

HERNDON CHIROPRACTIC CLINIC
2087 Cliff Gookin Blvd, Tupelo, MS 38801
662-842-8413 Fax 662-844-3292

PATIENT APPLICATION

DATE _____ FIRST NAME _____ LAST NAME _____ BIRTHDAY _____
E-MAIL _____ E-MAIL WILL NOT BE SHARED-USED ONLY FOR OFFICE ANNOUNCEMENTS
ADDRESS _____ CITY _____ STATE _____ ZIP _____
CELL _____ HOME # _____ SOCIAL SECURITY _____
OCCUPATION _____ EMPLOYER _____
MARTIAL STATUS _____

SPOUSE INFO

FIRST NAME _____ CELL # _____
OCCUPATION _____ EMPLOYER _____

Family Physician _____
Person to contact in case of emergency _____ Phone # _____
Have you ever been under Chiropractic Care? ___Y___N If yes Who? _____
Serious Illness? _____ When? _____
Infectious Diseases: _____ When? _____
Do you have a pacemaker: ___Y___N Have you ever had a spinal fusion, hip replacement or knee replacement? ___Y___N
Are you taking medications for: ___Pain Killers___ ___Insulin___ ___Blood Pressure___ ___Muscle Relaxers___ ___Birth Control___ ___Depression___

ACCOUNT INFORMATION

- ☐ INSURANCE (FILL OUT *INSURANCE INFORMATION* BLOCK)
☐ MEDICARE
☐ VETERAN
☐ AUTOMOBILE ACCIDENT (FILL OUT *AUTO ACCIDENT/WORKER'S COMP INFORMATION* BLOCK)
☐ WORKER'S COMP (FILL OUT *AUTO ACCIDENT/WORKER'S COMP INFORMATION* BLOCK)
☐ CASH I understand that all charges incurred at this clinic are my responsibility for payment.

Print name _____ Sign _____ Date _____

FEMALES: To the best of my knowledge, I am NOT pregnant, and Dr. Herndon has my permission to x-ray me for diagnostic interpretation.

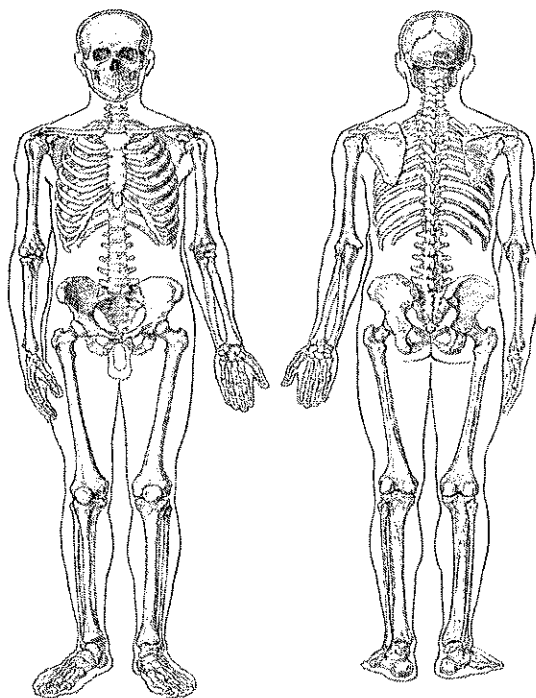
Initial: _____ Date: _____

COMMUNICATIONS REGARDING ACCOUNT

Until my account is settled, I give my direct consent to receive communications regarding my account from any service and any collectors of my account, through various means such as any cell, landline, or text number that I provide; any email address I provide; auto dial-er system; voicemail messages; and other forms of communications.

Initial: _____ Date: _____

Please mark with a number 1-7 each place that hurts:



Circle the severity (0=No Pain to 10=Very Severe Pain) and Frequency of pain.

1.-----0	1	2	3	4	5	6	7	8	9	10	On/Off	Occasional	Constant	Frequent
2.-----0	1	2	3	4	5	6	7	8	9	10	On/Off	Occasional	Constant	Frequent
3.-----0	1	2	3	4	5	6	7	8	9	10	On/Off	Occasional	Constant	Frequent
4.-----0	1	2	3	4	5	6	7	8	9	10	On/Off	Occasional	Constant	Frequent
5.-----0	1	2	3	4	5	6	7	8	9	10	On/Off	Occasional	Constant	Frequent
6.-----0	1	2	3	4	5	6	7	8	9	10	On/Off	Occasional	Constant	Frequent
7.-----0	1	2	3	4	5	6	7	8	9	10	On/Off	Occasional	Constant	Frequent

Circle the symptoms of each area.

1.-----Sharp	/	Dull	/	Burning	/	Aching	/	Throbbing	/	Stinging	/	Pulling	/	Shooting	/	Stabbing
2.-----Sharp	/	Dull	/	Burning	/	Aching	/	Throbbing	/	Stinging	/	Pulling	/	Shooting	/	Stabbing
3.-----Sharp	/	Dull	/	Burning	/	Aching	/	Throbbing	/	Stinging	/	Pulling	/	Shooting	/	Stabbing
4.-----Sharp	/	Dull	/	Burning	/	Aching	/	Throbbing	/	Stinging	/	Pulling	/	Shooting	/	Stabbing
5.-----Sharp	/	Dull	/	Burning	/	Aching	/	Throbbing	/	Stinging	/	Pulling	/	Shooting	/	Stabbing
6.-----Sharp	/	Dull	/	Burning	/	Aching	/	Throbbing	/	Stinging	/	Pulling	/	Shooting	/	Stabbing
7.-----Sharp	/	Dull	/	Burning	/	Aching	/	Throbbing	/	Stinging	/	Pulling	/	Shooting	/	Stabbing

Do any of the areas of pain radiate? ____Y____N if so, where_____

Circle the things that make your problems worse.

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

Is this condition interfering with ____Work____Sleep____Daily Routine____Recreation?

INSURANCE INFORMATION

Ins. Company _____ Ins Phone # _____ Fax # _____
ID# _____ Group # _____
Policy Holder Name _____ Policy Holder DOB _____
Policy Holder Employment _____ Policy Holder SSN _____

AUTO ACCIDENT/WORKER'S COMPENSATION INFORMATION

Insurance/Attorney Name _____ Phone# _____
Case# _____ Date of Injury _____ Case Adjusters Name _____
Explain in detail how your accident happened: _____

I hereby affirm that I have reported this injury to my Employer/Auto Insurance/Attorney/Workman's Compensation Insurance, and they have agreed to and acknowledges medical coverage and authorization for treatment from Herndon Chiropractic Clinic and said treatments by this office will be covered by Workman's Compensation Insurance/Auto Insurance.

Print Name _____ Sign Name _____

INFORMATION ABOUT YOU, YOUR APPOINTMENT TIME, OR YOUR EXAMINATION RESULTS CANNOT BE DISCLOSED TO PERSONS OTHER THAN YOU, UNLESS YOU AUTHORIZE US TO DO SO. IF YOU WISH FOR USE TO DISCLOSE INFORMATION TO PERSONS OTHER THAN YOU, PLEASE INDICATE WHO THEY ARE BELOW.

NAME	RELATIONSHIP	TELEPHONE NUMBER

SIGNATURE: _____

DATE: _____

HERNDON CHIROPRACTIC CLINIC

OFFICE FINANCIAL POLICY

It is our policy that following a preliminary exam, any services which are rendered by this office on the initial visit shall be paid for at that time, unless other arrangements have been made in writing. Our office is pleased to accept your insurance assignment as soon as your exact coverage is verified by the responsible party. However, it must be fully understood that the contract is between you and your insurance company, and you are fully responsible for all amounts not paid by your insurance. Our office policy is as follows:

1. Since by taking your insurance assignment, we must await payment, this courtesy may be withdrawn if warranted.
2. Insurance payments should be made every 30 days. The maximum time limit we extend is 60 days, then fees must be paid in full by the patient.
3. Our office will not guarantee that your insurance company will pay. At the beginning of your healthcare, we will make every attempt to receive verification of your policy coverage. However, if for any reason your claim is denied, you are responsible for the total amount due this office.
4. This office will not enter a dispute with your insurance company over your claim. This is your responsibility and obligation. We will, however, assist you in any way that we can.
5. You the patient must keep current with your insurance co-payment or co-insurance.
6. If your account is past due, it may be turned over to a collection agency. If our account is not paid in full and this account is turned over to a collection agency and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection agency fees of 50% of the balance due and costs and reasonable attorney fees of 33% of the balance.
7. If the insurance company sends you payment for our services, it is your responsibility and obligation to bring to us payment in full.
8. You are required to inform our office if your insurance coverage changes.

I have fully read, and agree to this financial policy as written:

Signed: _____

Date: _____

Witness: _____



HERNDON CHIROPRACTIC CLINIC

INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

Please read this entire document prior to signing it. It is important that you understand the information contained in this document.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed. I understand that in such chiropractic treatment, the doctor will use his/her bare hands including, but not limited to the use of any mechanical device in order to move my joints. That may cause an audible "pop" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed and there is no promise of cure. I understand and am informed that some risks are associated with chiropractic treatment, including, but not limited to sprains, dislocations, fractures, disc injuries, and stroke. I do not expect Herndon Chiropractic Clinic to be able to anticipate and explain all risks and complications, but based on the facts then known, I wish to rely on his judgment during the course of the procedures, which he feels is in my current best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, over-the-counter analgesics, medical care with prescription drugs such as muscle relaxants, and painkillers. I further understand that remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Consent to treatment

I hereby request and authorize Herndon Chiropractic Clinic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (if applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE FLIP PAGE OVER AND SIGN ON BACK

I have read or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with HERNDON CHIROPRACTIC CLINIC and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

DATE: _____

DATE: _____

Patients Name: _____

Doctors Name: DR. RON HERNDON

Signature: _____

Signature: _____

Signature of parent or guardian (if a minor) _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, have been informed of this office's Notice of Privacy Practices.

Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

