MEMPHIS SPINE & SPORT CHIROPRACTIC REHAB

DR. CHARLES HOGAN MS, DC, CCSP

1740 N. GERMANTOWN PKWY #6 | CORDOVA, TN 38016 | 901-752-4300 | MEMPHISSPINEANDSPORT.COM

CHIROPRACTIC CASE HISTORY/PATIENT INFORMATION

Date:_____

Patient # _____ Doctor: _____

Patient Name: _____

Home Phone:_____ Cell Phone: _____

Address: _____ City: _____ State:_____ Zip: _____

E-mail Address: _____ Fax #: _____

Age: _____ Birth Date: _____ Race: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Employer's Address:_____ Office Phone:_____

Spouse:_____

Occupation: _____ Employer: _____

Employer's Address:_____ Office Phone:_____

How Many Children: _____ Names and Ages of Children: _____

_____

Name of Nearest Relative: _____

Address: _____ Phone: _____

How were you referred to our office? _____

Have you seen a chiropractor before? ☐ Yes ☐ No If Yes, when? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before-signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care: _____ Date:_____

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Date:_____

Patient # _____ Doctor: _____

Patient Name: _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief complaint:_____ Purpose at this appointment: _____

Date symptoms appealed or accident happened: _____

Is this due to: ☐ Auto ☐ Work ☐ Other _____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe: _____

_____

Days lost from work:_____ Date of last physical examination: _____

Do you have a history of stroke or hypertension? ☐ Yes ☐ No

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? ☐ Yes ☐ No Women, please include information about childbirth (include dates): _____

Have you been treated for any health conditions by a physician in the last year? ☐ Yes ☐ No If yes, describe: _____

_____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? ☐ Yes ☐ No If yes, describe:_____

Do you have any allergies of any kind? ☐ Yes ☐ No If yes, describe: _____

Do you have any Congenital Conditions? ☐ Yes ☐ No If Yes, describe: _____

Women: Are you pregnant? ☐ Yes ☐ No

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions now or **P** if you have had these conditions previously.

	N = Now	**P = Previously**	
Headaches_____ Frequency_____		Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

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Date:_____

Patient # _____ Doctor: _____

Patient Name: _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions now or **P** if you have had these conditions previously.

	N = Now	**P = Previously**	
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Ulcers	_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

O = OFTEN S = SOMETIMES N = NEVER

_____	Vigorous Exercise	_____	Family Pressures
_____	Moderate Exercise	_____	Financial Pressures
_____	Alcohol Use	_____	Other Mental Stresses
_____	Drug Use	_____	Other (specify)_____
_____	Tobacco Use		_____
_____	Caffeine		_____
_____	High Stress Activity		_____

NOTICE OF PRIVACY PRACTICES

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

At Memphis Spine & Sport ("MSS"), we understand that medical information about you and your health is personal. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This Joint Notice ("Notice") applies to all of the records of your care generated by MSS, whether made by MSS personnel or your personal physicians and allied health practitioners.

This Notice will tell you about the ways in which MSS may use and disclose medical information about you, referred to below as protected health information ("PHI"). This Notice also describes your rights and certain obligations MSS has regarding the use and disclosure of PHI. This Notice describes MSS's practices and that of: all physicians and staff who are members of MSS.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

For Treatment. MSS may use and disclose PHI in the course of providing, coordinating or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide you health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, MSS may need to use/disclose PHI to that physician for purposes of treatment, or to other health care professionals who are assisting in your care.

For Payment. MSS may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, MSS may need two give PHI to your health plan in order to be reimbursed for the services provided to you. MSS may also disclose PHI to its business associates, such as billing companies, and claims processing companies. MSS may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations. MSS may use and disclose PHI as part of its operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of staff and physicians in caring for you, patient surveys, provider training, underwriting activities, compliance and risk management and administration. MSS may also disclose PHI to other health care providers and health plans for such entity's quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance, provided that such entity has, or has had in the past, a relationship with the patient who is the subject of the information.

As Required by Law and Law Enforcement. MSS may use or disclose PHI when required to do so by applicable law and when ordered to do so in a judicial or administrative proceeding. MSS may also use or disclose PHI to identify or locate a suspect, fugitive, material witness, or missing person, about criminal conduct, to report a crime, the location of the crime or victims, or the identity, description, or location of a person who committed a crime, or for other law enforcement purposes.

For Health Oversight Activities. MSS may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

Workers' Compensation. MSS may disclose PHI to comply with workers' compensation or other similar laws. These programs provide benefits for work-related injuries or illnesses.

Appointment Reminders; Disclosures to Individuals Involved in Your Health Care of Payment for Your Health Care. MSS may use and disclose your PHI to contact you and remind you of an appointment at MSS, or to inform you of treatment alternatives or other heals-related benefits and services that may be of interest to you. Unless you object, MSS may disclose your PHI to a family member, other relative, friend, or other person you identify as involved in your health care or payment for your health care. MSS may also notify these people about your location or condition.

OTHER USES AND DISCLOSURES. Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations; you have the right to revoke in writing. If you revoke your permission, MSS will no longer use or disclose PHI about you for the reasons covered in written authorization. You understand that MSS is unable to take back any disclosures already made with your permission, and that MSS is required to retain records of the care provided to you.

REGULATORY REQUIREMENTS. MSS is required by law to maintain the privacy of your PHI, to provide individuals with notice of MSS's legal duties and privacy practices with respect to PHI, and to abide by the terms described in the Notice currently in effect. We will provide you with a copy of this notice.

RIGHTS. You have the following rights regarding your PHI:

Restrictions. You may request that MSS restrict the use and disclosure of your PHI. For example, you could as that we not use or disclose information about a surgery you had. To request restrictions, you must make your request in writing to Memphis Spine & Sport. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the restrictions to apply, for example, disclosures to your spouse.

Alternative Communications. You have the right to request that communications of PHI to you from MSS be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, instead of your home address. Your requests must be made in writing and sent to the front desk. MSS will accommodate your reasonable requests without requiring you to provide a reason for your request.

Inspect and Copy. Generally, you have the right to inspect and copy your PHI that MSS maintains, provided that you make your request in writing. If you request copies of your PHI, we may impose a reasonable fee to cover copying and postage.

Amendment. If you believe that your PHI maintained by MSS is incorrect or incomplete, you may ask us to correct your PHI. Your request must be made in writing to the front desk, and it must explain why you are requesting an amendment to your PHI. We generally can deny your request if your request relates to PHI: (i) not created by MSS; (ii) not part of the records MSS maintains; (iii) not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, we will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and MSS's detail attached; and (iii) complain about the denial.

Right to File a Complaint. You may complain to MSS if you believe your privacy rights with respect to your PHI have been violated by submitting a written complaint to 1740 N. Germantown Pkwy #6, Cordova, TN 38016. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

If you have any further questions or concerns about this notice, please consult our front desk staff for further explanation.

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NOTICE OF HIPAA PRIVACY PRACTICES

My signature below acknowledges that I have read and understood the Privacy Practices of Memphis Spine & Sport. It also acknowledges that I received a copy of the Notice of Privacy Practices.

Printed Name: _____

Signature: _____ Date: _____

I hereby authorize Memphis Spine & Sport to release information regarding my protected Health information to include account status, treatment, test results and scheduled appointments to the person(s) listed below:

_____

_____

Signature: _____ Date: _____

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INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated the care, alternatives and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Printed Name: _____

Signature: _____ Date: _____

Witness Name: _____

Signature: _____ Date: _____

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COMMERCIAL VIDEO RELEASE

I hereby authorize and consent to the use and/or reproduction of all photographs/videos taken of me by Memphis Spine and Sport Chiropractic Rehab or their authorized representative for use in marketing and promotional videos. I understand and agree that I shall not receive and will not be entitled to compensation for the provision and use of such photos/videos. All photo negatives and photo positives, together with the prints and original tapes shall become the sole and exclusive property of Memphis Spine and Sport Chiropractic Rehab, and I release Memphis Spine and Sport Chiropractic Rehab and their authorized representatives from any right, title and/or interest of any kind I may have in these materials. I hereby release Memphis Spine and Sport Chiropractic Rehab, their employees and agents and any publisher of the videos (and their respective licensees and assigns) from any claims arising out of, or related to, any publication, distribution, broadcast transmission, or any other use of such materials.

I agree that this grant of permission is irrevocable and that Memphis Spine and Sport Chiropractic Rehab and/or its agents, employees, representatives, successors and assigns have the right to use this video in any format or medium, including posting the video on the internet.

I am over 18 years of age. ☐ Yes ☐ No

Model Name: _____
(Print Clearly)

Model Signature: _____ Date:_____

Address: _____

City: _____ State:_____ Zip:_____

Witness Name: _____
(Print Clearly)

Witness Signature: _____ Date:_____

If the person signing is under 18, consent should be given by a parent or legal guardian as follows:

I hereby certify that I am the parent or legal guardian of _____, the model named above, and I do give my consent without reservations to the foregoing on behalf of him or her or them.

Parent/Guardian Name: _____
(Print Clearly)

Parent/Guardian Signature: _____ Date:_____

Witness Name: _____
(Print Clearly)

Witness Signature: _____ Date:_____