Tinlin Chiropractic

NEW PATIENT INFORMATION

Name: _____ Date of Birth: _____ Today's Date: _____

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

Home Phone: _____ Alt. Phone: _____ Email: _____

Social Security Number: _____ Marital Status: ____ Occupation: _____

Employer: _____ Health Insurance: **Y-N** Insurance Company? _____

Who *referred* you to us? _____

Please list any and all **SURGERIES** you have undergone: _____

_____

Please list any and all **MEDICATIONS** you take: _____

_____

Please list any and all **ALLERGIES** you have: _____

_____

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.): _____

_____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

_____

HOW CAN WE HELP YOU?

What brings you in today? _____

How long have you had these issues? _____

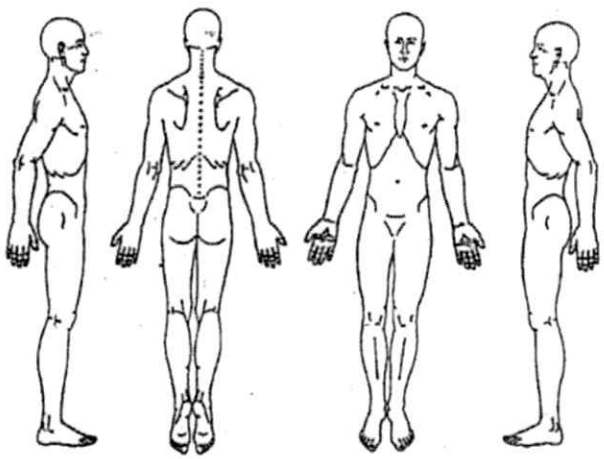
Is your health better, same or worse than it was this time last year? _____

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 below):

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*

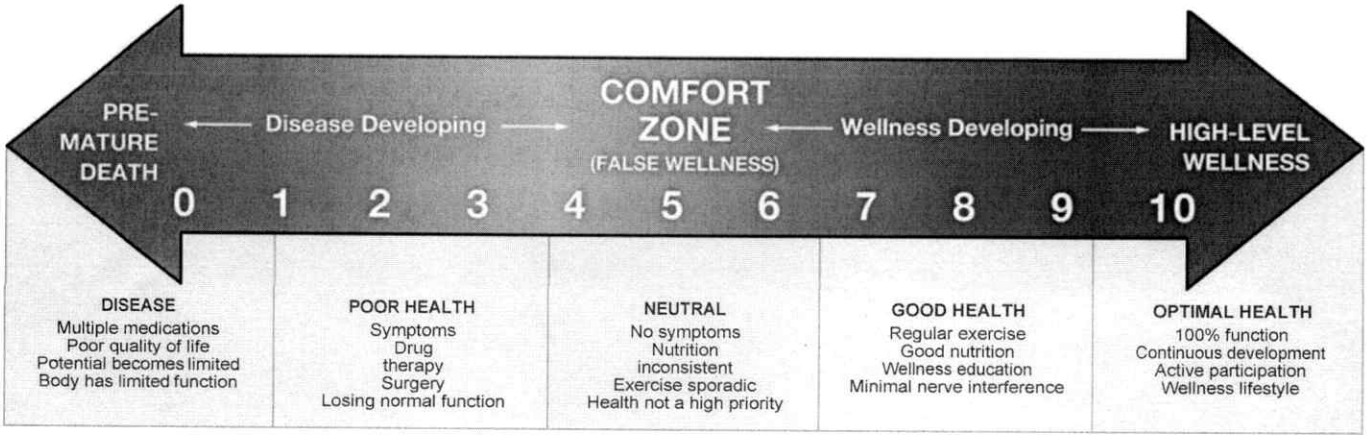
IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

******On a scale of 0 – 10 (0 being NOT committed, 10 being VERY committed), how committed are you to correcting this issue?*** _____

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

1. What number do you think represents your health today? _____
2. In what direction is your health currently headed (down/up)? _____

What are your **health goals**?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

Automobile Accident Questionnaire

Name:_____

Date of Accident:_____ **Today's Date:**_____

The following questions pertain to you ad the vehicle you were in:

VEHICLE TYPE:

___Car ___Pickup
___Van ___Truck
___Station Wagon ___Bus
___Other_____

VEHICLE SIZE:

___Subcompact ___Full-Size
___Compact ___Mini
___Mid-Size ___Light
___Heavy ___Other_____

YOUR POSITION IN THE VEHICLE:

___Driver
___Passenger
___Left ___Middle ___Right ___Front Passenger ____Rear Passenger
___Third Seat (rear) ____Other (please specify_____)

SPEED OF YOUR VEHICLE:

___Stopped ___Moving Moderately
___Parked ___Moving Fast
___Slowing ___Moving at apprx_____MPH
___Moving Slowly

WHY VEHICLE WAS SLOWED OR STOPPED:

___Traffic Signal ___Parking ___Stop Sign
___Pedestrian ___Traffic ___Busy Intersection

COLLISION TYPE:

___Drivers Side Impact ___Head-on Collision ___Front Impact
___Passenger Side Impact ___Rear Impact ___Pedestrian Incident

The following questions concern the other vehicle involved in the accident:

VEHICLE TYPE:

___Car ___Pick-up
___Van ___Truck
___Station Wagon ___Bus
___Other_____

VEHICLE SIZE:

___Subcompact ___Full-size
___Compact ___Mini
___Mid-Size ___Light
___Heavy ___Other_____

Conditions at the time of the accident:

TIME OF DAY:
___Full Daylight
___Dawn
___Dusk
___Night

ROAD CONDITIONS:
___Dry
___Damp
___Wet
___Snow-covered
___Ice-covered
___Patchy Ice/Snow

VISIBILITY:
___Excellent
___Good
___Fair
___Poor

VISIBILITY COMPROMISED BY:
___Brightness ___Darkness ___Fog
___Rain ___Snow ___Traffic

The following questions concern the moment of impact of the accident:

WERE YOU:
___Unaware that the accident was impending
___Aware that the accident was impending
___Aware that the accident was impending and braced for it

RESTRAINTS:
___Seat belt
___Shoulder harness
___No restraints

IF YOU WERE THE DRIVER OF THE VEHICLE, WAS YOUR FOOT ON THE BRAKE PEDAL?
___Yes ___No ___Knocked off by impact

WAS THE AIR BAG DEPLOYED:
___Car not equipped with airbag ___Air bag deployed ___Air bag not deployed

WHAT POSITION WAS YOUR HEADREST IN:
___High position ___Middle position ___Low position

POSITION OF YOUR HEAD AT IMPACT:
___Facing straight ahead ___Tilted forward
___Rotated to the left ___Rotated tot he right

WAS YOUR HEAD THROWN?
___Backward and then forward ___Forward and the backward
___To the left ___To the right
___To the left, then the right ___To the right, the the left

POSITION OF YOUR BODY AT TIME OF IMPACT:
___Straight ___Tilted forward ___Rotated to the left ___Rotated to the right

WAS YOUR BODY THROWN?
___Backward and then forward ___Forward and then backward ___To the left
___To the left then the right ___To the right then the left ___To the right
___Across the vehicle ___Outside of the vehicle

___Under the vehicle

DAMAGE TO THE VEHICLE YOU WERE IN:

___Incurred minimal damage
___Incurred moderate damage
___Incurred severe damage
___Was totaled
___Not known

CITATIONS:

___None issued
___Yourself
___Driver of vehicle in which you were passenger
___Driver of other vehicle
___Not sure

As a result of the force of the collision, which object in the vehicle did your body strike:

HEAD:

___Steering wheel
___Dashboard
___Windshield
___Armrest
___Headrest
___Rear view mirror
___Left door
___Right door
___Left window
___Right window
___Console
___Gearshift
___Front seat
___Backseat

LEFT ARM:

___Steering wheel
___Dashboard
___Dashboard
___Armrest
___Headrest
___Rear view mirror
___Left door
___Right door
___Left window
___Right window
___Console
___Gearshift
___Front seat
___Backseat

RIGHT ARM:

___Steering wheel
___Dashboard
___Windshield
___Armrest
___Headrest
___Rear view mirror
___Left door
___Right door
___Left window
___Right window
___Console
___Gearshift
___Front seat
___Backseat

TORSO:

___Steering wheel
___Dashboard
___Dashboard
___Armrest
___Headrest
___Rear view mirror
___Left door
___Right door
___Left window
___Right window
___Console
___Gearshift
___Front seat
___Backseat

LEFT LEG:

___Steering wheel
___Dashboard
___Windshield
___Armrest
___Headrest
___Rear view mirror
___Left door
___Right door
___Left window
___Right window
___Console
___Gearshift
___Front seat
___Backseat

RIGHT LEG:

___Steering wheel
___Dashboard
___Dashboard
___Armrest
___Headrest
___Rear view mirror
___Left door
___Right door
___Left window
___Right window
___Console
___Gearshift
___Front seat
___Backseat

The following questions concern the time period immediately following the accident:

DID YOU LOSE CONSCIOUSNESS:

___Yes ___No

IMMEDIATELY FOLLOWING THE ACCIDENT DID YOU FEEL…?

___Dizzy ___Weak ___Dazed ___Nervous ___Disoriented ___Nauseated

WERE YOU ABLE TO WALK UNAIDED?:

___Yes ___No

WHERE DID YOU GO…?

___Drove home ___Was driven home ___Drove to work
___Was driven to work ___Drove to hospital ___Was driven to hospital
___Drove to school ___Was driven to school ___Taken to hospital by ambulance

NEXT DAY DISCOMFORT…?

___Increased ___Decreased ___Same

DID YOUR MAJOR COMPLAINTS EXISTS BEFORE THE ACCIDENT?

___Yes ___No

IN WHAT AREAS DID YOU IMMEDIATELY FEEL PAIN?

___Head ___Shoulder (__Left __Right) ___Hip (__Left__Right)
___Neck ___Arm (__Left __Right) ___Thigh (__Left___Right)
___Upper back ___Elbow (__Left__Right) ___Knee (__Left__Right)
___Mid back ___Wrist (__Left __Right) ___Calf (__Left__Right)
___Ribs ___Hand (__Left__Right) ___Ankle (__Left__Right)
___Chest ___Fingers (__Left__Right) ___Foot (__left__Right)
___Abdomen ___Buttock (__Left__Right) ___Toes (__Left__Right)
___Lower back ___Pelvis

IN WHAT AREAS DID YOU EXPERIENCE LACERATIONS (CUTS)?

___Head ___Shoulder (__Left __Right) ___Hip (__Left__Right)
___Neck ___Arm (__Left __Right) ___Thigh (__Left___Right)
___Upper back ___Elbow (__Left__Right) ___Knee (__Left__Right)
___Mid back ___Wrist (__Left __Right) ___Calf (__Left__Right)
___Ribs ___Hand (__Left__Right) ___Ankle (__Left__Right)
___Chest ___Fingers (__Left__Right) ___Foot (__left__Right)
___Abdomen ___Buttock (__Left__Right) ___Toes (__Left__Right)
___Lower back ___Pelvis

AT THE HOSPITAL, WHAT AREAS WERE X-RAYED?

___Head ___Shoulder (__Left __Right) ___Hip (__Left__Right)
___Neck ___Arm (__Left __Right) ___Thigh (__Left___Right)
___Upper back ___Elbow (__Left__Right) ___Knee (__Left__Right)
___Mid back ___Wrist (__Left __Right) ___Calf (__Left__Right)
___Ribs ___Hand (__Left__Right) ___Ankle (__Left__Right)
___Chest ___Fingers (__Left__Right) ___Foot (__left__Right)
___Abdomen ___Buttock (__Left__Right) ___Toes (__Left__Right)
___Lower back ___Pelvis

WHERE DID YOU EXPERIENCE PAIN ON THE DAY FOLLOWING THE ACCIDENT?

___Head
___Neck
___Upper back
___Mid back
___Ribs
___Chest
___Abdomen
___Lower back
___Shoulder (__Left __Right)
___Arm (__Left __Right)
___Elbow (__Left__Right)
___Wrist (__Left __Right)
___Hand (__Left__Right)
___Fingers (__Left__Right)
___Buttock (__Left__Right)
___Pelvis
___Hip (__Left__Right)
___Thigh (__Left___Right)
___Knee (__Left__Right)
___Calf (__Left__Right)
___Ankle (__Left__Right)
___Foot (__left__Right)
___Toes (__Left__Right)

SIGNATURE:_____

Tinlin Chiropractic

710 Breckenridge Lane, Suite 201, Louisville, KY 40207
Phone: 502-897-5181 • Fax: 502-897-5122
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, specialized nervous system scanning, 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)
*Treatment of minor without legal guardian present/Minor has own driver's license and will come unattended

Witness Signature: _____ Date: _____

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Lien and Direction of Payment

Patient's Name:_____ Date:_____

As the person presenting for professional services at Tinlin Chiropractic I, the undersigned, do understand and agree that in order to receive credit in this office for treatment associated with a Personal Injury Protection (PIP) claim on my automobile insurance, I must authorize all payments to come directly to Tinlin Chiropractic and I acknowledge that I have not and will not sign a Direct Payment form from my insurance company obligating them to make payment directly to me.

I understand and agree that in the event I utilize legal services to resolve my PIP claim, either now, at the time I begin care in this office or at some point in the future, that I will inform that attorney that I have signed this agreement and require that attorney to pay this office directly any sums due for medical services provided to me due to this accident AND I also instruct and authorize any attorney I presently have or consign in the future regarding this case, to verify my outstanding account balance before settling a case of dispersing funds following a judgment or verdict. I am hereby giving Tinlin Chiropractic a lien on my case regarding any and all proceeds of any settlement, judgment or verdict that is paid to me or my attorney.

In exchange for Tinlin Chiropractic extending me credit for the professional services required to help me overcome and recover from my injuries I agree to never rescind this document and that a rescission will not be honored by my attorney. In the event another attorney is substituted in this matter, the new attorney will honor this lien and the terms of the direction of payment outlined above.

Regardless of my insurance coverage and my legal standing, I fully understand, agree and acknowledge that I am responsible for all fees generated by my participation in care in this office and that this agreement is made solely for the additional protection and consideration of Tinlin Chiropractic awaiting payment.

I agree to notify Tinlin Chiropractic doctors and staff if and/or when I retain an attorney to represent my interest in matters related to this accident I will require that attorney to sign this agreement affirming his/her understanding of the terms outlined above.

Patient's signature:_____ Date:_____

Attorney's Signature:_____ Date:_____

Credit card number kept in this patient's file in TC electronic medical records.

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FINANCIAL POLICIES

Our top priority is to help you achieve optimal health and wellness. However, when it comes to all forms of healthcare, the topic of financial coverage cannot be overlooked. Dr. Tinlin is a credentialed provider for some insurance companies, but not all. Each health insurance policy is different. You may have a co-pay at each visit, a high-deductible plan, or perhaps you have Medicare. Insurance regulations require us to follow specific guidelines, so we want to clearly explain how this affects your care.

Currently, Anthem Blue Cross Blue Shield is the ONLY major commercial health insurance carrier for which Dr. Tinlin is a participating provider. If you have another insurance carrier that we are not credentialed with, we will not be able to file a health insurance claim for you, and you will be regarded as a "private-pay" cash patient. Prior to your appointment, we strongly encourage you to contact your insurance carrier to determine your individual coverage, eligibility, and benefits. For your knowledge, the following is a general breakdown of each financial coverage category:

- **Anthem Blue Cross Blue Shield**: This is the only primary commercial health insurance carrier that our office accepts. For the most part, Anthem is a very lenient and favorable insurance for chiropractic care. They have minimal restrictions, and their coverage of our routine chiropractic services is adequate. They require less paperwork, and typically do not "recover" payments once they have been made. However, some Anthem plans are becoming more restrictive than others, and they will actively deny certain therapy service charges that we commonly perform, for which you will be financially responsible.

- **High-Deductible Plan**: If your insurance plan has a high deductible, we are obligated to charge you in accordance with the "Fee Schedule" that we have with that insurance carrier. In other words, we cannot charge you our "retail" fee schedule since we have agreed to a contracted fee schedule by your insurance carrier. The negotiated fees that we charge for the services we perform will go toward your plan's deductible. Once your deductible is met, your plan will transition to a co-pay or co-insurance plan. High-deductible insurance plans are becoming more common each year. If you have one of these plans, you are essentially a "discounted" cash patient; the only difference is that we file your claims with your insurance at each visit, and that amount goes toward your deductible.

- **Private-Pay (Cash)**: If you have no insurance or have a plan with a non-contracted carrier, you are regarded as a flat-fee cash patient. In our office, the flat fee for a standard chiropractic treatment (including laser, but excluding spinal decompression) is $75. Any new patient (or former patient who has not been seen in 5+ years) who seeks care at our office will be charged a separate, one-time $150 new-patient exam and consult fee. There

may also be instances when an established cash patient is charged a $50 re-examination fee if it has been a considerable amount of time since their last visit, or when they present with an acute injury or new condition that requires a clinical examination.

- **Medicare**: We accept Medicare. However, our office operates as a **non-participating provider** with Medicare, which means we will collect our normal cash fee up front, file Medicare claims for you, and any reimbursement checks for the claims we file will be sent to you personally from Medicare. Medicare only pays a small portion of "acute" care and does not cover other treatments (spinal manipulation only). Consequently, you will be asked to review and sign an ABN (Advanced Beneficiary Notification) verifying that you were made aware that Medicare does not pay for "maintenance" care or any other additional services and therapies. *Acute care means there was an event that limits your activities of daily living, and your care is intended to restore you to the level of function you had before the event. Maintenance care is routine care —say, once per month — designed to keep you functioning even in the absence of a precipitating event.* Maintenance care is intended to keep you in good working order, but **Medicare will NOT pay for maintenance services**. Therefore, we do not bill Medicare once you leave acute care and are on a "maintenance" or "wellness" care plan.

- **Auto Accident/Personal Injury Cases**: Personal injury cases involving a car accident are typically covered in full by the overseeing insurance provider. Most of the time, the patient only needs to show up for their appointment, with no personal payment required. In some circumstances, however, the patient's coverage may be limited or capped regarding the amount of PIP (Personal Injury Protection) coverage they have or the therapies allowed by their case carrier. In this instance, **the patient would be personally responsible for any outstanding fee balance that their carrier does not cover.**

Outstanding Account Balances: Most payments for our services are collected at the time of service. However, there may be instances when your patient account has an outstanding balance, especially when we file insurance claims on your behalf. While this does not happen often, any outstanding balance is most likely due to denied coverage or recoupment of payment from your insurance carrier. When this happens, you will be directly responsible for any outstanding balance on your account. You have the right to pay the balance via any payment method you desire. **If you already have a credit card on file with us and it is authorized for use, we will assume that is your preferred method of payment and charge your credit card accordingly. For any balance exceeding $40, we will contact you directly to notify you of the balance and the pending charge to your account.**

I have read and understand Tinlin Chiropractic's financial policies. I understand that if any service that Tinlin Chiropractic renders is either not covered, denied, or recuperated, I will be financially responsible for it at the time of service:

Signature: _____ Date: _____

Tinlin Chiropractic

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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 microcirculation, 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 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:

> **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 services, the fee is $20.

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

_____ _____

Patient Signature Date

Tinlin Chiropractic

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Phone: 502-897-5181 • Fax 502-897-5122

SPINAL DECOMPRESSION THERAPY

Purpose of Treatment:
I understand that spinal decompression therapy is a non-surgical treatment designed to relieve back pain and other symptoms caused by disc problems, degenerative disc disease, posterior facet syndrome, sciatica, numbness and tingling associated with nerve root compression, and other spinal conditions. The therapy works by gently stretching the spine to create negative pressure within the spinal discs, promoting the movement of water, oxygen, and nutrient-rich fluids into the discs to promote healing.

Nature of the Treatment:
I understand that I will be fitted with a harness and lie either prone (face down) or supine (face up) on a computer-controlled, motorized table that delivers controlled decompression forces to my spine. Treatment sessions typically last 10-20 minutes and may require multiple sessions over several weeks.

Potential Benefits:
The potential benefits include: relief of back and neck pain, relief of sciatica and radiating pain, improved disc health, increased mobility, and reduced pressure on spinal nerves.

Potential Risks and Side Effects:
While spinal decompression therapy is generally safe, I understand there are potential risks and side effects, including but not limited to: muscle soreness or spasm, temporary increase in pain, dizziness or lightheadedness, muscle fatigue, and in rare cases, increased disc herniation or injury

Contraindications:
I have informed my healthcare provider of any conditions that may contraindicate this treatment, including pregnancy, fractures, tumors, abdominal aortic aneurysm, advanced osteoporosis, metal implants in the spine, or severe instability of the spine.

Consent to Treat – Release & Waiver:
I voluntarily consent to receive spinal decompression therapy. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I have read and fully understand this consent form, and I authorize treatment. I hereby release Tinlin Chiropractic, PLLC, its employees, agents, and assigns from any and all liability for any injury or damage that may result from my participation in spinal decompression therapy, except in cases of gross negligence or willful misconduct.

Financial Responsibility:
Due to a lack of insurance coverage and the additional "table time" required for each spinal decompression service, our office charges a separate **$10.00 fee** per treatment for both insurance and cash-paying patients. This fee is in addition to any other charges for chiropractic care.

Right to Refuse Treatment:
Any recommendation for spinal decompression therapy is NOT a requirement and is based strictly on the doctor's professional judgment of clinical necessity for each individual patient case. I understand that I have a right to refuse spinal decompression at any time I may desire, even if recommended by the doctor.

I acknowledge that I have been given the opportunity to ask questions about the treatment and that those questions have been answered to my satisfaction. I have read this document in its entirety and fully understand its contents.

Signature: _____ Date: _____

Tinlin Chiropractic

Credit Card Authorization

To make it easier to pay your balance, we have implemented a procedure to automatically bill your credit card, which is stored **securely** in our system. Please complete the authorization form below to set up payment into your account within our office Square appointment scheduler, and payment collector:

I hereby authorize Tinlin Chiropractic to charge my credit card as indicated below for the amount specified. I understand that this authorization will remain in effect until I notify Tinlin Chiropractic in writing to cancel it.

Cardholder Information:

Cardholder Name: _____

Credit Card #: _____

Expiration Date: _____ CVV: _____

Billing Zip Code: _____

Privacy and Security Assurance: Your credit card information will be securely stored and processed in compliance with PCI DSS. We will not share your information with any third parties.

Revocation of Authorization: This authorization may be revoked at any time by providing written notice to Tinlin Chiropractic.

Authorization for Outstanding Account Balance: I authorize Tinlin Chiropractic to use my credit card information to clear any outstanding balance on my patient account. I understand that Tinlin Chiropractic will notify me of any balance greater than $40, and for any balance less, my credit card will be automatically processed to clear the balance on my account.

Cardholder Signature: _____ Date: _____

If you have any questions or wish to set up this automatic payment authorization, please contact our office at 502-897-5181.