Murfreesboro Family Chiropractic Rehabilitation, PLLC.

Patient Information Form

Please Print

Patient Information

Full Name ______________________ **Date** ___/___/___

Language ______________ Race ☐ American Indian or Alaska Native ☐ Asian

Ethnicity ☐ Not Hispanic or Latino ☐ Black or African American ☐ White

☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander

Date of Birth ___/___/___ Sex: ☐ Male ☐ Female Social Security # ______________

Home Address ______________________________________

Street City State Zip Code

Preferred Method of Contact ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Letter

Home Phone ( ) ________ Work Phone ( ) ________ Mobile Phone ( ) ________

Home Email ______________________ Fax # ( ) ________

☐ Student ☐ Employed ☐ Unemployed

Employer/School ______________________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Full Name ______________________ Date of Birth ___/___/___

Spouse's Social Security # ______________ Spouse's Work Phone ( ) ________

Spouse's Employer ______________________________

Primary Care Physician Office # ( )

Were you referred by a patient? Yes No If yes, please list name ______________

Consent for Treatment

I request and consent to the performance of chiropractic, examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating doctors of chiropractic on staff and/or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening symptoms. 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 on the facts then known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize Preston Murfreesboro Family Chiropractic & Rehabilitation, PLLC to treat me.

I have read and understand the foregoing.

Signed ______________________ **Date** ___/___/___

Murfreesboro Family Chiropractic Rehabilitation, PLLC.

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Patient Name ______________________ **D.O.B.** __________

Emergency Information

Name ______________ Home Phone ( ) __________ Work Phone ( ) __________

Privacy

Receipt of Notice of Privacy Practices Written Acknowledgement (Please Initial)

_______ I was provided a Notice of Privacy Practices by M.F.C.R., PLLC to read and keep as my own.

_______ I declined a copy that was offered to me, but I am aware of my rights.

_______ I authorize the release of my medical or incidental information necessary to provide continuity of my (the patient's) medical care and to process my (the patient's) medical insurance.

My Protected Health Information may be disclosed to:

☐ Self Only

☐ Parent/Guardian __________

☐ Spouse/Partner __________

☐ Other __________

Financial Policy

(Please Initial all notices)

_______ I understand that I am financially responsible for any balance. Our office participates with all major health plans. We will file primary and secondary claims for you. All deductible and copays are your responsibility.

_______ If your plan requires a referral, it is your responsibility to obtain that referral prior to your visit.

_______ For any services rendered, I authorize the assignment of benefits (payments) from my insurance to come direction to Murfreesboro Family Chiropractic & Rehabilitation, PLLC.

Insurance

Do you have medical insurance?

☐ **Yes** Please provide a copy of card at time of service. Co-payment is required at time of service.

☐ **No** Payment is expected at time of service. We accept Cash, Check, Visa or Mastercard.

Signed ______________________ **Date** ___/___/___