-9628 • Fax: (731) 288-9653

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Name: _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employment Information

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Responsible Party Information

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ (City, State, Zip): _____

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Person to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

Is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

How Were You Referred to Our Office?

☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Other

Please print the name of your source: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Gatlin Chiropractic & Wellness all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insuranc

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

What is your major symptom? _____

When was the first time you noticed this problem?_____

How did it originally occur?_____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

If yes, when and how_____

How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ____

How long does it last? All Day _____ Few Hours _____ Minutes_____

Any days lost from work? Yes _____ No _____ If yes, how many _____

Are there any other conditions or symptoms related to your major symptom? Yes _____ No _____.

If yes, describe _____

Are there other unrelated health problems? Yes _____ No _____. If yes, describe_____

_____

Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

Burning _____ Stabbing_____ Other_____

Is there anything you can do to relieve the problem? Yes ___ No ___.

If yes, describe _____. If no, what have you tried that has not helped? _____

What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending_____

Lifting _____ Twisting _____ Other _____

Have you had any broken bones? Yes ____ No ____. If yes, please list and give dates

_____

List any surgeries, major accidents or serious illnesses you have had other than those that might not be mentioned above: _____

_____

To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past presently? Yes ____ No ____. If yes, please explain _____

_____

Have you had the same or similar condition before? Yes _____ No _____ If yes, please explain

_____

Do you have a history of stroke or hypertension? Yes _____ No _____

Please list all medications you are currently taking: _____

_____

Have you ever been to a chiropractor before? Yes _____ No _____. If yes, how long has it been since your last adjustment? _____

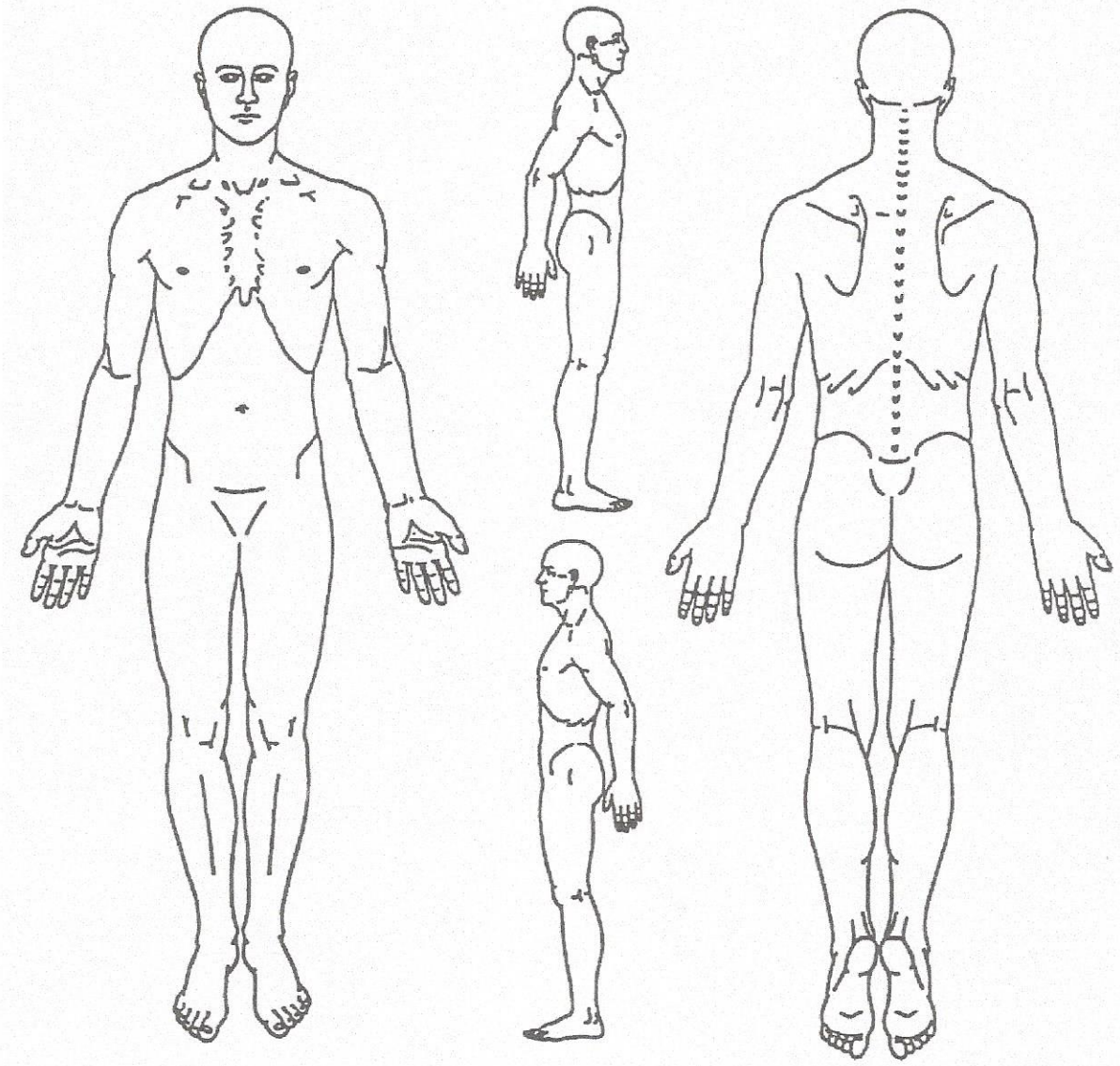
WOMEN ONLY: Are you pregnant or is there a chance you could be pregnant?

Yes _____ No _____Unsure _____

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

Gatlin Chiropractic and Wellness
Authorization for the Release of Medical Records

Patient Name:_____ Date of Birth:_____
(list maiden name or other names used)

I hereby request and authorize:

Gatlin Chiropractic and Wellness
1800 St. John Ave.
Dyersburg, TN 38024
Phone (731) 288-9628 Fax (731) 288-9653

_____**To Disclose information to:** _____**To Receive Information from:**

Provider:_____
Address:_____
City/State/Zip_____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____Other, specify:
_____

Purpose for disclosure:

_____ Treatment, Payment OR _____ Other (Specify)_____

This authorization will be effective for 1 year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____Date:_____
Signature of Patient

OR

_____Date:_____
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Gatlin Chiropractic and Wellness Center
1800 St. John Ave
Dyersburg,TN 38024
(731) 288-9628

Please read and sign this page if you do NOT want us to take x-rays.

Refusal of X-Ray

I, (Name) _____ have hereby been advised after a complete history and exam have been completed, that an x-ray analysis is necessary to properly and thoroughly treat my condition(s).

This X-ray analysis is needed to rule out the possibility of fractures, tumors, and other structural or biomechanical problems, which might complicate my condition and perhaps make treatment contraindicated.

After the importance and reasons for x-ray analysis have been explained, I do hereby refuse to have any x-rays taken at this time, and opt to continue with treatment without an x-ray examination. I fully understand the consequences of this decision and take full responsibility for this refusal.

The reason(s) I refuse to have an X-ray examination is as follows:

- ☐ I have had an x-ray analysis done within the past 6 months.
- ☐ I am currently pregnant or trying to get pregnant
- ☐ Other:_____
  _____
  _____
  _____
  _____

Signature_____Date_____

GATLIN CHIROPRACTIC AND WELLNESS PATIENT POLICY

SCHEDULING

All appointments during regular hours must be scheduled so as to reduce waiting time for you and others. You are free to stop in at anytime; however, you will have to wait until all previously scheduled patients are seen. You will be fit into the schedule as soon as possible.

PAYMENT

Payment is expected in full at time of services rendered. This includes all co-payments. For your convenience we accept Cash, Checks, MasterCard, Visa, American Express and Discover. Payments on your deductible will be made by paying per visit until the deductible is met. Should you discontinue care for any reason; any outstanding balances will become immediately due and payable in full by you. Overdue accounts will be charged interest and you are responsible for all or any collection and attorney fees.

PATIENTS WITHOUT INSURANCE

If you do not have insurance or have insurance with limited coverage, we do have several plans so those patients may receive care without undue financial difficulty. Please see our financial policy or ask the front desk about your payment and time of service discounts.

GROUP INSURANCE

We attempt to take out as much of the "insurance hassle" as possible for you. Our office will verify your insurance coverage in an effort to help you determine chiropractic coverage under your current policy. However, all insurance companies have strict policies; they do not guarantee any coverage or explanation of benefits. It is the responsibility of the patient to contact their insurance if there is a discrepancy or error in your benefits processing. You are always responsible for the portion of your bill that the insurance may not cover and for your annual deductible and/or co-pay. Remember that your insurance coverage is a contract between you, your employer, and/or your insurance company. We also file secondary insurance carriers at our discretion.

MEDICARE

We currently do accept assignment from Medicare. The payment is usually sent directly to our office for payment of the services that Medicare will cover, which for chiropractors is *ONLY MANUAL MANIPULATION of the spine.* Medicare pays for 80% of the allowable fee once the annual deductible has been met. You are required to pay the deductible and remaining 20% as well as any non-covered services. *Non-covered services may include therapy, exams, and x-rays.* Our office completes and files the forms for Medicare at no charge. If you have a secondary insurance or medigap policy, it may or may not pick up part of the remaining fees. Please ask the front desk if you have questions.

PERSONAL INJURY/WORKERS COMP

Please notify our front desk immediately if you were involved in an accident or if an attorney is representing you. Please notify your auto insurance or attorney of your visit to our office immediately. Although you are ultimately responsible for your bill, we will, at our discretion, wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees or services are due immediately. We have the right to ask for payment in full at anytime during your care.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have questions with regards to any of our policies, please let us know.

I, the undersigned, have read and agree to the guidelines of this policy.

Patient/Guardian Signature_____**Date**_____

Gatlin Chiropractic and Wellness

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only to be obtained one time for all subsequent care given in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request was presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name _____ **Date** _____

I agree to allow Gatlin Chiropractic to send appointment reminders and/or medical records to the following email address _____ **and/or the following mobile phone number as a text message** _____**. Please list mobile carrier for appointment reminders** (AT&T, Verizon, Etc.) _____

Gatlin Chiropractic and Wellness

1800 ST JOHN AVENUE | DYERSBURG TN, 38024 | (731) 288-9628

Written Financial Policy

Thank you for choosing Gatlin Chiropractic and Wellness. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash/check, Visa®, MasterCard®, American Express® or Discover Card®

  We offer a 25 to 40% courtesy accounting adjustment to patients who pay for their treatment with Cash/check/debit or Credit Card (including CareCredit) prior to completion of care.

- Convenient Monthly Payment Plans[1] from CareCredit
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Gatlin Chiropractic and Wellness requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

We also offer in-house financing. We charge 5% interest on all past due accounts.

For patients with insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Gatlin Chiropractic and Wellness charges $20 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.