Welcome to Trinity Chiropractic Clinic

Thank you for choosing our office for chiropractic care and the opportunity to maximize your health. We are committed to providing you and your family with the highest quality chiropractic care and education available in this area. We will be working together toward you reaching your health and wellness goals. During your initial visit you will receive some or all of the following: rolling thermal scan, surface EMG, orthopedic tests, chiropractic examination, X-rays, and therapy.

If you ever have any questions about your chiropractic care, please do not hesitate to ask one of our highly educated chiropractic team members at any time. All of your questions, even the ones that you never thought of asking, will be answered during your second visit or Report of Findings. Dr. Zeagler will offer a radiographic report and recommend a treatment specific to your individual needs.

We look forward to a long and healthy relationship with you and your family. Congratulations on choosing chiropractic care to make a difference in your health and improve your quality of life.

Trinity Chiropractic Clinic, Inc.
366 South Drive, Natchitoches, LA 71457
(318) 352-0099
Good Health Naturally!!!

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

2 INSURANCE / ATTORNEY

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)_____

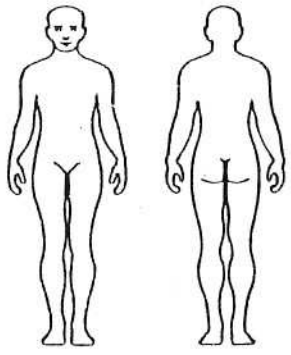
5 PATIENT CONDITION

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other_____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Other_____
Cataracts ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No	_____
Chemical Dependency ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No	_____
Chicken Pox ☐ Yes ☐ No	Measles ☐ Yes ☐ No		
Diabetes ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No		

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking Packs/Day_____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day_____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____

_____

Pharmacy Name_____

Pharmacy Phone _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of this practice may need to use your name, address, phone number, and clinical records to contact you with appointment reminders, information about additional treatment alternatives, birthday greetings, or clinic/chiropractic events that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us permission to contact you with these reminders and information.

This form also includes the authorization to release your medical information to other medical provides, insurance companies or legal representatives requesting your patient information when you have signed a medical information release form. Insurance companies may have a right to your health information if they decide to contest any of your claims. Information may be provided to any of the above mentioned sources via U.S. Postal Service, fax or copied for their records.

You may not restrict these individuals/providers where your health care information is released or revoke your authorization at anytime, however your revocation must be in writing and mailed/given to us at our office address. We will not be able to honor your request to revoke your authorization if we have already released your health information before we receive your request to revoke your authorization.

Information that we use or disclose based on the authorization you are giving may be subject to re-disclosure by anyone who has access to the information and may not be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. You may inspect or have a copy of the information that we use to contact you at any time.

This notice is effective as of 4/1/2003. This authorization will expires six (6) years after the day on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I may have a copy of this authorization at my request.

_____ _____

Name Printed Date

_____

Signature

_____

Provider Representative

Product Sale Authorization

From time to time, our practice strives to make you aware of the products that you may have an interest in purchasing. Your chiropractor or members of his practice staff may present these products to you. We are specifically requesting authorization to sell the following products to you if you request them or the doctor recommends them: dietary supplements from Standard Process, Nutri-West, Best Process, Natural Calm, Progressive Labs, Eyelights, CORE products, Chiroflow pillow, Biofreeze analgesic and Metagenics.

You may restrict any individual from our clinic from the sale of any of these products to you or revoke this authorization at any time. The revocation must be in writing and mailed/given to us at our office address. We do not give any information to any of these companies or release any personal information to anybody.

You have the right to refuse us this authorization. If you do not give us permission to sell these products to you, it will not affect the treatment we provide to you.

You may inspect or have a copy of this notice at any time.

This notice is effective as of 4/1/2003. This authorization will expire seven (7) years after the date on which you last received services from us.

I authorize you to sell the above listed products to me in your clinic. I am also acknowledging that I can have a copy of this authorization anytime at my request.

_____ _____

Name Printed Date

_____

Signature

_____

Provider Representative

Notice of Privacy Practices for Protected Health Information

Your Right to Complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Trinity Chiropractic Clinic, Inc.
Jon E. Zeagler, D.C.
366 South Drive
Natchitoches, LA 71457

To Contact Us

If you would like further information about our privacy policies and practices, please contact the address listed above.

This notice is effective as of _____. This notice will expire seven (7) years after the date upon which the record was created.

By signing below, I acknowledge that I can receive a copy of this notice at any time during that time at my request.

_____ _____
Patient Name Printed Date

_____ _____
Patient Signature Provider Representative

_____ _____
Personal Representative Printed (minor etc.) Personal Representative Signature

_____
Relationship to Patient Printed

Trinity Chiropractic Clinic Inc.
Office Fee Schedule and Financial Policy

Service

Consultation Only	No Charge
Individual Exams (Focused, Expanded, or Detailed)	$35, $60, $85
Initial Visit (Minimal, Focused, Expanded, or Detailed)	$20, $25, $60, $85
Re-Examination (Focused, Expanded or Detailed)	$35, $60, $85
Neurological Examination (Expanded or Detailed)	$60, $85
Surface EMG	$40
X-Rays	$30 per view
Subluxation correction adjustment	$40, $45
Subluxation correction adjustment (Medicare)	$25, $32
Interferential Therapy, Moist Heat, Ice Pack	$10 each
Mechanical Traction, Ultrasound, Diathermy	$20
Therapeutic Exercises (attended)	$28

Supplies

(We do not bill insurance for supplies. Supplies must be paid for when received.)

Biofreeze Roll On, Tube, or Spray, and Electrodes	$10
Ice Pack, Heel Lift	$5
Natural Calm (Magnesium)	$20, $30
Low Back Support Cushion	$25, $45
Neck Traction Unit	$35
Chiroflow Pillow, Tri-Core Pillow	$45
Tens Unit	$65

Financial Policy

We are committed to providing you with the best chiropractic experience possible in a caring environment. We have established our financial policies to achieve that goal. You will be expected to arrange payment for your chiropractic care. **All deductibles or co-payments will be due and payable each visit** unless you have made other financial arrangements with the **CareCredit credit service**. Please pick up a brochure with the information about this credit service at the front desk. Details of this service will be discussed with you during your chiropractic report of findings when Dr. Zeagler goes over his recommendations of how to utilize your payment options and get the best results from chiropractic care.

Office Fee Schedule and Financial Policy – Page 2

Health Insurance – If we are a provider for your insurance, we will gladly file your insurance for you. If we are not a provider, we will give you all the information you need to get reimbursed quickly. We have found it easier for your record keeping and our, if we give you receipts at the end of your first visit and then one-month after that. **Remember, your agreement with the insurance company is between you and them, not us and them.**

Please Note:

Regardless of what insurance coverage you have, our families and individuals do not generally come to our clinic based on whether or not they have good insurance. Our patients come here because of the quality of our care, and the commitments of the doctor and staff. They are people that value their health as one of their top priorities, and make the investment of time, energy, and money to insure they have an optimum quality of life. **They do not let their insurance company control what kind of health care they have. We do not make our recommendations based on your insurance coverage and hope you will not make your decision to participate in chiropractic care based on what type of insurance that you have.**

I have read and understand the above options and policies. I hereby give permission to Trinity Chiropractic Clinic, Inc. and Dr. Jon E. Zeagler, D.C. to release any information required by my insurance company during my treatment. **I understand that I am ultimately responsible for all fees for services rendered.** I understand that I am responsible for any and all expenses by Trinity Chiropractic Clinic, Inc. to collect monies owed including, but not limited to any attorney's fees, collection fees, court costs, and 1.5% interest per month, late fee, on any outstanding balance past 30 days.

_____ _____

Your Signature Date

Good Health Naturally!

Trinity Chiropractic Clinic – Good Health Naturally

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Terms of Treatment

ADJUSTMENT: An adjustment is a specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

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

VERTEBRAL SUBLUXATION: An injury or misalignment of one or more of the 24 vertebrae in your spinal column. A subluxation causes negative alteration of your nerve function and causes interference to the transmission of mental impulses from your brain to your body. This results in a lessening of the body's ability to maximize your health.

Dr. Zeagler's Objectives

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal evaluation, 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. We treat people, not diseases. Nor do we offer advice regarding treatment prescribed by other providers. Our practice objective is to eliminate major interference to the expression of your body's healing capabilities. We do not treat symptoms. We treat the cause of your symptoms. Our only method is specific adjustments to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding Dr. Zeagler's objectives pertaining to my care in this office have been answered to my complete satisfaction. I understand the terms of treatment and practice objectives and would like to participate as a patient in this office.

_____ _____
Signature Date