Tinlin Chiropractic

Confidential Patient Information

710 Breckenridge Lane, Suite 201
Louisville, KY 40207
Phone: 502-897-5181 ▪ Fax: 502-897-5122

Today's Date: _____ Your Social Security Number: _____

Name: _____ Home Phone: _____ Alt. Phone: _____

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

Date of Birth: _____ Marital Status: ____ Occupation: _____ Email: _____

Employer: _____ Work Phone: _____ Referred By: _____

Do you have Health Insurance: **Y N** Insurance Company? _____

When was your last examination? _____ Have you ever suffered from any of the following:

Headache **Y N** Low Back Pain **Y N** Heart Trouble **Y N** Dizziness **Y N** Cancer **Y N** Neck Pain **Y N**

Please list any and all surgeries you have undergone: _____

_____

Please list any and all medications you take now: _____

_____

Please list remarkable family history (I.E. parents or siblings, aunts, and uncles who have had strokes, heart attacks, cancer, diabetes, etc.)_____

_____

Lifestyle (hobbies, level of exercise, diet, alcohol, tobacco and drug use, etc.): _____

_____

Why are you consulting us at this time? _____

How long have you had these issues? _____

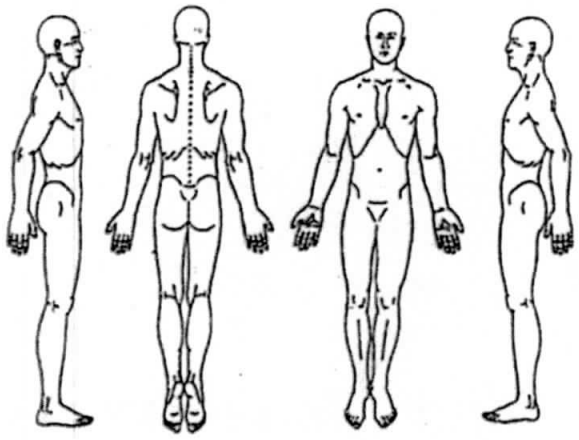
Is your health better, same or worse than it was this time last year? _____

List other doctors you have seen for this same condition: _____

_____

ASSESS YOUR CONDITION ON THE DIAGRAM INDICATING WHERE YOU ARE EXPERIENCING PAIN OR OTHER SYMPTOMS AND CHOOSE THE QUALITY(s) OF THE CONDITION (please circle):

Aching /Burning /Numbness /Pins & Needles /Stabbing /Tingling/Sharp/Shooting Throbbing /Deep/Nagging/Other _____



When did the condition start? _____

Was this caused by an auto accident/personal injury/WC? YES/NO

What were you doing when you noticed the condition?

_____

How frequent is the condition present, how long does it last?

_____

Does anything aggravate the condition?

_____

Does anything make the condition better?

_____

GRADE PAIN *(please circle)*													
Headache	*no pain*	0	1	2	3	4	5	6	7	8	9	10	*extreme pain*
Neck Pain	*no pain*	0	1	2	3	4	5	6	7	8	9	10	*extreme pain*
Mid-Back Pain	*no pain*	0	1	2	3	4	5	6	7	8	9	10	*extreme pain*
Low Back Pain	*no pain*	0	1	2	3	4	5	6	7	8	9	10	*extreme pain*
Shoulder—R L	*no pain*	0	1	2	3	4	5	6	7	8	9	10	*extreme pain*
Arm Wrist Hand-R L	*no pain*	0	1	2	3	4	5	6	7	8	9	10	*extreme pain*
Hip—R L	*no pain*	0	1	2	3	4	5	6	7	8	9	10	*extreme pain*
Leg Ankle Foot-R L	*no pain*	0	1	2	3	4	5	6	7	8	9	10	*extreme pain*

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care, I will immediately settle any outstanding balance I have through credit extended to me for any and all professional services rendered to that point.

Patient's Signature: _____ **Date:** _____

Guardian's Signature (if patient is a minor) _____ **Date:** _____

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Steven M. Tinlin, DC

INFORMED CONSENT TO CHIROPRACTIC CARE & ADMINISTRATIVE FEES

I hereby request and consent to the performance of medical treatment and assessment, Chiropractic adjustments and rehabilitation procedures performed at Tinlin Chiropractic and performed by the doctors listed above. I understand that treatment methods in this office vary from doctor to doctor and are based on my condition. I represent that I have come here for care at my own direction and by my own choice.

I have had the opportunity to discuss with the Doctors and/or with other office personnel the purpose and benefits of the services recommended in my case. I have had the opportunity to discuss any short or long-term consequences, favorable or unfavorable, to any therapy, including Class IV laser therapy, applied to me. I have had the opportunity to discuss alternative treatment of my condition and have personally decided that the care being offered here is reasonable as presented.

Though all therapies provided at Tinlin Chiropractic, including Chiropractic adjustments and Class IV laser therapy to my brain and nervous system, are intended to improve one's health and vitality, I understand and am informed by means of this document that some risks exist when any treatment is intended to change bodily function. Risks may include (but are not limited to) fractures, disc injuries, dislocations, sprains and possible, and very rarely strokes. Some treatments to ill or injured person may exceed the metabolic capacity of an individual. Every effort is made to insure the person is capable to receive whatever care is provided. I realize I have had ample opportunity to ask any doctor on this staff to outline potential risk in my case based on the findings of my evaluation.

In the course of my care or simply for health screening and examination, x-ray and/or specialized imaging, may be prescribed in order to achieve a more accurate "diagnosis" and to provide insight into functional risk indicators that may aid the primary care physician in clinical decision making.

I understand that rehabilitation to brain, brain stem, spinal cord, muscles, joints, tendons and nerves as well as interpretation of imaging is not an exact science. I understand that reputable, well-trained practitioners cannot fully guarantee results. No guarantee or assurance has been made by anyone at Tinlin Chiropractic, nor is treatment by one doctor a reflection on or the responsibility of the others. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I hereby release, do not hold responsible and waive any liability concerning the diagnosis and or treatment of my condition from the doctors at Tinlin Chiropractic. I hereby consent to the proposed treatment recommended on my report of findings and affirm that I have made full disclosure regarding all information that would influence my care or place the specific treating doctor at risk. I agree to hold the non-treating doctors harmless for my care.

Signature of Patient: _____ Date: _____

Signature of Parent: _____ Date: _____
(Or Guardian/Spouse)
*Treatment of minor without legal guardian present/Minor has own driver's license and will come unattended

Witness Signature: _____ Date: _____

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Insurance Verification Form

Tinlin Chiropractic is pleased to accept select insurance policies in order to help you with your health care finances. Please note that we file your chiropractic health care claims with your insurance as a courtesy. In order to prevent any confusion or unexpected charges, it is strongly recommended that you personally contact your insurance carrier **prior** to your appointment so that you have an understanding of your policy coverages and parameters (i.e. deductible, co-pay/co-insurance, pre-authorization, etc.). Any quoted fee for service in junction with your insurance policy is based on an **estimation** that is determined via a certified health insurance claim clearinghouse. In some instances, any service or therapy that is denied or not covered by your policy, you may be individually responsible for.

Patient Name: _____

Insurance Company: _____

Policy ID: _____

Group # _____

Policy Holder: _____

I understand and agree that the health and accident policies are an arrangement between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: _____ Date: _____

Guardian's Signature (if patient is a minor): _____ Date: _____

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K-Laser Cube

The K-Laser Cube is the most powerful therapeutic laser on the US market today.

This device improves and promotes healing, reduces pain and spasm, increases joint flexibility, improves peripheral micro-circulation, detoxifies and eliminates trigger points.

The power of this device is unparalleled in therapeutic lasers. More power means greater depth to target tissues, shorter treatment times, and faster recovery.

Numerous studies show laser therapy can help with tendonitis, carpel tunnel, trigger points, ligament sprains, muscles strains, plantar fasciitis, osteoarthritis, rheumatoid arthritis, shingles, trigeminal neuralgia, diabetic neuropathy, fibromyalgia, sports injuries, auto and industrial injuries to soft connective tissues.

For all of the merits K-Laser Cube has earned, the procedure is a non-covered service by ALL medical insurances including Medicare. Our two treatment options are listed below and are effective January 30, 2023:

> **Primary Treatment**: When the K-Laser Cube is the only service provided during an office visit, the fee charged for that visit is $75. This may be appropriate for the very acute or the very chronic cases where spinal adjusting procedures are not advised until swelling is reduced or tissues are made more flexible by enhanced circulation.
>
> **Adjunctive Treatment**: When the K-Laser Cube is utilized in-addition-to spinal adjusting or rehabilitation exercises the fee is $20.

I have read and understand the information provided to me and agree to the above fees.

_____ _____

Patient Name Date

_____ _____

Staff member Tinlin Chiropractic Date

Tinlin Chiropractic - Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Circle Card Type: Mastercard VISA Discover AMEX Other_____

Cardholder's Name on Card: _____

Expiration Date (mm/yy):_____ **ZIP Code of Billing Address**_____

Last 4 numbers of the card being used: _____ **Security Code**_____

I,_____, authorize Tinlin Chiropractic to charge my credit card above for agreed upon purchases of services and products. I understand that my information will be saved in the Tinlin Chiropractic ***Square Up*** account and my Electronic Medical Records for future transaction on my account.

_____ _____

Patient's Signature **Date**

Once the information above and below is entered into your file, this section will be detached and shredded in our office, in your presence if you prefer and we will scan the top section into your electronic medical records file.

Credit Card Number: _____

Thank you for your understanding and cooperation.