DIXON CENTER OF CHIROPRACTIC

HARPETH VALLEY HEALTH CENTER

PATIENT INFORMATION

Please provide the information below in full and present your driver license and insurance card (if applicable).

Have you been to our office before? ☐ Yes ☐ No If Yes, when? _____

Have you ever received chiropractic care? ☐ Yes ☐ No

How did you find out about our office? ☐ Referral_____ ☐ Other_____

Full Legal Name: _____ **Preferred Name:** _____

DOB: _____/_____/_____ **SSN:** _____-_____-_____ **Cell/Home Phone:** _____

Address: _____ **City:** _____ **State:**_____ **Zip:**_____

Employer: _____ **Occupation:** _____ **Office Phone:** _____

Sex: _____ **Pronouns:** _____

Spouse Name:_____ **Employer:**_____**Occupation:**_____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Preferred Contact Number: ☐ Cell ☐ Home ☐ Work | Alt. number:_____

Email address: _____

How would you like to be reminded about your appointment?

☐ Text ☐ Email ☐ Cell ☐ Work ☐ Home ☐ None

PROVIDER & PHARMACY INFORMATION

Primary Care Physician: _____ **Phone #**:_____City/State:_____

Preferred Pharmacy: _____ **Phone #**:_____

Current Medications, Supplements, Vitamins, & Dosages:_____

_____

PERSONAL & MEDICAL HISTORY

What are you being seen for today? _____

How long have you had symptoms? _____

What are your symptoms? _____

What makes your symptoms worse? _____

PERSONAL & MEDICAL HISTORY, CONT'D

What makes your symptoms better? _____

What previous treatment(s) have you had? _____

What may have caused your symptoms? _____

Are you pregnant? ☐ Yes ☐ No *If yes, how many weeks pregnant?* _____

Please list all known allergic reactions: drugs, food, chemicals, or environmental: _____

_____

Do you smoke currently or have you smoked in the past? ☐ Yes ☐ No *If yes, please explain*.

_____

Do you drink alcohol? ☐ Yes ☐ No *If yes, please explain*. _____

Do you have a pacemaker? ☐ Yes ☐ No

Have you been diagnosed with heart disease, heart attack, stroke, or vascular disease? ☐ Yes ☐ No

RECENT ACCIDENT HISTORY: ☐ Job ☐ Auto ☐ Other _____ Date: _____

☐ Job ☐ Auto ☐ Other _____ Date: _____

RECENT SURGICAL HISTORY:

Procedure: _____ Date: _____ Doctor: _____

Procedure: _____ Date: _____ Doctor: _____

Please indicate any medical conditions that apply to yourself or family in the chart below.

Self	**Mother** ☐ Living ☐ Deceased	**Father** ☐ Living ☐ Deceased
☐_____	☐_____	☐_____
☐_____	☐_____	☐_____
☐_____	☐_____	☐_____
☐_____	☐_____	☐_____
☐_____	☐_____	☐_____

PREVENTION & SCREENING HISTORY

PROCEDURE	YEAR	PROCEDURE	YEAR	PROCEDURE	YEAR
Cholesterol Check		Physical Exam		Bone Density Test	
Colonoscopy		Pneumonia Vaccine		Mammogram	
Diabetes Check		Tetanus Shot		Pap Smear	
Flu Vaccine		Vision Test		Prostate Exam	
COVID Vaccine		Dental Exam		Lung Screening	

ALLERGY SURVEY

It is very common for insurance companies to cover allergy testing. If you are interested in finding out what you might be allergic to we can verify your insurance to see what your coverage will be. Would you like us to verify your insurance to see if you have coverage? ❑**YES** ❑**NO**

Have you ever had a sever reaction to a bee sting: (i.e. swelling in the face/throat, difficulty breathing, or had to go to the emergency room)? ❑YES ❑NO

Do you suffer from allergies? If yes, list symptoms:_____ ❑YES ❑NO

_____

Do you take any allergy meds to relieve symptoms? ❑YES ❑NO

Do you get chronic infections? If yes, list:_____ ❑YES ❑NO

Do you have a chronic cough or wheezing? ❑YES ❑NO

Do you have any pets? ❑YES ❑NO

Do you have eczema or rashes? ❑YES ❑NO

Do you have any form of pain or discomfort after eating? ❑YES ❑NO

Do you have breathing problems? ❑YES ❑NO | If yes, what kind? ❑*Asthma* ❑*COPD* ❑*Short Breath*

What time of year are your symptoms worse? ❑Winter ❑Spring ❑Summer ❑Fall ❑All Year

FINANCIAL RESPONSIBILITY

It is your responsibility to keep our office updated with your correct insurance information. All charges not covered by your plan are your responsibility. Payment is required at the time of service. According to your insurance, you are responsible for any and all co-payments, deductibles, and coinsurances. Standard rates will apply to self-pay patients unless the patient enrolls with a Direct Primary Care Membership or prepaid plan in advance, which may entitle patients to cash discounts or payment options. Bills unpaid for more than 90 days may be turned over to a collection agency unless other arrangements have been made. There is a service fee of $25 for returned checks. If you are having trouble paying your bill, please disucss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent you from receiving the care that you need.

If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment. We require a 24-hour notice for cancelling appointments. A $25 fee will be charged for missed appointments with our medical and massage therapy appointments, this fee does not apply to chiropractic appointments.

Payment is due at the time of service unless prior arrangements have been made.

I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I agree to pay all balances over 90 days from the original due date, as well as court costs and resonable collection/attorney's fees, with or without suit, incurred in collecting any past due balance. I certify that the information I am providing is correct to the best of my knowledge. I will not hold my doctor, provider, or any other staff member responsible for errors that I may have made in completion of this form.

I will be responsible for all copay, deductible, or coinsurance that may apply per my insurance company. If I am self-pay, I am responsible for the pre-determined self-pay fees. (name of financially responsible party if patient is under 18)

Name: _____ _____ _____

Printed Name **Signature** **Date**

211 & 213 Old Hickory Blvd • Bellevue, TN 37221 • Ph: 615-646-1003 • Fax: 615-646-5686
DixonCenter.com • HarpethValleyHealth.com

CONSENT TO TREAT & INFORMED CONSENT

I hereby authorize Dixon Center or Harpeth Valley Heath Center, and whomever may be designated as assistants, to administer chiropractic treatment, medical treatment, or massage therapy, as they deem medically necessary.

Chiropractic Services Informed Consent

Although extremely rare, there is a reported association between chiropractic adjustments and cervical arterial dissections that could lead to strokes.

Medical Services Informed Consent

Medical procedures and associated potential risks are explained to patients prior to being performed. I have the opportunity to ask any questions. I am aware that in the practice of medicine individual results may vary.

If patient under 18 years old, name of parent/legal guardian: _____

Address:_____ DOB:_____ Contact #: _____

Relationship:_____ Signature:_____

Please note for massage therapy, patient's 16 years of age or under must have a parent or legal guardian present in the room during the massage.

If a minor should be seen without being accompanied by an adult, a letter must be given to the staff, giving permission for care prior to the patient seeking treatment by any provider in our facility.

Patient/Legal Guardian Signature: _____ Date: _____

HIPAA PRIVACY PRACTICES NOTICE & DISCLOSURE & AUTHORIZED PERSON

1. Your health care provider and members of the 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 you.
2. You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization at any time. Your recovaction request must be in writing and mailed to our office at the address below. We will not be able to honor your revocation request if we have already released your health information before we receive your request. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.
3. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
4. Ultimately, we want to protect you and your health information as enforced by the Department of Health & Human Services. Should you have concerns, please contact us in writing at the address below.

By initialing here, _____, I acknowledge that I have received a copy of this authorization, the Notice of Privacy Practices AND I authorize you to use/disclose my health information in the manner described above.

I hereby authorize Dixon Center/Harpeth Valley Health Center to disclose my protected health information to:

Name: _____Relation: _____ Telephone Number: _____

The following information may be disclosed to the above-mentioned name(s):

❑ All Information ❑ Results Only ❑Appointment Status

DIXON CENTER DISCLOSURE OF FINANCIAL INTEREST

TN law and federal Medicare regulations require physicians, doctors of chiropractic, and other health care providers to make certain disclosures to patients when they refer a patient to a facility in which the provider has significant financial interest. Andrew Dixon, D.C. is an investor and percentage owner in Harpeth Valley Health, and is also an investor and percentage owner in the Dixon Center, to which you (or the patient for whom you are the legal representative) are being referred from Harpeth Valley Health for chiropractic treatment/therapy. Please be aware you are not required to utilize the Dixon Center for these services. Patients have the right to be treated at another health care facility of their choice. If you would like to utilize the services of an alternate health care facility, please contact Harpeth Valley Health immediately.

ACKNOWLEDGEMENT OF RECEIPT

By signing below, you or your legal representative, acknowledge you have received, read and understand this information (verbally and in writing) in advance of the date of your treatment.

_____

Signed Date

HARPETH VALLEY HEALTH DISCLOSURE OF FINANCIAL INTEREST

TN law and federal Medicare regulations require physicians, doctors of chiropractic, and other health care providers to make certain disclosures to patients when they refer a patient to a facility in which the provider has significant financial interest. Andrew Dixon, D.C. is an investor and percentage owner in Dixon Center, and is also an investor and percentage owner in Harpeth Valley Health, to which you (or the patient for whom you are the legal representative) are being referred from Dixon Center for medical treatment/therapy. Please be aware you are not required to utilize the Harpeth Valley Health for these services. Patients have the right to be treated at another health care facility of their choice. If you would like to utilize the services of an alternate health care facility, please contact Dixon Center immediately.

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Signed Date