FRONT ONLY

CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask one of our office staff. PLEASE PRINT.

Today's Date: ______________________

Name: ____ Home Phone: ______________________

Address: ______________________________ City: ______________ State: _____ Zip: ______________

Age: _____ Birth Date: ______________________ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children: _____

Referred By: ______________________ Email Address: ______________________________

Please Check Type of Payment: ☐ Cash ☐ Check ☐ Master Card/Visa

Your Employer: ______________________ Occupation: ______________ Years on Job: ______________

Employer Address: ______________________ City: ______________ State: _____ Zip: ______________

Office Phone: ______________ Cell Phone: ______________ SS#: ______________

Do You Have Health Insurance? ☐ Yes ☐ No Insurance Company: ______________________________

Insurance Plan/Group#: ______________________ Your Work Hours: ______________________

Do You Have Medicare? ☐ Yes ☐ No Medicaid? ☐ Yes ☐ No

Name of Spouse or Parent: ______________________________ Birth Date: ______________________

Spouse's Employer: ______________________________ Occupation: ______________________

Office Phone: ______________ Cell Phone: ______________ Spouse's SS#: ______________

Describe the Major Complaints That Bring You To Our Office: ______________________________

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Is Your Condition Due To An Accident? ☐ Yes ☐ No Date of Accident: ______________________

Type of Accident: ☐ Auto ☐ Work/Job ☐ Home ☐ Other: ______________________________

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees and professional services rendered will be immediately due and payable.

Patient's Signature: ______________________________ *Date:* ______________________

Guardian's Signature (for Minors): ______________________________ *Date:* ______________________

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

The Upper Cervical Spine Center

Dear Future Patient,

Welcome to The Upper Cervical Spine Center, the most revolutionary health care procedure on the planet today. We have had the privilege of seeing thousands of patient's lives changed by this procedure over the past twenty-five years. Upper Cervical Health Care originated in 1923. There are currently only 2000 Upper Cervical doctors in the world. Upper Cervical Health Centers of America is a professional network of doctors providing Upper Cervical Health Care to thousands across the United States.

Upper Cervical Health Care is a unique form of Chiropractic that focuses on the upper two bones in the neck: the atlas and the axis. The brainstem extends down from your head into these two bones and is responsible for controlling and regulating every function in your body. So, if one of those top two bones gets slightly misaligned, it can reduce or completely cut off the nerve supply from your brain to any one or several different parts of your body, causing that area to malfunction, or possibly even shut down. This will result in a wide range of health problems. This misalignment can cause so many different problems that it would be impossible to even begin to list them in this letter. That is why we offer everyone and their entire family a consultation at NO CHARGE!

During your consultation with the Upper Cervical doctor, he will determine if you have an Upper Cervical problem. If you do and he feels he can help you, he will explain what he needs to do in order to fix your problems once and for all. If the Upper Cervical doctor does not feel he can help you, then he will at least try to find someone he believes can better help you.

Thank you for caring enough about your health, as well as the health of your family, to consider The Upper Cervical Spine Center for your health care needs. We sincerely hope we can help you and your whole family achieve ultimate health! We look forward to seeing you for your consultation and exam.

Sincerely,
Dr. Brittany Zellar

The Upper Cervical Spine Center • 82 White Bridge Pike, Nashville, TN 37205 • (615) 953-7406 • Fax (615) 352-5544 • uppercervicalspinecenternashville.com

FINANCIAL OFFICE POLICY

1. All patients are on a cash basis until their respective insurance coverage and deductible are verified by our staff.

2. The Doctor will give you an estimate of the fees for service before they are performed or rendered.

3. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.

4. After coverage and deductible are verified, this office may accept assignment on most policies provided the Insured/ Patient signs an appropriate assignment of benefits and or lien (authorizing payment to be sent to the Doctor).

5. Waiting for insurance payment is a courtesy, and it may be withdrawn under certain circumstances.

6. As a patient, it is your responsibility to take care of the co-payment (usually 20%) and any non-covered services on a weekly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your Report of Findings. If you feel you need some assistance from a family member or parent with making a decision about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.

7. This office does not warrant or guarantee that your insurance will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.

8. Any services not covered or coverage reduction by your insurance will be the patient's responsibilty.

9. This office will resubmit a claim *ONE TIME*. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated by uncovered services, and you will be expected to pay such charges on a timely basis.

10. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made AFTER YOUR BALANCE IS COMPLETELY CLEARED WITH THIS OFFICE.

11. If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken, or if the check is an assignment to this office.

12. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the Doctor, the bill is due and payable in full immediately, regardless of any claims submitted.

13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.

14. This office accepts Mastercard, Visa, Cash, and Personal Checks.

15. If you have any questions concerning this or any other matter, please speak with someone at our front office or our insurance department prior to seeing the Doctor.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_______________________________ (Patient Signature)

_______________ (Date)

HEALTH HISTORY

Name: ______________________________ Today's Date: ______________

List All Current Health Problems: ______________________________

List Any Other Doctors Seen, Treatments, and Results Obtained: ______________________________

List Your Current Physician(s)/Therapist(s): ______________________________

List All Surgeries and Their Dates: ______________________________

List Any Medications You Are Taking: ______________________________

List Any Traumas and Their Dates: ______________________________

Please Check the Conditions You Have or Have Had:

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Carpel Tunnel
- ☐ Concussions
- ☐ Chronic Fatigue
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Disorders
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Head/Neck Pain
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Low Back Pain
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Problems
- ☐ Tinnitus
- ☐ TMJ
- ☐ Trigeminal Neuralgia
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Vision Problems
- ☐ Whiplash Injuries
- ☐ Other: ______________

Please Check All Present Symptoms:

CARDIOVASCULAR

- ☐ Blue/Purple Nails
- ☐ Blue/Purple Skin
- ☐ Chest Pain
- ☐ Cold Hands/Feet
- ☐ General Swelling
- ☐ Irregular Heartbeat
- ☐ Pounding Heartbeat
- ☐ Rapid Heartbeat
- ☐ Swelling in Face
- ☐ Swelling in Legs
- ☐ Swelling Near Eyes

VERTEBROBASILAR

- ☐ Area of Numbness
- ☐ Blindness
- ☐ Blood Vessel Disease
- ☐ Blurred Vision
- ☐ Burning Sensations
- ☐ Cigarette Smoker
- ☐ Dizziness
- ☐ Double Vision
- ☐ Fainting
- ☐ Family History of Stroke
- ☐ Head/Neck Injury
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Hypertension
- ☐ Inability to Form Words
- ☐ Loss of Coordination
- ☐ Loss of Memory
- ☐ Muscle Weakness
- ☐ Ringing in Ears
- ☐ Stroke
- ☐ Taking Birth Control Pills

HEALTH REVIEW

Please Check All Present Symptoms:

SKIN, HAIR, NAILS

- ☐ Eczema
- ☐ Itchy Skin
- ☐ Rough, Scaly Skin
- ☐ Dry Skin
- ☐ Oily Skin
- ☐ Yellow Skin
- ☐ Bruise Easily
- ☐ Baldness
- ☐ Paper Thin Nails
- ☐ Nail Biting

EYES

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Fatigue
- ☐ Excessive Tearing
- ☐ Lack of Tearing
- ☐ Light Bothers Eyes
- ☐ Excessive Itching
- ☐ Pain in Eyeball

EARS

- ☐ Loss of Hearing
- ☐ Not Sufficient
- ☐ Pain in Ears
- ☐ Discharge from Ears
- ☐ Vertigo
- ☐ Ringing in Ears

NOSE & SINUSES

- ☐ Nose Bleeds
- ☐ Pressure Over Eyes
- ☐ Nose Obstruction
- ☐ Frequent Colds
- ☐ Sinusitis
- ☐ Loss of Smell
- ☐ Allergies

MOUTH & THROAT

- ☐ Pain in Throat
- ☐ Bleeding Gums
- ☐ Abscessed Teeth
- ☐ Dentures
- ☐ Difficulty Swallowing

RESPIRATORY

- ☐ Shortness of Breath
- ☐ Dry Cough
- ☐ Coughing Up Blood
- ☐ Wheezing
- ☐ Productive Cough

GASTROINTESTINAL

- ☐ Poor Appetite
- ☐ Constant Snacking
- ☐ Difficulty Swallowing
- ☐ Indigestion
- ☐ Nausea & Vomiting
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids

GENITOURINARY

Urination is:

- ☐ Frequent
- ☐ Not Sufficient

The Amount is:

- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Frequent Urination at Night
- ☐ Intense Desire to Urinate
- ☐ Difficulty Urinating
- ☐ Lack of Control
- ☐ Pain with Urination
- ☐ Dribbling
- ☐ Bloody Urine
- ☐ Cloudy Urine

VENEREAL DISEASE

- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Other

WOMEN ONLY

- ☐ Painful Periods
- ☐ Spotting
- ☐ Premenstrual Symptoms
- ☐ Irregular Periods
- ☐ Lumps in Breast
- ☐ Vaginal Discharge

# of Pregnancies _____

# of Deliveries _____

SOCIAL HISTORY

- ☐ Smoking
- ☐ Other Tobacco Use
- ☐ Alcohol Use
- ☐ Drink Coffee or Tea

Diet is:

- ☐ Balanced
- ☐ Not Balanced

Rest is:

- ☐ Sufficient
- ☐ Not Sufficient

Recreation is:

- ☐ Sufficient
- ☐ Not Sufficient

Family Stress is:

- ☐ Severe
- ☐ High
- ☐ Moderate
- ☐ Minimal
- ☐ None

Job Stress is:

- ☐ Severe
- ☐ High
- ☐ Moderate
- ☐ Minimal
- ☐ None

MENTAL HEALTH

- ☐ Nervousness
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Panic Attacks
- ☐ Problems Sleeping
- ☐ Run-Down Feeling

MUSCULOSKELETAL SYSTEM

Please Check All Present Symptoms:

HEAD

- ☐ Frequent Headaches
- ☐ Severe Headaches
- ☐ Head Feels Heavy
- ☐ Vertigo
- ☐ Dizziness
- ☐ Light Headedness
- ☐ Loss of Taste
- ☐ Loss of Smell
- ☐ Loss of Hearing
- ☐ Loss of Balance

NECK

- ☐ Pain in Neck
- ☐ Pain with Movement
- ☐ Swelling in Neck
- ☐ Stiffness in Neck
- ☐ Pinched Nerve in Neck
- ☐ Neck Feels Out of Place
- ☐ Muscle Spasms in Neck
- ☐ Grinding Sounds in Neck
- ☐ Popping Sounds in Neck
- ☐ Limited Neck Movement

MID-BACK

- ☐ Mid-back Pain
- ☐ Pain between Shoulder Blades
- ☐ Sharp, Stabbing Pain
- ☐ Dull Ache
- ☐ Pain from Front to Back
- ☐ Pain over Kidney Area
- ☐ Muscle Spasms

LOWER BACK

- ☐ Lower Back Pain
- ☐ Lower Back Feels Out of Place
- ☐ Muscle Spasms

SHOULDERS

- ☐ Pain in Shoulders
- ☐ Pain Across Shoulders
- ☐ Muscle Spasms
- ☐ Cannot Raise Arm
  - ☐ Above Shoulder
  - ☐ Above Head

ARMS & HANDS

- ☐ Pain in Upper Arm
- ☐ Pain in Forearm
- ☐ Pain in Hands
- ☐ Pain in Fingers
- ☐ Pins & Needles
  - ☐ In Arms
  - ☐ In Fingers
- ☐ Fingers Go to Sleep
- ☐ Cold Hands
- ☐ Swollen Fingers
- ☐ Loss of Grip Strength

HIPS, LEGS & FEET

- ☐ Pain in Buttocks
- ☐ Pain in Hip
- ☐ Pain Down Leg
- ☐ Knee Pain
- ☐ Leg Cramps
- ☐ Pins & Needles in Legs
- ☐ Numbness in Legs
- ☐ Numbness in Toes
- ☐ Cold Feet
- ☐ Swollen Ankles
- ☐ Swollen Feet

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, The Upper Cervical Spine Center may use and disclose protected health information (PHI) to carry out treatment, payment, and healthcare options (TPO). Please refer to The Upper Cervical Spine Center Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The UCSC reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The UCSC.

With my consent, The UCSC may call my home or other designated location and leave a message or voicemail, or in person in reference to any item that assists the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my chiropractic care.

With my consent, The UCSC may mail to my home or other designated location any items that assist the practice in carrying out TPO, *such as appointment reminder cards and patient statements*.

By signing this form, I am consenting to The Upper Cervical Spine Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Upper Cervical Spine Center may decline to provide treatment to me.

______________________________ Signature of Patient or Legal Guardian

______________________________ Print Name of Patient or Legal Guardian

Authorization to Pay Doctor/Clinic:

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

______________________________ (Signature)

________________ (Date)

Authorization to Pay/Release is Granted To:

The Upper Cervical Spine Center
82 White Bridge Pike
Nashville TN, 37205

TERMS OF ACCEPTANCE

When a patient seeks Upper Cervical Health Care, and we accept a patient for such care, it is essential for both to be working towards the same objectives.

Upper Cervical Care has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or dissapointment.

Correction: An upper cervical correction is the specific application of forces to facilitate the body's correction of the vertebral subluxation. Our method of correction is by specific adjustments to the upper cervical spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treate any disease or condition other than a vertebral subluxation. However, if during the course of an upper cervical examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. *OUR ONLY PRACTICE OBJECTIVE* is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjustments to correct the vertebral subluxations.

I, ____, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____ (Signature)

____________________ (Date)