STEWART
CHIROPRACTIC CENTER

Important Information needed for MVA/PI

Name: ______________________________________

Date of Accident: ______________________________

Were you determined “at fault”? YES NO

Have you filed a claim with your auto insurance? YES NO

“At Fault” Insurance Company: ___________________________

Claim #: _____________________________________

Does your auto policy have Medical/MedPay available?

YES NO If so, how much ______________

Medical MVA Insurance Adjuster Name: _______________________

Medical MVA Insurance Adjuster Number: ______________________

Medical MVA Insurance Adjuster Fax Number: ______________________

Medical MVA Insurance Adjuster Email address: ______________________

Attorney Name: _______________________________

Attorney Number: _____________________________

Other healthcare sought due to this MVA?

____

**Please provide a copy of your “Auto Insurance Declaration Page”

Drs. Samuel & Clare Stewart, D.C.

STEWART
CHIROPRACTIC CENTER

Date: ________________________________

Attention: _____________________________________
(Adjuster / Firm)

I, ____________________________________, am requesting and authorizing
(Practice Member / Patient)

______________________________________ to directly make payments to Stewart Chiropractic Center,
(Adjuster / Firm)

Drs. Samuel and Clare Stewart, for Chiropractic Care related to injury claims upon settlement.

I understand that I am directly and fully responsible to said Doctors for all chiropractic bills submitted by him/her for services rendered to me. This agreement is made solely for the Doctor's additional protection and in consideration of his/her awaiting payment. I also understand that payment is not contingent on any settlement, claim, judgement or verdict by which I may recover said fees.

____________________________________ ________________________ ____________________________

Signature of Practice Member / Patient | Date | Stewart Chiropractic Representative

---

_____________________________________agrees to make direct payment to Stewart Chiropractic Center
(Adjuster / Firm)

Drs. Samuel and Clare Stewart, for Chiropractic services rendered to ______________________________
(Practice Member / Patient)

upon settlement of his/her injury claim.

____ ____

Adjuster Name / Firm ***PLEASE PRINT*** | Adjuster Signature and Date

____________________________________ ____

Adjuster Phone | Adjuster email ***PLEASE PRINT***

PLEASE FAX SIGNED LIEN AGREEMENT ALONG WITH A LETTER OF REPRESENTATION TO (615) 447-5244

www.gostewarthealth.com
326 New Shackle Island Rd., Suite 100. Hendersonville, TN 37075. 615-447-5088. FAX 615-447-5244

STEWART CHIROPRACTIC CENTER HEALTH PROFILE

Name__________________________________ Today's Date____/____/____ Age_____ Male Female

Address______________________________________City___________________State_____Zip__________

Primary Contact #: ____________________ Home ( ) Cell ( ) Work ( ) Date of Birth_____/_____/______

Email __________________________________ Cell Carrier: ________________

Occupation__________________________________ Employer's Name _____________________________

Single / Engaged / Married / Divorced / Widowed Spouse's Name (or Parent if a minor) _______________

# of Children______ Names, Ages & Gender____

Who may we thank for referring you to us? ____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. ____________________	______________	____________	______________	_____________	____________
2. ____________________	______________	____________	______________	_____________	____________
3. ____________________	______________	____________	______________	_____________	____________
4. ____________________	______________	____________	______________	_____________	____________
5. ____________________	______________	____________	______________	_____________	____________

PLEASE DESCRIBE HOW YOUR HEALTH CONCERNS ARE AFFECTING YOUR LIFE _________________________

____

IF YOU ARE EXPERIENCING PAIN, IT IS _____SHARP _____DULL

DOES THE PAIN TRAVEL OR RADIATE ANYWHERE? _____YES _____NO

IF YES, PLEASE DESCRIBE FURTHER____

SINCE YOUR PROBLEM STARTED, IT IS _____SAME ______GETTING BETTER ______GETTING WORSE

WHAT MAKES IT WORSE? _______________________WHAT MAKES IT BETTER? _______________________

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES NO

CHIROPRACTOR? _______________ MEDICAL DOCTOR? ___________________OTHER_________________

WHO AND WHEN?____

LIST ALL SURGICAL OPERATIONS AND YEARS ____

____

LIST ALL Over the counter & PRESCRIPTION MEDICATIONS YOU ARE ON _____________________________

____

WHEN WAS YOUR MOST RECENT AUTO ACCIDENT____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? **YES** **NO**

IF YOU HAVE, DR. & DATE____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? **YES** **NO** **FRACTURED A BONE?** **YES** **NO**

IF YES, PLEASE DESCRIBE____

OTHER TRAUMA:____

___

CIRCLE ***ALL CURRENT PROBLEMS YOU HAVE***

DIZZINESS	***THROAT ISSUES***	***KIDNEY PROBLEMS***	***LIVER DISEASE***	***NERVOUSNESS***
HEADACHES	***THYROID PROBLEMS***	***MID BACK PAIN***	***SHOULDER PAIN***	***EPILEPSY***
VERTIGO	***ASTHMA***	***IRRITABLE BOWEL***	***CHRONIC FATIGUE***	***DISC PROBLEM***
EAR INFECTIONS	***ULCERS***	***SCIATICA***	***LUPUS***	***INFERTILITY***
NAUSEA	***NUMBNESS IN ARMS***	***NUMBNESS IN LEGS***	***FIBROMYALGIA***	***GASTRIC REFLUX***
TMJ	***NUMBNESS IN HANDS***	***NUMBNESS IN FEET***	***CHEST PAIN***	
NECK PAIN	***MENSTRUAL DISORDER***	***LOW BACK PAIN***	***ARM PAIN***	***OTHER***____________
MIGRAINES	***HEART DISORDERS***	***HIP PAIN***	***ADD/ADHD***	__________________
ANXIETY	***STOMACH DISORDERS***	***LEG PAINS***	______________	__________________
CHRONIC SINUS	***BLADDER PROBLEMS***	***KNEE PAIN***	_______________	__________________

CIRCLE ***ANY CONDITION YOU HAVE NOW/ HAVE HAD:***

STROKE **CANCER** **HEART DISEASE** **SPINAL SURGERY** **SEIZURES** **SPINAL BONE FRACTURE** **SCOLIOSIS** **DIABETES**

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN WRITTEN CONSENT FOR A CHILD:

Practice member name who is a minor/child ___________________________________

Name of person filling out profile and relationship _______________________________

I authorize Dr. Samuel Stewart and/or Dr. Clare Stewart and any and all Stewart Chiropractic Center staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Stewart Chiropractic Center.

Please Circle: I DO / DO NOT authorize my child to drive themselves or be brought by another family member or friend to receive recommended chiropractic adjustments or reassessments throughout their care.

_____________________________ DATE

_____________________________ GUARDIAN SIGNATURE

_____________________________ WITNESS SIGNATURE

_____________________________ GUARDIAN'S RELATIONSHIP TO MINOR / CHILD

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.** THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF STEWART CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

______________________________ ______________
PRINT YOUR NAME HERE **DATE**

______________________________ ______________
SIGNATURE **YOUR AGE**

FEMALE PATIENTS ONLY: TO MY KNOWLEDGE, I BELIEVE (CIRCLE ONE) **I AM NOT PREGNANT / I AM PREGNANT**
AT THE TIME X-RAYS ARE TAKEN AT STEWART CHIROPRACTIC CENTER. BY SIGNING BELOW, I CONSENT TO X RAYS TAKEN OF THE AGREED-UPON SPINAL REGIONS ONLY.

______________________________ ______________
SIGNATURE **DATE**

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MA 300 Size14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _______________
CM_________ Kvp ________
MAS________ MA________
Size ______________

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17

Notes: ______________________________

CA Initials: ____________

Practice Member Information (Must be Completed Before Services Can Be Rendered)

NAME: ____
FIRST MIDDLE LAST

PHONE: Home______________________ Cell______________________ Work__________________

SOCIAL SECURITY NUMBER: _____________________ MARITAL STATUS: ____________

DATE OF BIRTH: _____________________

CONTACT IN CASE OF EMERGENCY: _________________________ Phone #: _________________

NAME OF PRIMARY INSURANCE CARRIER: ____

Name of Insured_________________________ Insured Date of Birth __________________

Insured Social Security Number __________________

NAME OF SECONDARY INSURANCE CARRIER: ____

Name of Insured_________________________ Insured Date of Birth __________________

Insured Social Security Number: __________________

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check $50-$75.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $40 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Samuel Stewart, DC or Clare Stewart, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed_______________________________________ **Date**________________

P.I PATIENT PROVIDER CONTRACT AND PROMISSORY NOTE

Entered This Day between Dr. Sam Stewart or Dr. Clare Stewart (hereinafter "Provider") and

______________________ (hereinafter "Patient"). Provider hereby agrees to establish an active account for the Patient and to provide essential services for the purposes of benefiting and improving Patient's current health conditions. Patient hereby agrees to pay Provider in full for services performed by Provider. Patient and Provider acknowledge that Patient retains any and all rights of suit to procure payment for and benefit Patient may be entitled.

In consideration of and for Provider rendering chiropractic services to Patient, and for the temporary suspension of any collection activity by Provider by the maintenance of an active account while not receiving payment at the point of service, Patient hereby authorizes and directs the following actions taken on Patient's behalf:

I. PATIENT AUTHORIZATIONS TO LIABILITY INSURANCE CARRIER: In consideration of the services to be rendered to Patient by Provider, and in lien of Provider sending direct billing to liability insurance carrier, Patient authorizes and directs liability insurance company to disclose the settlement status of Patients claim to Provider upon request, including settlement amounts thereof. After such time that Patient has settled the claim with the liability carrier, in consideration that Provider has not demanded payment at the point of service, Patient directs the liability carrier to include the name of Provider on any check to Patient upon settlement. In the event payment is made to Patient attorney after settlement of the claim, Patient further authorizes and directs the liability company to issue check to provider for the full amount owed for chiropractic services rendered to fully satisfy Patient's obligation to Provider.

II. PATIENT AUTHORIZATIONS TO ATTORNEY IF REPRESENTED: If Patient hires an attorney, Patient acknowledges that Patient is represented by _____________________ Attorney of Law. Patient and Provider stipulates, that representation by the above named attorney prior to settlement, judgement or verdict in the Patient's claim, Provider shall have the option to terminate this agreement and immediately collect from the Patient the full amount then owed to Provider. Patient further directs attorney to honor this agreement and to pay for services rendered after any settlement, judgement, or verdict rendered in patient's claim. Patient acknowledges and agrees to remain personally liable to Provider for any unpaid account balance to Provider.

III. BINDING ARBITRATION: In the event liability insurance carrier or Patient's attorney do not honor this agreement, both parties agree to submit to binding arbitration prior to the insurance with any funds after settlement is reached.

IV. PROMISORY NOTE: For the consideration stated above, Patient promises to pay Provider the full balance in Patient's account for services rendered to Patient. Payment shall be due and payable within 30 days of the last date of service or within 3 (three) days of settlement with liability carrier for injuries sustained by Patient and treated by Provider whichever occurs first, provided agreement has not been terminated by parties prior to these events, in which case the account balance will be due in full 3 (three) days after termination. Further the Patient agrees to the following:

IN THE EVENT PATIENTS ACCOUNT IS NOT PAID IN FULL WITHIN 30 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER OR ATTORNEY FOR INJURIES SUSTAINED BY PATIENT AND TREATED BY PROVIDER, WITHIN 3 (THREE) DAYS OF TERMINATION, WHICHEVER EVENT OCCURS FIRST, PATIENTS ACCOUNT SHALL BECOME DELIINQUENT.

Either party may terminate this agreement at any time, provided Patient's account remains in active status. It is agreed that, in the event Patient terminates this agreement, Patient shall pay full balance of Patient's account within 3 (three) days of termination or the account shall be in default. Patient has read and fully understands the terms of this agreement.

Date of Agreement: ____________________ ____

Patient Signature (or Guardian if a Minor)

____________________________________ ____

Witness Provider

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

____________________________ **(Signature)** ____________________ **(Date)**

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

____________________________ **(Signature)** ____________________ **(Date)**

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

____
PRINT PRACTICE MEMBER'S NAME HERE

____ _________________________
PRACTICE MEMBER'S SIGNATURE **DATE**

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

____ _________________________
SIGNATURE OF PRACTICE MEMBER OR GUARDIAN **DATE**

____
RELATIONSHIP TO MINOR/CHILD

____ _________________________
WITNESS SIGNATURE (OFFICE STAFF) **DATE**

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE ______________________ PLEASE PRINT YOUR NAME HERE ______________________

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					