DIXON CENTER OF CHIROPRACTIC
Andrew Dixon, DC • Christy Diaz, DC
Hannah Dixon, DC

HARPETH VALLEY HEALTH CENTER
Ben Baggett, FNP-C • John Wood, MD

Patient Information

Please provide the information below in full and present your driver license and insurance/discount card (if applicable).

Have you been to our office before? ☐ Yes ☐ No If Yes, when? _____

Have you ever received chiropractic care? ☐ Yes ☐ No

How did you find out about our office? ☐ Referral_____ ☐ Other_____

Full Legal Name: _____ **Preferred Name:** _____

DOB: _____/_____/_____ **SSN:** ____-___-____ **Cell/Home Phone:** _____

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

Employer: _____ **Occupation:** _____ **Office Phone:** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Caucasian ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other ☐ Declined to State

Spouse Name:_____ **Employer:**_____**Occupation:**_____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Preferred Contact Number: ☐ Cell ☐ Home ☐ Work | Alt. number:_____

Email address: _____

How would you like to be reminded about your appointment?

☐ Text ☐ Email ☐ Cell ☐ Work ☐ Home ☐ None

Patient Information

- We value the time we have set aside to see and treat you. If you are not able to keep a provider appointment we would appreciate notice as soon as possible.
- If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
- We require a 24-hour notice for cancelling appointments. A $25 fee will be charged for missed appointments with our medical/wellness practitioners, this fee does not apply to chiropractic visits. appointments.

Provider & Pharmacy Information

Primary Care Physician: _____ **Phone #**:_____City/State:_____

Preferred Pharmacy: _____ **Phone #**:_____

Current Medications, Supplements, Vitamins, & Dosages:_____

_____

_____***By initialing on this line, you are giving Harpeth Valley Health Center permission to access your pharmaceutical history from your pharmacy.***

LIST ALL KNOWN ALLERIC REACTIONS: DRUGS, FOOD, CHEMICALS or ENVIRONMENT

_____

_____

Personal History

What are you being seen for today? _____

How long have you had symptoms? _____

What are your symptoms? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

What previous treatment(s) have you had? _____

What may have caused your symptoms?_____

Do you smoke? ☐ Yes ☐ No **If yes, how much?** _____

If yes, what do you smoke? ☐ Cigarettes ☐ Cigars ☐ Smokeless (Dip/Vape) ☐ Other_____

If no, did you smoke in the past? ☐ Yes ☐ No **If yes, how much?** _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, what do you drink? ☐ Beer ☐ Liquor ☐ Wine **If yes, how much?** _____

ACCIDENT HISTORY: ☐ Job ☐ Auto ☐ Other _____Date:_____

☐ Job ☐ Auto ☐ Other _____Date:_____

SURGICAL HISTORY:

Procedure:_____ Date:_____Doctor: _____

Procedure:_____ Date:_____Doctor: _____

Procedure:_____ Date:_____Doctor: _____

Medical History

PRINTED NAME:_____ **DOB:**_____

Please indicate any medical conditions that apply to yourself or family in the chart below. If the condition applies to a family member, please mark which family member it applies to.

Mother: ❑ Living ❑ Deceased **Father:** ❑ Living ❑ Deceased

---------- **S=Self M=Mother F=Father** ----------

S	M	F		S	M	F		S	M	F	
❑	❑	❑	Anemia	❑	❑	❑	Headaches	❑	❑	❑	Numbness
❑	❑	❑	Anxiety	❑	❑	❑	Heart Attack/CHF	❑	❑	❑	Polio
❑	❑	❑	Arthritis	❑	❑	❑	Heart Disease	❑	❑	❑	Poor Circulation
❑	❑	❑	Asthma	❑	❑	❑	Hepatitis	❑	❑	❑	Reproductive Disorder
❑	❑	❑	Back Pain	❑	❑	❑	High Blood Pressure	❑	❑	❑	Rheumatic Fever
❑	❑	❑	Bladder Trouble	❑	❑	❑	High Cholesterol	❑	❑	❑	Rheumatism
❑	❑	❑	Bone Fracture	❑	❑	❑	HIV	❑	❑	❑	Seizures
❑	❑	❑	Bowel Control Loss	❑	❑	❑	Indigestion/GERD	❑	❑	❑	Serious Injury
❑	❑	❑	Cancer	❑	❑	❑	Kidney Disorder	❑	❑	❑	Sleep Apnea
❑	❑	❑	Chest Pain	❑	❑	❑	Kidney Stones	❑	❑	❑	Sinus Trouble
❑	❑	❑	Concussion	❑	❑	❑	Measles	❑	❑	❑	STDs
❑	❑	❑	Dementia	❑	❑	❑	Menstrual Cramps	❑	❑	❑	Substance Abuse
❑	❑	❑	Diabetes	❑	❑	❑	Multiple Sclerosis	❑	❑	❑	Stroke
❑	❑	❑	Dislocated Joints	❑	❑	❑	Muscular Dystrophy	❑	❑	❑	Thyroid Disease

Prevention & Screening History

Procedure	Year	Procedure	Year	Procedure	Year
Cholesterol Check		**Physical Exam**		**Bone Density Test****	
Colonoscopy		**Pneumonia Vaccine**		**Mammogram****	
Diabetes Check		**Tetanus Shot**		**Pap Smear****	
Flu Vaccine		**Vision Test**		**Prostate Exam***	

Men Only** ****Women Only

Allergy Survey

It is very common for insurance companies to cover allergy testing. If you are interested in finding out what you might be allergic to we can verify your insurance to see what your coverage will be. Would you like us to verify your insurance to see if you have coverage? **❑YES ❑NO**

Have you been diagnosed with: heart disease, heart attack, stroke, or vascular disease? ❑YES ❑NO

Have you ever had a sever reaction to a bee sting: i.e. swelling in the face/throat, difficulty breathing, or had to go to the emergency room)? ❑YES ❑NO

Do you suffer from allergies? If yes, list symptoms:_____ ❑YES ❑NO

_____

Do you take any allergy meds to relieve symptoms? ❑YES ❑NO

Do you get chronic infections? If yes, list:_____ ❑YES ❑NO

Do you have a chronic cough or wheezing? ❑YES ❑NO

Do you have any pets? ❑YES ❑NO

Do you have eczema or rashes? ❑YES ❑NO

Do you have any form of pain or discomfort after eating? ❑YES ❑NO

Do you have breathing problems? ❑YES ❑NO | If yes, what kind? ❑*Asthma* ❑*COPD* ❑*Short Breath*

What time of year are your symptoms worse? ❑Winter ❑Spring ❑Summer ❑Fall ❑All Year

Insurance Plans

- It is your responsibility to keep our office updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- It is your responsibility to understand your benefit plan with regard to, for instance:
  - If a written referral or authorization is required to see specialists or if preauthorization is required prior to a procedure.
  - Some charges may or may not be covered. While the filing of insurance claims is a courtesy that we extend to our patients, not all plans cover all services performed in a chiropractic/medical office. All charges not covered by your plan are your responsibility.

Financial Responsibility

1. Payment is required at the time of service. We accept cash, check, major credit cards, and Care Credit, for those who qualify.
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. If we do not participate with your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
4. Self-pay patients must pay at the time of service in full. Standard rates will apply unless the patient enrolls with a Direct Primary Care Membership or prepaid plan in advance, which may entitle patients to cash discounts or payment options.

5. For scheduled appointments, prior balances must be paid prior to the visit.
6. General benefit verification will be provided on the second visit as a courtesy to patients, however this is not a guarantee of payment and final determination will be applied off the explanation of benefits.
7. Bills unpaid for more than 90 days may be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may incur additional fees.
8. There is a service charge of $25 for returned checks.
9. Please call or email if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.
10. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent you from receiving care you need.
11. If special circumstances make immediate payment impossible, our business office staff must approve payment arrangements in advance.

Payment is due at the time of service unless prior arrangements have been made.

I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. I agree to pay all balances over 90 days from the original due date, as well as court costs and reasonable collection and attorney's fees, with or without suit, incurred in collecting any past due balance. I certify that the information I am providing is correct to the best of my knowledge. I will not hold my doctor, provider, or any other staff member responsible for errors or omissions that I may have made in completion of these forms. I hereby authorize Dixon Center and Harpeth Valley Heath Center to administer such examination and treatment, as they deem necessary.

I will be responsible for all copay, deductible, or coinsurance that may apply per my insurance company. If I am self-pay, I am responsible for the pre-determined self-pay fees.

We reserve the right to collect any self-pay fees, copay, deductible, and/or coinsurance at the time of service.

Name: _____ _____ _____
Printed Signature Date

NAME OF FINANCIALLY RESPONSIBLE PARTY; PATIENT UNDER 18: _____

ADDRESS:_____DOB_____

RELATIONSHIP:_____SIGNATURE_____

If a minor should be seen without being accompanied by an adult, a letter must be given to the staff, giving permission for care prior to the patient seeking treatment by any provider in our facility.

HIPAA Policy

Our goal is to provide and maintain a good physician-patient relationship. By informing you in advance of some of our policies, it allows for good communication and enables us to achieve our goals. Please read each section carefully. If you have any questions, please do not hesitate to ask a member of our staff.

1. We are concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.
2. Your health care provider and members of the staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you.
3. You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims, unless you have paid your out of pocket costs in full.
4. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
5. This authorization will expire seven years after the date on which you last received services from us. Ultimately, we want to protect you and your health information as enforced by the Department of Health & Human Services.

By initialing here, _____, I acknowledge that I have received a copy of this authorization, the Notice of Privacy Practices AND I authorize you to use/disclose my health information in the manner described above.

I hereby authorize Dixon Center/Harpeth Valley Health Center to disclose my protected health information to:

Name: _____ Relation: _____ Telephone Number: _____

The following information may be disclosed to the above-mentioned name(s):

❑ All Information ❑ Results Only ❑Appointment Status

Name: _____ Relation: _____ Telephone Number: _____

The following information may be disclosed to the above-mentioned name(s):

❑ All Information ❑ Results Only ❑Appointment Status

Your Protected Health Information may be disclosed to you via:

❑ Home Voicemail ❑ Mobile Voicemail ❑Work Voicemail ❑ Email

DIXON CENTER DISCLOSURE OF FINANCIAL INTEREST

TN law and federal Medicare regulations require physicians, doctors of chiropractic, and other health care providers to make certain disclosures to patients when they refer a patient to a facility in which the provider has significant financial interest. Andrew Dixon, D.C. is an investor and percentage owner in Harpeth Valley Health, and is also an investor and percentage owner in the Dixon Center, to which you (or the patient for whom you are the legal representative) are being referred from Harpeth Valley Health for chiropractic treatment/therapy. Please be aware you are not required to utilize the Dixon Center for these services. Patients have the right to be treated at another health care facility of their choice. If you would like to utilize the services of an alternate health care facility, please contact Harpeth Valley Health immediately.

ACKNOWLEDGEMENT OF RECEIPT

By signing below, you or your legal representative, acknowledge you have received, read and understand this information (verbally and in writing) in advance of the date of your treatment.

_____

Signed Date

HARPETH VALLEY HEALTH DISCLOSURE OF FINANCIAL INTEREST

TN law and federal Medicare regulations require physicians, doctors of chiropractic, and other health care providers to make certain disclosures to patients when they refer a patient to a facility in which the provider has significant financial interest. Andrew Dixon, D.C. is an investor and percentage owner in Dixon Center, and is also an investor and percentage owner in Harpeth Valley Health, to which you (or the patient for whom you are the legal representative) are being referred from Dixon Center for medical treatment/therapy. Please be aware you are not required to utilize the Harpeth Valley Health for these services. Patients have the right to be treated at another health care facility of their choice. If you would like to utilize the services of an alternate health care facility, please contact Dixon Center immediately.

ACKNOWLEDGEMENT OF RECEIPT

By signing below, you or your legal representative, acknowledge you have received, read and understand this information (verbally and in writing) in advance of the date of your treatment.

_____

Signed Date