Live Well Chiropractic
131 Maple Row Blvd., Ste. D400, Hendersonville, TN 37075
(615) 431-2397

INFORMED PATIENT CONSENT AND RELEASE

I hereby authorize the doctor/provider (Live Well Chiropractic) to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, Physical Therapy, Massage Therapy, Acupuncture, and/or Nutritional Counseling, and I give authorization for these procedures to be performed. Also, I authorize the doctor/provider to consult with other professionals concerning my care and treatment.

I authorize my doctor to submit my x-rays for radiological interpretation to any doctor deemed qualified by my doctor. I understand that I will receive a statement from the radiologist's office (Douglas Gregerson, DC, DACBR). I authorize the release of medical information for billing of my insurance if applicable; and I hereby consent to the release of any medical information necessary to process this claim and to request that payment of insurance benefits be made either to me or to my doctor if he/she accepts assignment.

I understand that Live Well Chiropractic, its doctors, and staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination, or doctor's care, I understand that a guarantee of improvement or complete recovery cannot be made, and it is even possible that no change will occur. I further understand that in the practice of chiropractic, physical therapy, massage therapy, acupuncture, and nutritional counseling there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions and reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the procedure(s) which the doctor/provider feels at the time is in my best interest.

Patients have the right to refuse treatment but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Having read this document fully, I give my full consent to the doctor/provider to render treatment on me or to the minor for whom I am legally responsible, by a health care provider of Live Well Chiropractic. I have been informed by Dr. Penwell and his office staff of the type of treatment to be provided, and any known risks of that treatment. I hereby consent to and request treatment as my voluntary act.

Printed Name of Individual	Signature of Individual
Signature of Legal Representative	Relationship
Date Signed	Witness

Revised 04/06/22

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BILLING POLICIES

I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you, based upon the charges submitted for products and services rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me (the patient). Furthermore, I understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. The facility will prepare any necessary reports and forms to assist me in making collections from the insurance company and any amount authorized to be paid directly to the facility will be credited to my account upon receipt. I also understand that if I suspend or terminate my care and understand and agree that I will be charged $25.00 for balances 30 days old if no payment is received within 10 days of receipt of my statement. I further understand that any balance over 90 days may be turned over to a collection agency or attorney. I agree to be responsible for all reasonable fees necessary for the collection of the delinquent amount including, but not limited to, collection agency fees up to 50% of the balance due, costs, and reasonable attorney fees.

Medicare Patients understand that Medicare does not cover radiologist services, but that supplemental insurance may, and supplemental insurance will be billed if applicable. Whether or not I am a Medicare patient, I understand and agree that the amount paid to the doctor for x-rays is for examination only, and not for the x-ray film itself. Accordingly, I agree that the x-ray negatives will remain the property of the facility, where they may be viewed by me or an authorized representative at any time. Finally, I agree that if a copy of my x-ray or x-rays is needed, I will pay a reasonable charge for the original negative or a copy, if I require it to be removed from my doctor's office.

Printed Name of Individual	Signature of Individual
Signature of Legal Representative	Relationship
Date Signed	Witness

Revised 04/06/22

Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Live Well Chiropractic *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____

(Print) Date

Signature of Personal Representative: _____

Relationship to Patient: _____Drivers License Number: _____State____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the *Notice of Privacy Practices*:

Attempt 1: _____Date _____ Staff: _____

Attempt 2: _____Date _____ Staff: _____

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize Live Well Chiropractic disclosure of my individually identifiable health information to the individuals listed:

1. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ____/____/____
- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Midwest Healthcare Center, SC in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Live Well Chiropractic until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

_____ _____

Signature of Personal Representative Date

Relationship to Patient: _____ Drivers License Number: _____ State____

Live Well Chiropractic
131 Maple Row Blvd., Ste. D400, Hendersonville, TN 37075
(615) 431-2397 Privacy Officer: Dr. Zac Penwell

Notice of Privacy Practices
Your Rights & Our Responsibilities

Effective: May 1st, 2022

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical health condition and related health care services. **Please review it carefully.**

Your Rights

This section explains your rights and how we are required to acknowledge them.

Request a copy of your paper or electronic medical record

- Upon request, we will supply you with a Request to Inspect or Copy Patient Information form. The form contains the name of our privacy official and his/her contact information.
- We will provide a copy or a summary of your health information, usually within 60 days of your request. We may charge a reasonable fee for cost of labor, postage, and supplies associated with your request (in compliance with state and federal laws regarding medical records request). We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program.

Receive a paper copy of this Notice of Privacy Practices

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Request correction of your medical record

- Upon request, we will supply you with the Request to Amend Patient Record form.
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request; our response will be in writing within 60 days

Request confidential or alternative communication

- Request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail.
- Request alternative communications; you must make your request in writing to our privacy office, a Request for Alternative Communications form will be provided upon request.

Ask us to limit the information we share

- List individuals who are involved in your care and as a result PHI can be disclosed; a PHI Use and Disclosure Authorization form will be provided, upon request.
- Restrict payer access. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You must make your request in writing to our privacy office; a Request to Restrict Disclosure to Health Plan form will be provided upon request.

Receive a list of those with whom we've shared your information

- You have the right to request an accounting of disclosures of your health information made by us. We are not required to list certain disclosures, including: disclosures made for treatment, payment, and health care operations purposes (TPO).
- You must submit your request in writing, a Request for Accounting of Disclosure of PHI form will be provided upon request. The first accounting of disclosures (Response to Request for Disclosure form) you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures.

Right to Receive Notice of a Breach

- We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach.

File a complaint if you believe your privacy rights have been violated

- If you believe your privacy rights have been violated, you may file a complaint with our privacy officer; we will supply you with a Complaint Form upon request (form contains the name of our privacy official and his/her contact information).

- All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visitingwww.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

This section addresses your choices regarding health information we may share.

You have the choice to tell us to:

- Share information with your family and friends about your condition.
- Disclose your health information when disaster relief organizations seek your health information to coordinate your care. Note: If you are unable to communicate your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.

We will never share your information in these cases without permission:

- Marketing purposes. We are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.
- Sale of your information. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization

Our Uses and Disclosures

This section lists ways in which we may use your information and disclose it.

Healthcare Treatment

- Plan your care and treatment, including preauthorization and precertification.
- Communicate with other providers such as referring physicians.
- Billing and coordination of payment for services with health plan administrator.
- Quality and outcome assessments for improvement of care we render.
- Contracted third-party business associates for services, such as answering services, transcriptionists, record keeping, consultants, and legal counsel.
- Communicate to you via newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Public Health and Safety Issues

- Product recalls
- Reporting suspected abuse, neglect or domestic violence in compliance with state and federal laws.

Compliance with the law

- Department of Health and Human Services investigations for complying with federal privacy laws.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions such as a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law.
- If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

Our Responsibilities

- If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information.
- We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach.
- To provide you with notice, such as this Notice of Privacy Practices and abide by the terms of our most current Notice of Privacy Practices;
- Notify you if we are unable to agree to a requested restriction.

Changes to the Terms of this Notice

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain. Should our information practices change; a revised Notice of Privacy Practices will be available upon request. We will not use or disclose your health information without your authorization, except as described in our most current Notice of Privacy Practices. If you have limited proficiency in English, you may request a Notice of Privacy Practices in English.

We have transitioned to an open adjusting format. You understand and accept that any conversation may be overheard. A private room is available upon request for sensitive conversations or treatment.

Live Well Chiropractic

Name: _____ Patient #: _____ Age: _____ Date: _____

Address _____
Residence and Mailing City State Zip Code

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

E-Mail Address _____ Male _____ Female _____

Social Security # _____ Birth date _____ # of Children _____

Occupation /Employer's Name & Address _____

(Marital Status) S___ M___ D___ W___ Emergency Contact _____

Reason for consulting our office _____

Whom may we Thank for referring you to our office? _____

Name of your primary physician _____

YOUR HEALTH PROFILE

	YES	NO		YES	NO
Do / did you smoke?	❑	❑	Do / did you play any adult sports?	❑	❑
Do / did you drink alcohol?	❑	❑	Do / did you participate in extreme sports?	❑	❑
Have you been in any accidents?	❑	❑	Were you vaccinated for COVID-19?	❑	❑
Have you had any surgery?	❑	❑	Did you have any childhood illnesses or injuries?	❑	❑

If you answered **YES** to any of the above questions, please explain on lines below.

_____

_____

_____

_____

_____

Please check (❑) all that apply

- ❑ Anorexia
- ❑ Back pain
- ❑ Blue Extremities
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Buzzing in Ears
- ❑ Cancer
- ❑ Cold Feet
- ❑ Cold Hands
- ❑ Cold Sweats
- ❑ Constipation
- ❑ Depression
- ❑ Diarrhea
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever
- ❑ Fractures
- ❑ Glaucoma
- ❑ Gout
- ❑ Headaches
- ❑ Heartburn
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Hot Flashes
- ❑ Irritability
- ❑ Kidney Disease
- ❑ Lights bother eyes
- ❑ Loss of balance
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Measles
- ❑ Menstrual Irregularity
- ❑ Menstrual Pain
- ❑ Migraine Headaches
- ❑ Mononucleosis
- ❑ Mood Swings
- ❑ Mumps
- ❑ Neck pain
- ❑ Neck stiff
- ❑ Nervousness
- ❑ Numbness in fingers
- ❑ Numbness in toes
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Phobias
- ❑ Pinched Nerve
- ❑ Pins and needles in arms
- ❑ Pins and needles in legs
- ❑ Polio
- ❑ Problems Urinating
- ❑ Prosthesis
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Ringing in Ears
- ❑ Scarlet Fever
- ❑ Sleeping problems
- ❑ Stomach Upset
- ❑ Swollen Extremities
- ❑ Tension
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors, Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Whooping Cough

CONTINUED ON BACK

Chart#_____

Family Health History:

List any past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of.

Mother_____

Father_____

Brothers_____

Sisters_____

Are you pregnant? ❑ YES ❑ NO

Date of Last: Physical Exam _____ OB-GYN Exam _____ Spinal Exam _____

Spinal X-Ray _____ Chest X-Ray _____ MRI, CT-Scan, Bone Scan_____

List any medications you are taking_____

_____

_____

_____

_____

Other Doctors seen for this problem (Please list)

❑ Chiropractor_____

❑ Medical Doctor_____

❑ Other_____

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

Diet_____ Exercise_____ Sleep_____ General Health _____

Work Activity ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

On a scale of 1-10 describe your stress level:
(1=none / 10=extreme) Occupational_____ Personal_____

The statements made on this form are accurate to the best of my recollection. _____ _____
Signature Date

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History of Present Illness

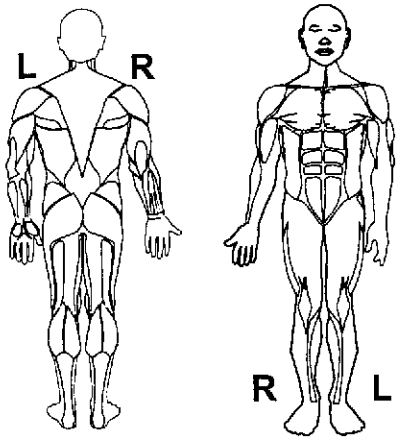
Patient Name _____ # _____ Date _____

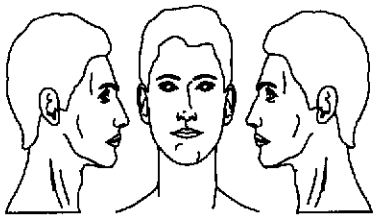
Chief Complaint _____

RIGHT SIDE	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Stinging	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Head																								
Neck																								
Upr Back																								
Mid Back																								
Low Back																								
Shoulder																								
Elbow																								
Wrist																								
Hand																								
Hip																								
Knee																								
Ankle																								
Foot																								

LEFT SIDE	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Stinging	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Head																								
Neck																								
Upr Back																								
Mid Back																								
Low Back																								
Shoulder																								
Elbow																								
Wrist																								
Hand																								
Hip																								
Knee																								
Ankle																								
Foot																								

Mark Pain Location





Symptom Start Date _____ **How Did it Start:** __ Gradual __ Sudden (explain)_____

Are You Getting? __ Better __ Worse __ Same **When Is It Worse?** __ Morning __ Afternoon __ Evening __ Night

If Your Complaint Includes Pain, Is It Aggravated By?
__Coughing __Sneezing __Reaching __Lifting __ Bending __Sitting __ Standing __Walking __Straining At Stool
__Neck Movement __Other _____

If Your Complaint Includes Pain, Is It Relieved By?
__Nothing __Rest __Ice __Heat __Stretching __Exercise __Sitting __ Standing __Other_____

Have You Noticed A Change In? __Bowel function __Bladder Function __Sexual function __NO

Since Your Last Exam, Have You Had Any: __Accidents __ Illnesses __ Exam or Treatments Elsewhere __ NO
__Other _____