



**MONTGOMERY
COUNTY**
CHIROPRACTIC

Dr. Ty Haston, D.C.

101 Burle Way Suite 108 Clarksville, TN 37042

931-444-6626/ Fax 931-342-1946

Please provide the information below in full and present your driver's license and primary/secondary insurance cards (if applicable).

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

Have you ever received chiropractic care? Yes No If Yes, who _____

Email address: _____

How would you like to be reminded about your appointment?

Email Text **Cell Phone Carrier for appointment reminders:** _____

Appointments

- 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.

Provider & Pharmacy Information

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

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

Current Medications, Supplements, Vitamins & Dosages: _____

LIST ALL KNOWN ALLERGIC REACTIONS: DRUGS, FOOD, CHEMICALS, LATEX, BANDAIDS, ADHESIVE, ETC



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Prevention & Screening History

Complete the information below as it relates to your screening, prevention, and testing 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***

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.
- 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.



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Financial Responsibility

1. Payment is required at the time of service. We accept cash, check, major credit cards.
2. According to your insurance plan, you are responsible for 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. For scheduled appointments, prior balances must be paid prior to the visit.
5. 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.
6. 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 will have a 35% fee attached to the unpaid account, the patient may also be responsible for any legal fees associated with collecting the unpaid balance.
7. There is a service charge of \$25 for returned checks.
8. 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.
9. 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.
10. 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 French Family Chiropractic 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; 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.

Witness Signature: _____ Date: _____

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Privacy 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 AND I authorize you to use/disclose my health information in the manner described above.

I hereby authorize French Family Chiropractic to disclose my protected health information to:

Name: _____ Relation: _____ Telephone Number: _____

Name: _____ Relation : _____ Telephone Number: _____

Your Protected Health Information may be disclosed to you via:



_____ Mobile Voicemail or Text Message

_____ Email

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Muscle Stim Pad Agreement

This agreement is to inform you that during your care at French Family Chiropractic, you may receive therapies that require muscle stimulation pads.

The office provides a universal set that is used on multiple patients at no charge.

However, you have the right to purchase your own set that will be used solely by you. Your stim pads will be kept at the office and placed with your chart at each visit. The cost for these pads is \$20.00 and are not covered by your insurance.

Please choose **one** of the following, and sign below which one you agree to:

Option 1: I want to purchase my own set.

If you do choose to purchase your own set, please sign below. By signing, you understand that the pads are not covered by insurance and payment will be required before receiving the stim pads.

Patient Signature: _____ Date: _____

Option 2: I want to use the universal set used by other patients.

French Family Chiropractic has explained to me the use of muscle stimulation pads and I understand that a common set will be used. I fully accept the risks and will not hold French Family Chiropractic or any staff liable.

Patient Signature: _____ Date: _____



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Informed Consent for Chiropractic Spinal Manipulation and Treatment, Authorization and Release

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed doctors of chiropractic of Montgomery County Chiropractic or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involved the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of insurance benefits directly to Montgomery County Chiropractic. I understand and agree to allow this office to use my Confidential Patient Health Information forms for treatment, payment, healthcare operations and coordination of care and authorize Montgomery County Chiropractic to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand and agree 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.

I understand the Federal Government has deemed it mandatory to notify my doctor of any other part of insurance company who may be responsible for reimbursement for my treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

If treatment is rendered to a minor, we request that the legal parent or guardian be present at the initial appointment and if an appointment is rendered that the legal parent or guardian cannot attend, we require a written consent by the legal parent of guardian. By signing this agreement, you are giving consent to treat the minor child.

Patient Signature: _____ Date: / ____ / ____

Printed Name: _____

Witness Signature: _____ Date: / ____ / ____