Welcome to Our Office

Name: _____ Age: _____ Date: _____
Address: _____
Residence and Mailing City State Postal Code
Home Telephone ( ) _____ Work Phone ( ) _____
Male ___ Female ___ Social Security #_____ Birthdate_____
Employer's Name and Address_____
Single ___ Married ___ Divorced ___ Widowed ___ Spouse's Name _____
Of children ___ Email _____
Reason for consulting our office? _____
Who may we "Thank" for referring you to our office? _____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have no symptoms or complaints and are here for wellness services, please check here ___and skip to the back side of this form.

If you are experiencing pain, is it…

( ) Sharp
( ) Dull
( ) Comes & Goes
( ) Travels
( ) Constant

Since the problem started, it is…

( ) About the same
( ) Getting Better
( ) Getting Worse

What makes it worse? _____
_____

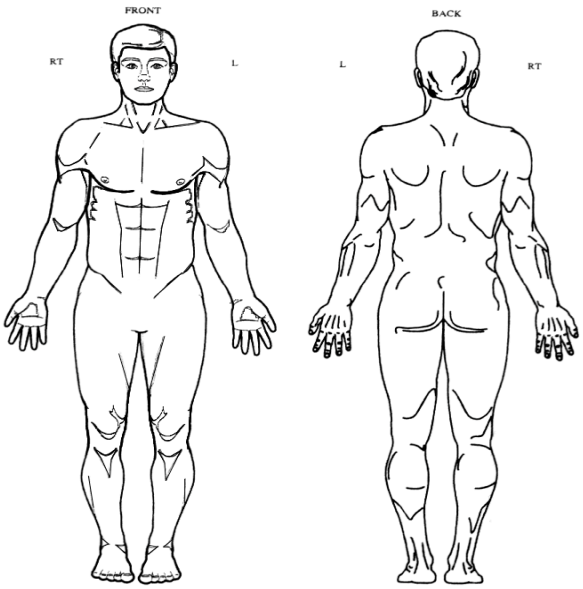
It interferes with…

( ) Work ( ) Sitting
( ) Sleep ( ) Hobbies
( ) Walking ( ) Leisure

Other Doctors seen for this problem:

Chiropractors_____
Medical Doctors_____
Other_____

Please "X" areas of discomfort and pain



Your Childhood Years

Research has shown that many of the health challenges that occur in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability. (Y= yes; N= no; ?= unsure)

Did you have any childhood illnesses? Y N ?

Did you have any serious falls as a child? Y N ?

Did you play youth sports? Y N ?

Did you take/use any drugs? Y N ?

Did you have any surgery? Y N ?

Have you fallen/jumped from a height over three feet? Y N ?

Were you involved in any car accidents as a child? Y N ?

Was there any prolonged use of medicine such as antibiotics or an inhaler? Y N ?

Did you suffer any other trauma? (Physical or Emotional) Y N ?

Were you vaccinated? Y N ?

As a child, were you under regular Chiropractic care? Y N ?

COMMENTS:_____

_____

ADULT- (18- Present)

Do/did you smoke? Yes No

Do/did you drink alcohol? Yes No

Have you been in any accidents? Yes No

Have you had any surgery? Yes No

Do/did you play any adult sports? Yes No

Do/did you participate in extreme sports? Yes No

On a scale of 1-10 describe your stress level:
(1= none/ 10= Extreme)
Occupational _____
Personal _____

On a scale of Poor, Good, or Excellent describe your:

Diet_____ Exercise_____ Sleep_____ General Health_____

Please check (√) all symptoms you have had, even if they do not seem related to your current problem:

	Headaches		Pins & Needles in legs		Fainting		Neck Pain
	Pins & Needles in arms		Loss of Smell		Back Pain		Loss of Balance
	Dizziness		Buzzing in Ears		Ringing in Ears		Nervousness
	Numbness in Fingers		Numbness in Toes		Loss of Taste		Upset Stomach
	Fatigue		Depression		Irritability		Tension
	Sleeping Problems		Stiff Neck		Cold Hands		Cold Feet
	Diarrhea		Constipation		Fever		Hot Flashes
	Cold Sweats		Sensitive Eyes		Problems Urinating		Heartburn
	Mood Swings		Menstrual Pain		Menstrual Irregularity		Ulcers

Please list all medications you are currently taking:_____

_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____

Signature **Date**

Total Body Healthcare

Dr. Edward Thomas
family chiropractor

1307 Central Court
Hermitage, TN 37076
(615) 678-8745
(615) 818-0758

The Chiropractic Office of

Dr. Edward Thomas, III

Patient Authorization regarding chiropractic care being provided in an "open adjusting"environment

It is the practice of this office to provide chiropractic care in an"open adjusting"environment."Open adjusting"involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff.This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings.These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an"incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting"environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.Your decision will have no adverse effect on your care from Dr. Edward Thomas, III or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____

_____

Name (printed) Signature
Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

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Dr. Edward Thomas, III

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Total Body Healthcare we may use or disclose personal and health related information about you in the following ways: *Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. *Your health care records as well as your billing records may be disclosed to another party,such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of services provided to you. *Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office. Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances: *If we provide health care services to you in an emergency. *If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so. *If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care. *If we are ordered by the courts or another appropriate agency. You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to redisclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to

your preferences. You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Edward Thomas, III. If you would like further information about our privacy policies and practices please contact: Dr. Edward Thomas, III. You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever. 3 This notice is effective as of .

This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Printed) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____

Personal Representative (Printed) Personal Representative Signature Date

Description of the authority to act on behalf of the patient.

Total Body Healthcare

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X-RAY AUTHORIZATION

This is to confirm that I have been advised by the doctor/staff that x-rays can be hazardous to an unborn child. At this time,to the best of my knowledge, I am not pregnant and consent to radiographic pictures.

Date of last menstrual period: _____

Signed: _____ Date: _____

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APPOINTMENT POLICY

Request an appointment by calling 615-678-8745. Please arrive on time for your appointment, or if you need to reschedule, allow us 24 hours notice so that we can open that time slot up for other patients. A $55.00 missed appointment fee may be charged to your account for frequently missing appointments without calling. We accept walk-in patients as well that will be worked into the schedule accordingly. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

FINANCIAL POLICY

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services including those not reimbursed by third-party payors. All payments are expected at the time of service, or at the end of each week. Patient balances may not exceed $150 AT ANY TIME. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 2% per month. Total Body Healthcare, Inc. is dedicated to keeping medical costs down for you, the consumer. As you know the purpose of insurance company is to make money for their owners. This id accomplished by denying as many claims as possible. HMO's and PPO's further restrict your ability to choose who you can go to and what services they can provide. Insurance is a privilege. Therefore when we accept insurance from you there are a few things you need to know. You are considered to be a cash patient until our office "qualifies" your coverage to determine the extent of benefit under your policy. All deductible payments MUST be made prior to insurance submittal. All co- payments are payable when service are rendered or at the end of each week. A $150 co- payment balance must not be exceeded at any time. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted. This office does not promise that an insurance company will reimburse you for usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement. Since we do not own your policy and occasionally experience difficulty in collecting from he carrier, we may ask for you assistance in collecting payment from your insurance company. Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions about your health care or any of our policies, please let us know. We look forward to your referrals and to a doctor –patient relationship that works for our mutual benefit. I herby accept responsibility for charges and agree to reimburse Total Body Healthcare, Inc. for reasonable attorney's fees and collection costs in the event it becomes necessary to collect monies owed Total Body Healthcare, Inc.

Signed _____ Date_____

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Signed: _____ Date: _____