Confidential Patient Information Account #:_____

Name: _____ Hm Phone: _____ Wk/Cell Phone:_____

Address: _____ City:_____ St: _____ Zip:_____

Date of Birth: _____ Age_____ Marital Status (circle one) M S D W

Social Security Number _____-____-_____ E-mail Address _____

Occupation: _____ Employer:_____

Work Address: _____ City, St, Zip: _____

Spouse's Name: _____ # of Children: _____

Who may we thank for referring to our office: _____

Have you ever had Chiropractic care before? Yes ☐ No ☐ Date: _____

Is this injury/illness related to: Automobile Accident ☐

Date/Time: _____ Location:_____

Your Auto Insurance Co: _____ Phone:_____

Third Party Auto Insurance Co:_____ Phone: _____

Due to changes in health insurance fees, patient self billing has become a much more cost effective way for you, the patient, to get reimbursement for your care. Self billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longer be sent to your insurance provider. Statements will be provided for individuals to submit their own bills ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you.

All charges are due when services are rendered…

Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

---

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program. **Please Circle the type of care that best meets your needs.**

RELIEF CARE

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I authorize Smoot Family Chiropractic to render necessary services to me and understand that I am responsible for all charges incurred.

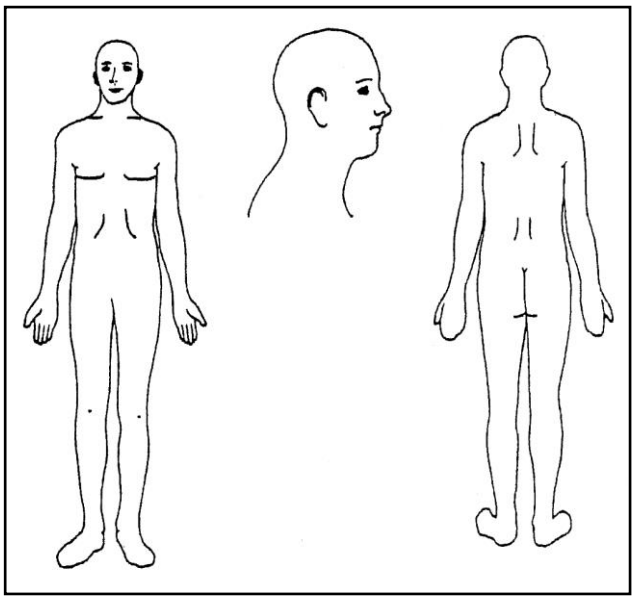
Patient Signature: _____ Date: _____

Parent or Legal Guardian Authorizing Care: _____

THANK YOU FOR ALLOWING US TO SERVE YOU!

Name: _____

PLEASE MARK AN X ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?

1. _____
2. _____
3. _____
4. _____

When do you think these problems originally started?

1. _____
2. _____
3. _____
4. _____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

1. _____
2. _____
3. _____
4. _____

Check any of the following you have had in the six months:

( ) Headaches
( ) Sinus Congestion/ Allergies
( ) Vision Problems
( ) Ear Aches
( ) Dizziness
( ) Heart Problems
( ) Lung Problems / Congestion
( ) Blood Pressure Problems
( ) Ankle Swelling
( ) Prostate/ Sexual Dysfunction
( ) Menstrual Cycle Dysfunction
( ) Numbness
( ) Frequent Nausea/ Vomiting
( ) Abdominal Cramps
( ) Constipation
( ) Diarrhea
( ) Poor / Excessive Appetite
( ) Excessive Thirst
( ) Painful / Excessive Urine
( ) Discolored Urine
( ) Diabetes
( ) Cancer

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure

SMOOT FAMILY CHIROPRACTIC
TERMS OF ACCEPTANCE

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.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the 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 infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, 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. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

SMOOT FAMILY CHIROPRACTIC

NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Smoot Family Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practice with respect to your protected health information.

Disclosure of your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment and healthcare operations.

Example:

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Smoot Family Chiropractic."

"It is our policy to provide a substitute health care provider, authorized by Smoot Family Chiropractic, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment of health care operations. (Example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier if your case is a Personal Injury for the purpose of payment to Smoot Family Chiropractic for health care services rendered. If you have personal health Insurance that you would like to bill please inform us so that at the beginning of the current month we will print off an itemized statement of the prior month visits that you can mail to your insurance company, they will send reimbursement checks to you if they deem necessary. The billing statement contains medical information, including diagnosis, date of injury or condition and codes which describe the health care service received"

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding

Law Enforcement

We may disclose your health information to a law enforcement official for purpose such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purpose.

Public Safety

It may be necessary to disclose your health information to appropriate person in order to prevent or lessen a serious and imminent to the health or safety of a particular person or to the general public

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purpose.

Patient Testimonials

Most patients **agree to share their personal testimony of how chiropractic has helped them**. In the event that patients wish to share their chiropractic story to help encourage other patients, we will only do so with the written consent of the patient.

Sign in Sheet

Our office utilizes a sign in sheet for clerical purpose; if you choose not to sign in we can make other arrangements.

Telephone

We may contact you for the purposes as described below: (example)

"As a courtesy to our patients, sometimes we may call your home on the evening prior to your scheduled and remind you of your appointment time. If you are not at home we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment".

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Smoot Family Chiropractic".

Change of Ownership

In the event that Smoot Family Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restriction on certain uses and disclosures of your health information. Please be advised, however, that Smoot Family Chiropractic is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Smoot Family Chiropractic amend your protected health information. Please be advised, however, that Smoot Family Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason (s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Smoot Family Chiropractic.
- **You have a right to a paper copy of this Notice of Privacy Practice at any time upon request.**

Change to this Notice of Privacy Practice

Smoot Family Chiropractic reserves the right to amend this Notice of Privacy Practice at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Smoot Family Chiropractic is required by law to comply with this Notice.

Smoot Family Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practice with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights contact Dr. Brian Smoot at (831) 751-3939

Complaints

Complaints about your Privacy rights or how Smoot Family Chiropractic has handled your health information should be directed to Dr. Brian Smoot by calling this office at (831) 751-3939. You may make an appointment for a personal conference in person or by telephone within two working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. S.W
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____
I have read the Privacy Notice and understand my rights contained in the notice

By way of my signature, I provide Smoot Family Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

ABRIBIATION AGREEMENT AND INFORMED CONSENT

I Hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and /or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, include those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/ or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks of treatment, including, but not limited to, fractures, disc injuries, strokes, dislocation and sprains. I do not expect the doctor to be able to anticipate and explain all risk and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctors feel at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment

PATIENTS SIGNATURE (OR PATIENT REPRESENATIVE)	(Date) (indicate relationship if signing for patient)
OFFICE SIGNATURE	(Date)

Dr. Smoot
Smoot Family Chiropractic
34 Iris Dr.
Salinas, CA 93906
831.751.3939

VIC:_____ DATE:_____