Tinkle Chiropractic

212 N. 8th St.
Richmond, IN 47374

On behalf of Dr. Tinkle and his staff, we would like to thank you for allowing us to provide care for you and your family. It is the intention of our office to provide thorough and efficient treatment. Service to our patients is successful when there is complete and mutual cooperation.

Answers to some common questions referring to the initial visit:

- The initial appointment is devoted to a thorough exam and x-rays which are necessary to properly diagnose and recommend treatment.
- Payment at the time of service unless financial arrangements have been made in advance.
- Insured patients are required to supply his/her insurance card, which we will copy and keep on file.
    - Co-pay is due at the time of treatment.
    - As a courtesy to our patients, the office will bill insurance claims.
    - Your insurance co-pay is based on your policy. We can only estimate your co-pay based on the information we receive from your insurance company.

If you have any questions or concerns regarding your treatment, please ask any of our office staff we are here to serve you.

Signature: _____ Date: _____

Whom may we thank for referring you to our office?

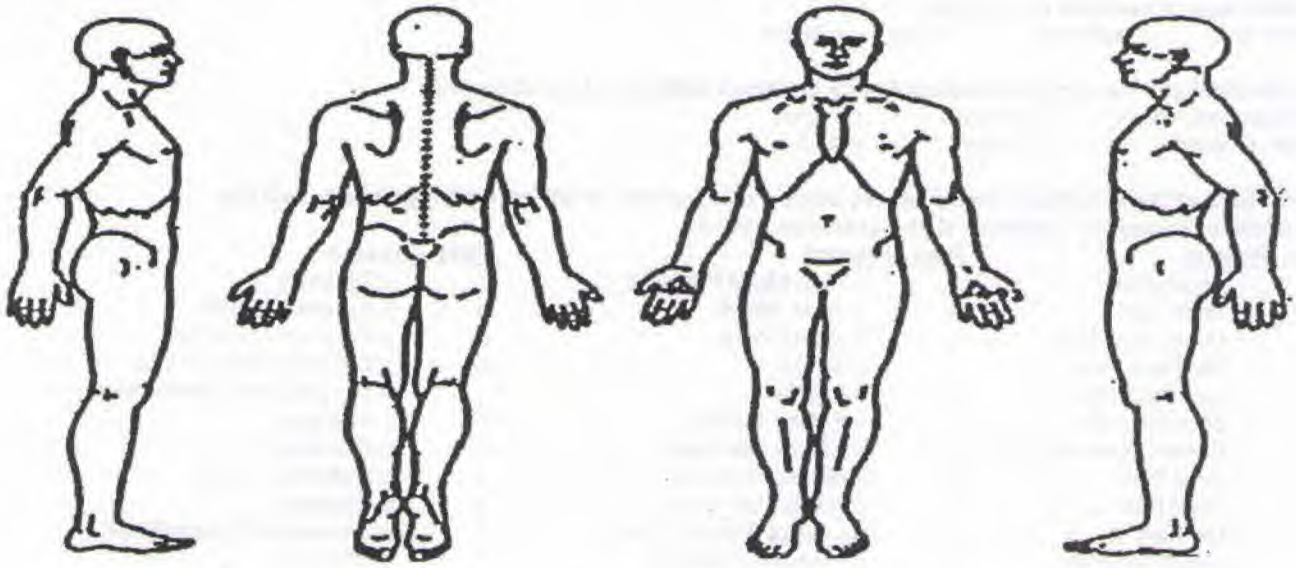
_____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other

2. Indicate on the drawings below where you have pain/symptoms:



3. How often do you experience your symptoms?
□ Constantly □ Occasionally
□ Frequently □ Intermittently

4. How would you describe the type of pain? (check all that apply)
□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. Who else have you seen for your current problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

over →

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13. What aggravates your problem? (example: sitting, standing, bending, work, litting, etc)

_____

14. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

15. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

16. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past or "present" if you currently have it.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	**For Females Only**		
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

17. List all prescription medications you are currently taking:

_____

18. List all of the over-the-counter medications you are currently taking:

_____

19. List all surgical procedures you have had (include year):

_____

20. What activities do you do at work?
□ **Sit:** □ Most of the day □ Half the day
□ **Stand:** □ Most of the day □ Half the day
□ **Computer work:** □ Most of the day □ Half the day
□ **Lifting:** □ Most of the day □ Half of the day

21. What activities do you do outside of work?

_____

22. Have you ever been hospitalized? □ No □ Yes
if yes, why _____
23. Have you had significant past trauma? □ No □ Yes Explain:_____
_____

Patient Signature_____ **Date:**_____

Patient Information Sheet

Tinkle Chiropractic
212 N. 8th Street
Richmond, IN 47374

Patient:

Last Name: _____ First Name: _____ Middle: _____

Gender: M F Date of Birth: _____ Age: _____ SS# _____

Home Address: _____

City: _____ State: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Employer Information:

Employer Name: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____

Emergency Contact:

Last Name: _____ First Name: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Relationship to Patient: _____

Please see reverse side for Consent of Treatment

Consent for Treatment

Signature: (Patient, parent, legal guardian or responsible party)

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting payment from the insurance and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am responsible for payment.

I understand that if I suspend or terminate my care at this office I guarantee payment in full of patients account in accordance with the financial arrangements made at the time of discharge or if no such arrangements are made then payment shall be made in full within thirty (30) days of discharge.

I agree that in the event of a default in payment, a reasonable collection agency fee equal to 50% of the delinquent balance and reasonable attorney fees shall be added to amount due on the account, plus any applicable court costs.

If special financial arrangements need to be made, please speak with the office manager.

Date: _____ Signature: _____

I hereby authorize the Doctor to release any information concerning my examination or treatment.

Date: _____ Signature: _____

I hereby authorize payment directly to this office for professional services rendered and I shall be responsible for any unpaid balance to the Doctor.

Date: _____ Signature: _____

For those who do not have insurance or the insurance carrier will not pay for chiropractic coverage, we have the following methods of payment: Cash, Check, Mastercard, and Visa.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request correction to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosure of your information; and
6. The right to a paper copy of this Notice

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

Please list any family members/friends that we may talk to regarding your treatment here at Tinkle Chiropractic.

1. _____
2. _____
3. _____

Anyone _____ No One_____

To protect your privacy, anyone not listed above will not be allowed to discuss any aspect of your treatment at our office.

If you have any questions about this Notice, the name and phone number of our contact person listed on the page.

Effective Date of this Notice: _____
Contact Person: Kim Drook
Phone Number: 765-935-1000

Acknowledgment of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of the practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

_____

Patient or Representative Name (Please Print)

_____

Patient or Representative signature

_____

Date

- ☐ Patient refused to sign
- ☐ Patient was unable to sign because

_____