Dunn Chiropractic Cl_ic
The Office of Dr. Ray Saeedpour
& Associates

2416 21st. Avenue South Ste.101
Nashville, TN. 37212
Office (615) 383-1246
Fax (615) 383-8260

1 PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

2 INSURANCE INFORMATION

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 certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) ______ Home Phone (_____) ______

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) ______

2416 21st Avenue South, Suite 101
Nashville, TN 37212
Ph: (615) 383-1246
Fax: 9615) 383-8260

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS

PLEASE FILL OUT FORM COMPLETELY, IF IT DOES NOT APPLY TO YOU PUT "NONE" NEXT TO THE QUESTION.

WHAT IS YOUR MAJOR SYMPTOM OR COMPLAINT?

____

TO WHAT EXTENT DOES THIS PROBLEM AFFECT YOUR DAILY ACTIVITIES(WORK, SLEEP, EATING, ETC.)?

____

HOW LONG HAS IT BEEN SINCE YOU FIRST NOTICED ANY SYMPTOMS?

____

IF THIS IS A RECURRENCE, WHEN WAS THE FIRST TIME YOU NOTICED THIS PROBLEM?

____

HAS IT BECOME WORSE RECENTLY? YES NO SAME BETTER GRADUALLY WORSE

IF YES, WHEN AND HOW?

____

HOW FREQUENT IS THE CONDITION? CONSTANT DAILY INTERMITTENT NIGHT ONLY

HOW LONG DOES IT LAST? ALL DAY FEW HOURS MINUTES

IS THERE ANYTHING YOU CAN DO TO RELIEVE THE PROBLEM? YES NO IF YES, DESCRIBE:

____

IF NO, WHAT HAVE YOU TRIED TO DO THAT HAS NOT HELPED? ______________________________

WHAT MAKES THE PROBLEM WORSE? STANDING SITTING LYING BENDING LIFTING TWISTING OTHER:______________________________

HAD YOU HAD ANY BROKEN BONES? YES NO IF YES, WHEN AND DESCRIBE: ______________________________

____

IS THE CONDITION DUE TO INJURIES OR SICKNESS ARISING OUT OF EMPLOYMENT? YES NO

IS THE CONDITION DUE TO INJURIES OR SICKNESS ARISING OUT OF AN AUTO OR OTHER ACCIDENT? YES NO

HAVE YOU BEEN GIVEN A DIAGNOSIS FOR THE PROBLEM BY YOUR FAMILY PHYSICIAN? YES NO

IF SO, WHAT IS IT? ______________________________

WHAT KIND OF TREATMENT OR THERAPY HAVE YOU TRIED? ______________________________

NUMBER OF DAYS LOST FROM WORK ____________ DATE SYMPTOMS APPEARED OR ACCIDENT OCCURRED ____________

HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION? YES NO IF YES, WHEN AND DESCRIBE:

____

WOMEN ONLY: ARE YOU PREGNANT OR IS THERE A POSSIBILITY YOU MAY BE PREGNANT? YES NO UNCERTAIN

REMARKS: ______________________________

PAST MEDICAL HISTORY (PLEASE PUT A √ ON THE APPROPRIATE SPACE)

DATE OF LAST PHYSICAL EXAM: ______________________________

WHAT OPERATIONS HAVE YOU HAD? ______________________ WHEN? ______________

SERIOUS ILLNESS: ______________________ WHEN? ______________

____ ALLERGIES ____ ANEMIA ____ ARTHRITIS ____ ASTHMA ____ BACKACHES

____ CANCER ____ DIABETES ____ DIGESTIVE DISORDERS ____ DIZZINESS ____ HEADACHES

____ HEART DISEASE ____ HERNIA ____ NERVOUSNESS ____ NEURITIS ____ NUMBNESS

____ RHEUMATIC FEVER ____ SEIZURES ____ SINUS PROBLEMS ____ TEST POSITIVE FOR HIV /AIDS

FAMILY MEDICAL HISTORY

____ ALLERGIES ____ ASTHMA ____ CANCER ____ DIABETES ____ HEART DISEASE

____ HIGH BLOOD PRESSURE ____ SEIZURES ____ STROKE ____ OTHER

OCCUPATIONAL

OCCUPATIONAL STRESS FACTORS (PHYSICAL, PSYCHOLOGICAL, CHEMICAL): ______________________________

____

LIFESTYLE

DO YOU FOLLOW A REGULAR EXERCISE PROGRAM? YES NO

IF YES, PLEASE DESCRIBE: ______________________________

____

PLEASE DESCRIBE YOUR DAILY DIET: ______________________________

____

PLEASE CHECK ANY OF THE FOLLOWING HABITS THAT APPLY. HOW MUCH AND HOW OFTEN DO YOU USE THEM?

____ CIGARETTE SMOKING ____ COFFEE, TEA OR COLA ____ ALCOHOLIC BEVERAGES

LIST MEDICATION TAKEN WITHIN THE LAST TWO MONTHS (VITAMINS, DRUGS, HERBS, ETC.): ______________

____

PLEASE DESCRIBE ANY USE OF DRUGS FOR NON-MEDICAL PURPOSES: ______________________________

____

PLEASE PUT A √ NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE (3) MONTHS.
INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION

GENERAL

____ POOR APPETITE ____ WEIGHT GAIN ____ NIGHT SWEATS ____ INSOMNIA ____ WEIGHT LOSS

____ FEVER ____ DISTURBED SLEEP ____ CHANGES IN APPETITE ____ CHILLS ____ SWEATING EASILY

____ LOCALIZED WEAKNESS ____ SUDDEN ENERGY DROP ____ CRAVINGS ____ TREMORS ____ STRONG THIRST

____ POOR BALANCE ____ BLEEDING OR BRUISING EASILY

OTHER UNUSUAL OR ABNORMAL CONDITIONS YOU HAVE NOTICED IN YOUR GENERAL SENSE OF HEALTH:

____

SKIN AND HAIR

____ RASHES ____ ECZEMA ____ RECENT MOLES ____ ULCERATION'S ____ PIMPLES

____ HIVES ____ DANDRUFF ____ ITCHING ____ HAIR LOSS ____ CHANGES IN SKIN OR HAIR TEXTURE

HEAD, EYES, EARS, NOSE, THROAT

____ DIZZINESS ____ COLOR BLINDNESS ____ CONCUSSIONS ____ CATARACTS ____ NOSE BLEEDS

____ RECURRENT SORE THROAT ____ MIGRAINES ____ BLURRY VISION ____ GRINDING TEETH

____ GLASSES ____ EARACHES ____ SPOTS IN FRONT OF EYES ____ JAW CLICKS ____ FACIAL PAIN

____ EYE PAIN ____ POOR HEARING ____ TEETH PROBLEMS ____ POOR VISION ____ HEADACHES

____ NIGHT BLINDNESS ____ SINUS PROBLEMS

CARDIOVASCULAR

___ DIZZINESS ____ HIGH BLOOD PRESSURE ____ SWELLING OF FEET ___ LOW BLOOD PRESSURE

___ FAINTING ___ BLOOD CLOTS ___ CHEST PAIN ___ COLD HANDS OR FEET

___ DIFFICULTY BREATHING ___ PHLEBITIS ___ IRREGULAR HEARTBEAT ___ SWELLING OF HANDS

ANY OTHER HEAD OR NECK PROBLEMS: ______________________________

RESPIRATORY

____ COUGH ____ BRONCHITIS ____ DIFFICULTY BREATHING WHILE LYING DOWN ____ ASTHMA

____ COUGHING UP BLOOD ____ PNEUMONIA ____ PAIN WITH DEEP INHALATION

____ EXCESSIVE PHLEGM (COLOR?)

ANY OTHER LUNG PROBLEMS: ______________________________

GASTROINTESTINAL

____ NAUSEA ____ RECTAL PAIN ____ VOMITING ____ BLACK STOOLS ____ HEMORRHOIDS

____ BLOOD IN STOOLS ____ CONSTIPATION ____ INDIGESTION ____ GAS ____ CHRONIC LAXATIVE USE

____ ABDOMINAL PAIN OR CRAMPS

ANY OTHER PROBLEMS WITH STOMACH OR INTESTINES? ______________________________

GENITOURINARY

____ PAIN ON URINATION ____ URGENCY TO URINATE ____ DECREASE IN FLOW ____ FREQUENT URINATION
____ UNABLE TO HOLD URINE ____ IMPOTENCE ____ BLOOD IN URINE

DO YOU WAKE UP AT NIGHT TO URINATE? YES NO IF SO, HOW OFTEN? ____________________

ANY PARTICULAR COLOR TO YOUR URINE? YES NO IF SO, WHAT COLOR? ____________________

ANY OTHER GENITAL OR URINARY PROBLEMS? ____________________

REPRODUCTIVE AND GYNECOLOGIC

____ PREMESTRUAL CHANGES ____ HEAVY MENSTRUAL FLOW ____ PREMATURE BIRTHS ____ MISCARRIAGES
____ MENSTRUAL CLOTS ____ LIGHT MENSTRUAL FLOW ____ PAINFUL MENSES ____ IRREGULAR MENSES
____ UNUSUAL MENSES ____ OTHER PROBLEMS: ____________________

DO YOU PRACTICE BIRTH CONTROL? YES NO IF SO, WHAT TYPE? ____________ FOR HOW LONG? ________

OTHER GYNECOLOGIC PROBLEMS? ____________________

MUSCULOSKELETAL

____ NECK PAIN ____ BACK PAIN ____ HAND/WRIST PAIN ____ MUSCLE PAINS ____ MUSCLE WEAKNESS
____ SHOULDER PAIN ____ KNEE PAIN ____ FOOT / ANKLE PAIN ____ HIP PAIN

ANY OTHER BONE OR JOINT PROBLEMS? ____________________

NEUROPSYCHOLOGICAL

____ SEIZURES ____ POOR MEMORY ____ ANXIETY ____ DIZZINESS ____ BAD TEMPER
____ LACK OF COORDINATION ____ LOSS OF BALANCE ____ CONCUSSION ____ DEPRESSION
____ EASILY SUSCEPTIBLE TO STRESS ____ AREAS OF NUMBNESS

HAVE YOU EVER BEEN TREATED FOR EMOTIONAL PROBLEMS? YES NO

HAVE YOU EVER CONSIDERED SUICIDE? YES NO

ANY OTHER NEUROLOGICAL OR PSYCHOLOGICAL PROBLEMS? ____________________

COMMENTS

PLEASE LIST ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS:

____

____

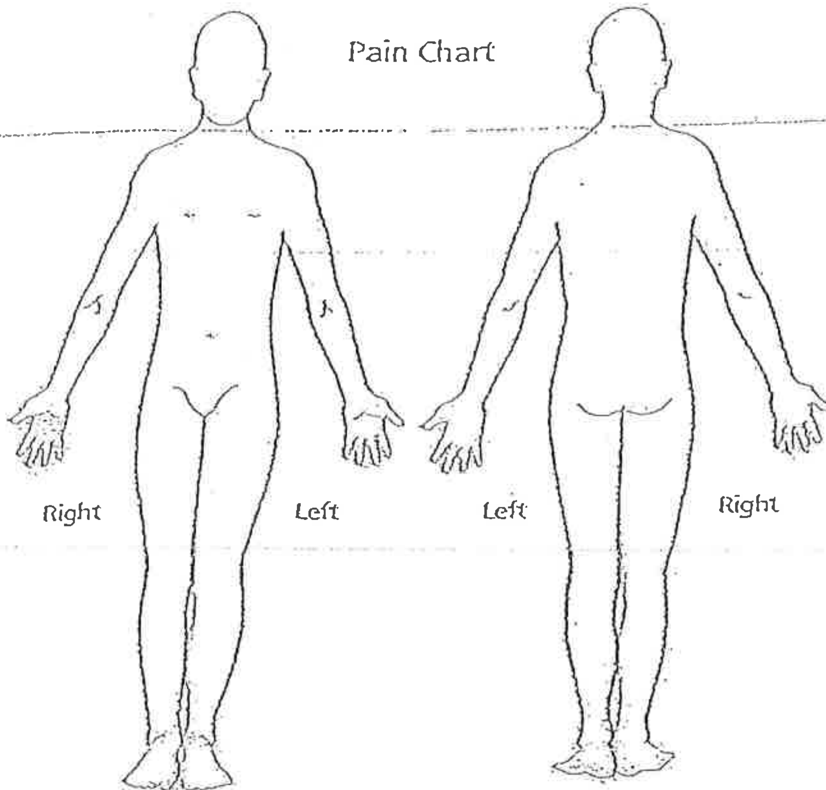
Patient Signature: ____________________

Date: ____________________

Show Area(s) of Pain or Symptoms that Concern You

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark all areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - -	00000000	XXXXXXXX	********	/ / / / /
- - - - - - - -	00000000	XXXXXXXX	********	/ / / / /
- - - - - - - -	00000000	XXXXXXXX	********	/ / / / /
- - - - - - - -	00000000	XXXXXXXX	********	/ / / / /



Please mark on the pain scale from 0 to 10 the pain you feel with this condition, 10 being the worst pain you have felt with this condition.

Pain Scale

Neck-Shoulder-Arm Pain
On a scale of 0 to 10.
I rate my discomfort as follows

0 no pain — 10 severe pain

Mid-Back Pain
On a scale of 0 to 10.
I rate my discomfort as follows

0 no pain — 10 severe pain

Lower Back Pain
On a scale of 0 to 10.
I rate my discomfort as follows

0 no pain — 10 severe pain

Date

Signature

CONSENT TO CARE
Dunn Chiropractic Clinic
Nashville TN. 37212

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known to the treating Chiropractic Physician of whatever he/she is currently (presently) or previously (in the past) suffering from (examples may include = cancer, cancer treatments, previous fractures, infections, medical or cosmetic or dental surgeries, implants of any kind, pace makers or any other implanted medical device, hospitalizations, medications, supplements, allergies, falls, accidents or injuries, bone softening disorders, osteoporosis, osteopenia, cardio-vascular problems or disorders, latent pathological defects or disorders, illnesses, or deformities which would otherwise not come to the attention of the treating Doctor).

I have read and understand the foregoing.

Patient's Signature ________________________ Date ____________

X-RAY QUESTIONNAIRE: **FOR WOMEN ONLY**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ______________________________

- ☐ There is a possibility that I may be pregnant at this time.
- ☐ **Yes. I am definitely pregnant**
- ☐ **No. I am definitely not pregnant at this time**
- ☐ I request that x-ray films not be taken because ______________________________

____

____

Date of last menstrual period: ____________

Patient's Signature ________________________ Date ____________

DUNN CLINIC
INTEGRATED PAIN SOLUTIONS

2416 21st Avenue South, Suite 101
Nashville, TN 37212
Office: (615) 383-1246 FAX: 615-383-8260

Medical Records Request

Patient Name: ______________________ **DOB:** ______________ **Date:** ______________

Requesting Provider: □ Dr. Ken Homolya, MD □ Dr. Barry Allen, MD □ Alison Anderson, ANP-BC, NP-C
□ Dr. Ray Saeedpour, DC □ Dr. Jordan Quint, DC □ Dr. Christine Wilkerson, DC
□ Rebekah Towne PA-C

Records Provider: ____

Fax: ______________________ **Phone:** ______________________

***Records**

□ **Complete Records:** ________________
□ **X-Ray Film/Region:** ________________
□ **X-Ray Report/Region:** ________________
□ **Labs:** ________________________

□ **Medical Records:** ________________
□ **MRI Report/Region:** ________________
□ **MRI Films/Region** ________________
□ **Other:** ________________

□ **Please fax records**

□ **Please mail records to above address**

I understand that this authorization allows the release of all information in my medical records. This authorization allows such record to be mailed or faxed. I understand that I may revoke this consent at any time. This consent will automatically expire without my expressed revocation 90 days form this date on this form.

Patient Signature: ______________________ Date: ______________

Clinic Representative: ______________________

Financial Policy

The following is an explanation of our clinic policy. We believe that a clear definition of our policy will allow us both to concentrate on the big issue-establishing, retaining and maintaining your health. We will be happy to answer any questions you have regarding our policy, your account and your insurance coverage.

Payments

At Dunn Clinic your health care needs are our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in attempt to assist you in meeting your financial obligations without increasing stress in your life.

- If you do not have insurance ALL payments are expected at the time of service. Prepayments are also allowed as well as financial arrangement if needed.
- If you have insurance ALL COPAYS & CO-INSURANCE are due at time of service. By taking care of this while you are in the office the need for an invoice is minimized.
- There will be a 1.5% finance charge added to all balances after 60 days.
- There will be a $25.00 charge on all returned checks.
- If you need any additional documentation other than a receipt please feel free to ask the front desk as we are able to provide that to you at no additional charge.

Insurance Coverage

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment or you will make payment arrangements with us.

X-rays & Treatment Notes

We will release your X-rays and treatment notes to another doctor only after you sign a release/transfer form and your account has been paid in full, unless you have been referred for a consultation. We need 48 hours notice to enable us to mail your records in time for your appointment.

Appointment/Treatment

Your scheduled time is very important to Dunn Clinic in order for us to provide excellent patient care. Rehabilitation and Massage Therapy appointments cancelled/ rescheduled less than 24 hours in advance or no showed, will receive a $25.00 fee. This includes all Acupuncture and Decompression therapy appointments. For all Medical office and procedure appointments missed, a fee of $50.00 will apply.

I have read and understand Dunn Clinic's office policies and I will honor them.

Patient's Printed Name:

Signature:______________________ Date:______________

Witness:______________________ Date:______________

{NAME OF PRACTICE}
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care.

This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

(b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Practice may also use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations –

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice:

a) a postcard mailed to you at the address provided by you; and

b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

____________________________________ ____________________

Patient Name (please print) Date

____

Parent, Guardian or Patient's legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Please list below the names and relationships of people to whom you authorize the Practice to release PHI.

____________________ ____________________

____________________ ____________________

____________________ ____________________

Patient Reminder Preferences

Welcome to the Dunn Chiropractic Clinic! Our office has several different contact methods to remind you of your upcoming appointments. We would appreciate if you could please check and initial the method most convenient to you:

- o _____ Email Reminder Only
- o _____ Text Reminder Only
- o _____ Email and Text Reminder
- o _____ Reminder Appointment Card

Our typical reminder program will send a reminder one week prior to your appointment, if you confirm via email to this no secondary follow up reminder will be sent. If you do not confirm to the first email message, a reminder will be sent 2 days before your appointment. A final reminder will be sent 3 hours before your scheduled appointment.

The reminder messages are for your benefit. Your appointment will not be altered if you do not confirm.

Do not reply to a text message.

We DO NOT accept changes via email or text. To change or make an appointment, please call the office.

If you need changes made to this, please notify the front desk and we can accommodate your needs.

Thank you