Tellor Chiropractic

Date______________________________________

E-Mail Address___________________________________

1. REQUIRED FOR YOUR CASE HISTORY FILE:

Name_____________________________________ S.S. #________________________________

Address____________________________City_______________State___Zip______________

Telephone (   ) ______________________ Age ______ Birthdate ________________________

Sex_____ Marital Status (circle one) M S W D No. of Children__________

Occupation______________________________Employer______________________________

Work Telephone (   )______________________ Spouse's Name________________________

Person Responsible For This Account ____

Why Did You Choose This Office? ____

Major Complaints and Symptoms____

When Did You First Notice This? ____

Has This Ever Happened Before? ______________ When? _____________________________

Current medications: ____

Allergies: ____

Height___________ Weight__________

Smoking Status ______________________

FEMALE PATIENTS: ARE YOU PREGNANT? __ YES __ NO

Other Comments: ____

____

Name of Nearest Living Relative____

Address___________________________________ Phone (   ) ____________________________

2. INSURANCE INFORMATION: (PLEASE CHECK ONE OR MORE OF THE FOLLOWING)

AUTO ACCIDENT ☐ WORK INJURY ☐ GROUP HEALTH INSURANCE ☐

PRIVATE HEALTH INSURANCE ☐ MEDICARE ☐ CASH PAYMENT ☐

NAME OF INSURANCE CO.______________________________

GROUP#______________ POLICY #__________________ CLAIM #____________

ADDRESS______________________________________

INSURANCE PHONE (   ) _______________ AGENT__________________________

3. ACCIDENT-INJURY INFORMATION:

DATE__________________ TIME_________AM/PM POLICE REPORT MADE? _______

DESCRIPTION OF ACCIDENT/INJURY______________________________________

____

____

DRIVER'S LICENSE STATE/NUMBER__________________________________

PATIENT'S SIGNATURE______________________________________

AGREEMENT OF PAYMENT FOR SERVICES RENDERED

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE CARRIER AND ME. THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

SIGNED____WITNESSED__________________________

DATE____

TELLOR CHIROPRACTIC

CONSENT TO CHIROPRACTIC SERVICES

I, _______________________________, AUTHORIZE THE PERFORMANCE UPON MYSELF ANY OF THE FOLLOWING PROCEDURES AS DEEMED CLINICALLY NECESSARY:

-PHYSICAL EXAMINATION
-REGIONAL EXAMINATION
-CHIROPRACTIC ADJUSTMENTS
-PHYSICAL THERAPEUTIC MODALITIES
-BLOOD WORK
-URINE ANALYSIS
-OTHER LABORATORY SERVICES
-RADIOGRAPHIC EXAMINATION
-ADVANCED IMAGING

I UNDERSTAND THERE ARE CHARGES FOR THESE SERVICES AND SPECIFIC CHARGES WILL BE EXPLAINED TO ME UPON REQUEST.

THESE TESTS ARE TO BE PERFORMED BY DR. MATTHEW J TELLOR.

I ALSO CONSENT TO THE PERFORMANCE OF OTHER DIAGNOSTIC AND THERAPEUTIC PROCEDURES IN ADDITION TO OR DIFFERENT FROM THOSE STATED ABOVE, WHETHER OR NOT ARISING FROM PRESENTLY UNFORESEEN CONDITIONS, THAT THE ABOVE NAMED DOCTOR MAY CONSIDER NECESSARY OR ADVISABLE IN THE COURSE OF MY HEALTH CARE. I UNDERSTAND THERE ARE FEES FOR THESE SERVICES AND I WILL BE CHARGED ACCORDINGLY. SPECIFIC CHARGES WILL BE EXPLAINED TO ME UPON REQUEST.

THE NATURE AND PURPOSE OF THE PROCEDURES, POSSIBLE ALTERNATIVES, THE RISKS INVOLVED, THE POSSIBLE CONSEQUENCES, AND THE POSSIBILITY OF COMPLICATIONS HAVE BEEN EXPLAINED TO ME BY THE ABOVE MENTIONED DOCTOR.

DATE: ______________________ SIGNED: ____

WITNESS: _______________________ RELATIONSHIP: _____________________________

FEMALE PATIENTS ONLY: THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT AND THAT DR. TELLOR HAS PERMISSION TO TAKE X-RAYS. ***IF YOU EVEN SUSPECT THAT YOU MIGHT BE PREGNANT, PLEASE INFORM THE DOCTOR. ***

DATE OF LAST MENSTRUAL PERIOD: ____________SIGNED:_______________________

PATIENT CONSENT FORM

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
- OBTAIN PAYMENT FORM THIRD-PARTY PAYERS.
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE BEEN INFORMED BY YOU OF YOUR *NOTICE OF PRIVACY PRACTICES* CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I HAVE BEEN GIVEN THE RIGHT TO REVIEW SUCH *NOTICE OF PRIVACY PRACTICES* PRIOR TO SIGNING THIS CONSENT. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS *NOTICE OF PRIVACY PRACTICES* FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS BELOW TO OBTAIN A CURRENT OF THE *NOTICE OF PRIVACY PRACTICES.*

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

PATIENT NAME: ____

SIGNATURE: ____

RELATIONSHIP TO PATIENT: ______________________________________

DATE: ______________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA"). I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
- OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND YOUR *NOTICE OF PRIVACY PRACTICES* CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE IT *NOTICE OF PRIVACY PRACTICES* FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS ABOVE THE OBTAIN A CURRENT COPY OF THE *NOTICE OF PRIVACY PRACTICES.*

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT NOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENT NAME: ______________________________

RELATIONSHIP TO PATIENT: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE:	INITIALS:	REASON:

SYMPTOMS

GENERAL	severe	mild	none
Allergy	☐	☐	☐
Chills	☐	☐	☐
Convulsions	☐	☐	☐
Dizziness	☐	☐	☐
Fainting	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Headache	☐	☐	☐
Loss of sleep	☐	☐	☐
Loss of weight	☐	☐	☐
Nervousness	☐	☐	☐
Neuralgia	☐	☐	☐
Numbness	☐	☐	☐
Sweats	☐	☐	☐
Wheezing	☐	☐	☐
Weakness in arms, legs	☐	☐	☐

MUSCLE AND JOINT	severe	mild	none
Backache	☐	☐	☐
Faulty posture	☐	☐	☐
Foot trouble	☐	☐	☐
Hernia	☐	☐	☐
Pain between shoulders	☐	☐	☐
Painful tailbone	☐	☐	☐
Spinal curvature	☐	☐	☐
Stiff neck	☐	☐	☐
Tremors	☐	☐	☐
Swollen joints	☐	☐	☐

CARDIO-VASCULAR	severe	mild	none
Hardening of arteries	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Pain over heart	☐	☐	☐
Paralytic stroke	☐	☐	☐
Poor circulation	☐	☐	☐
Previous stroke	☐	☐	☐
Rapid beating heart	☐	☐	☐
Slow beating heart	☐	☐	☐
Swelling of ankles	☐	☐	☐

SYMPTOMS

GASTRO-INTESTINAL	severe	mild	none
Belching or gas	☐	☐	☐
Colitis	☐	☐	☐
Colon trouble	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Difficult digestion	☐	☐	☐
Distention of abdomen	☐	☐	☐
Excessive hunger	☐	☐	☐
Gall bladder trouble	☐	☐	☐
Hemorrhoids	☐	☐	☐
Jaundice	☐	☐	☐
Liver trouble	☐	☐	☐
Nausea	☐	☐	☐
Pain over stomach	☐	☐	☐
Poor appetite	☐	☐	☐
Vomiting	☐	☐	☐
Vomiting of blood	☐	☐	☐

E.E.N.T.	severe	mild	none
Asthma	☐	☐	☐
Crossed eyes	☐	☐	☐
Deafness	☐	☐	☐
Dental decay	☐	☐	☐
Earache	☐	☐	☐
Ear discharge	☐	☐	☐
Ear noises	☐	☐	☐
Enlarged glands	☐	☐	☐
Enlarged thyroid	☐	☐	☐
Eye pain	☐	☐	☐
Failing vision	☐	☐	☐
Frequent colds	☐	☐	☐
Hay fever	☐	☐	☐
Hoarseness	☐	☐	☐
Gum trouble	☐	☐	☐
Nasal congestion	☐	☐	☐
Nose bleeds	☐	☐	☐
Near sightedness	☐	☐	☐
Sinus infection	☐	☐	☐
Sore throat	☐	☐	☐
Tonsillitis	☐	☐	☐

SYMPTOMS

RESPIRATORY	severe	mild	none
Chest pain	☐	☐	☐
Chronic cough	☐	☐	☐
Difficult breathing	☐	☐	☐
Spitting up blood	☐	☐	☐
Spitting up phlegm	☐	☐	☐

SKIN	severe	mild	none
Boils	☐	☐	☐
Bruises	☐	☐	☐
Dryness	☐	☐	☐
Hives or allergy	☐	☐	☐
Itching	☐	☐	☐
Sensitive skin	☐	☐	☐
Skin eruptions	☐	☐	☐
Varicose veins	☐	☐	☐

GENITO-URINARY	severe	mild	none
Bed wetting	☐	☐	☐
Blood in urine	☐	☐	☐
Frequent urination	☐	☐	☐
Inability to control urine	☐	☐	☐
Kidney infection	☐	☐	☐
Kidney stones	☐	☐	☐
Painful urination	☐	☐	☐
Prostate trouble	☐	☐	☐

FOR WOMEN ONLY	severe	mild	none
Premenstrual tension	☐	☐	☐
Congested breast	☐	☐	☐
Menstrual cramps	☐	☐	☐
Menstrual backache	☐	☐	☐
Excessive flow	☐	☐	☐
Hot flashes	☐	☐	☐
Irregular cycle	☐	☐	☐
Lumps in breast	☐	☐	☐
Menopausal symptoms	☐	☐	☐
Painful menstruation	☐	☐	☐
Vaginal discharge	☐	☐	☐
Are you pregnant?		Yes ☐	No ☐

NAME ______________________________