SMITH CHIROPRACTIC
PATIENT REGISTRATION FORM

Date _____

Social Security #

_____

First Name

_____

Middle Initial _____

Last Name

_____

Suffix: _____

Called Name: _____

Sex

☐ Male
☐ Female

Marital Status: _____

Birthdate: _____

Address:

_____

City _____

State _____

Zip Code _____

Home Phone

_____

Work Phone

_____

Cell Phone:

_____

Best time and place to Contact you:

_____

Email Address:

_____

Referred By:

_____

Insurance Information

Insurance Name

_____

Insured's Social Security #:

_____

Insured's Birthdate:

_____

Insured's ID#:

_____

Group Number:

_____

Employer/School Information

Name:

_____

Address:

_____

Phone: _____

Average Pain Intensity:

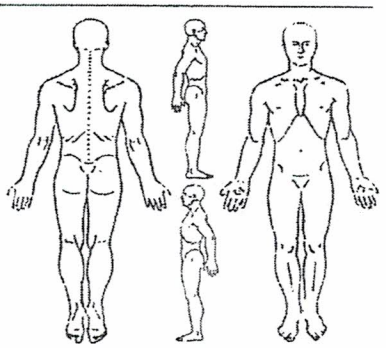
① ② ③ ④ ⑤
⑥ ⑦ ⑧ ⑨ ⑩

Briefly describe your symptoms:

_____

_____

_____



Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to *SMITH CHIROPRACTIC LLC* 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.

SMITH CHIROPRACTIC LLC 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.

Signature of Patient

_____

_____

Indicate where pain or other symptom

PATIENT HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name of other doctor(s) who have treated you for your condition.

_____

Date of Last: _____ Physical Exam _____ Spinal X-Ray _____ Blood Test
_____ Spinal Exam _____ Chest X-Ray _____ Urine Test
_____ Dental X-Ray _____ MRI, CT Scan, Bone Scan

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Alcoholism	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease		
Anorexia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No		☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Bleeding Disorders			Prothesis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No		☐ Yes	☐ No	Gout	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatoid Arthritis		
Bronchitis	☐ Yes	☐ No					☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Thyroid Problems		
Mononucleosis	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No		☐ Yes	☐ No
Multiple Sclerosis			Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	High Blood Pressure		
Diabetes	☐ Yes	☐ No	Migraine Headaches				☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No		☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Chemical dependency			Tumors/Growths	☐ Yes	☐ No
Fractures	☐ Yes	☐ No		☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Sexually transmitted Diseases			Ulcers	☐ Yes	☐ No
Goiter	☐ Yes	☐ No		☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
						Other _____		

EXERCISE	WORK ACTIVITY	HABITS	
☐ NONE	☐ Sitting	☐ Alcohol	Drinks/Week _____
☐ MODERATE	☐ Standing	☐ Coffee/Caffeine Drinks	cups/day _____
☐ DAILY	☐ Light Labor	☐ High Stress Level	Reason _____
☐ HEAVY	☐ Heavy Labor	☐ Smoking	Packs a day _____

Injuries/Surgeries you have had _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Allergies Vitamins/Herbs/Minerals Medications

SMITH CHIROPRACTIC

1417 N. Brown St.
El Paso, Texas 79902-4759

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ____/____/_____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? Yes / No

Medication Name	Reaction	Onset Date

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____ Pulse: _____

SMITH CHIROPRACTIC LLC
FINANCIAL POLICY

Insurance Policy

Welcome to **SMITH CHIROPRACTIC LLC** your insurance policy is an agreement between you and you insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment, and/or deductible. Our clinic will call your insurer to verify your benefits; **WE ARE NOT RESPONSIBLE FOR YOUR INSURER'S FINAL PAYMENT AND BENEFIT DETERMINATIONS.**

The following items are ***NON-COVERED*** charges by **any and all** insurance companies:

Vitamins / Supplements
Topical Ointments
Support belts
Therabands
Heel lifts
Electrodes
Ice packs
Pillows

Payments

In order to help you determine your responsibility toward payments for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (Please initial one)

A _____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are provided.

B _____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (Please initial)

C _____ I would like this clinic to bill my insurance. I understand I am responsible for the cost of treatment.

Missed Appointments

It is the policy of **SMITH CHIPROPRACTIC LLC** to assess a $25 missed appointment fee to patients who fail to cancel appointments with in a 24-hr notice. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____ My initials here indicate that I understand the above missed policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the terms and conditions of this policy.

_____ _____

Signature Date

08/2015

SMITH CHIROPRACTIC

INFORMED CONSENT TO TREATMENT

Our chiropractic examination procedures include, but are not limited to, your health history, posture and range of motion evaluation, orthopedic and neurological testing, palpation of various body structures, spinal and extremity mobilization, manual or mechanical muscle testing and palpation, and referral for specialized testing such as blood evaluations, diagnostic imaging, and other tests

1. Chiropractic therapeutic procedures include, but are not limited to, spinal and extremity manipulation/mobilization, manual or mechanical muscle therapy, exercise demonstration and prescription, physiotherapy applications such as ice, heat, ultrasound, and electrotherapy, referrals to other practitioners, nutritional recommendations, and advice on posture and home based self-care.

2. The most common adverse effects of chiropractic treatment are **short-term soreness and/or a temporary increase in pain.** The likelihood of initial soreness or increased pain has been found to be similar to that of starting an exercise program. In fact, a systematic review of the literature indicated that most adverse events that could be attributed to spinal manipulation were benign and transitory. Fractures are rare and usually the result of an underlying bone pathology that we will try to assess during your history and examination.

Naturally, we will discuss our treatment plan with you. We will also inform you of other options for care, to the best of our knowledge. Please note that all forms of healthcare include some form of risk. In fact, there are even risks to not receiving care that may include a worsening of your current complaint or development of other untoward complications.

Please read the above before signing this consent. If you have further questions or desire more information, simply ask and we will provide it.

Upon signing this form, I hereby request and authorize the doctor, and whomever he may designate as his assistant or authorized representative, to administer chiropractic care as he deems necessary. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature: _____ Date: _____

Witness: _____ Date: _____

SMITH CHIROPRACTIC LLC
1417 N. BROWN ST.
EL PASO, TX 79902
915-533-2225

ASSIGNMENT OF BENEFITS/ ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from SMITH CHIROPRACTIC LLC. on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to SMITH CHIROPRACTIC LLC. I certify that the health insurance information that I provided to SMITH CHIROPRACTIC LLC is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize SMITH CHIROPRACTIC LLC to submit claims, on my and/or my dependents behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to SMITH CHIROPRACTIC LLC, in good faith. I also hereby instruct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and provider upon request. Upon proof of such non-assignment I instruct my benefit plan (or its administrator) to make out the check and mail it directly to SMITH CHIROPRACTIC LLC.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from SMITH CHIROPRACTIC LLC are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductible.

Authorization to Release Information

I hereby authorize SMITH CHIROPRACTIC LLC to : (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination and/or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to SMITH CHIROPRACTIC LLC to the full extent permissible under law and under any applicable insurance policy and/ or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim(s) connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R* §2560.5031 (B)(4)) with respect to any healthcare expense incurred as a result of the services I received from SMITH CHIROPRACTIC LLC and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/ Insured Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

SMITH CHIROPRACTIC
1417 Brown St
El Paso, TX 79902
Phone: (915) 533-2225
Fax: (915) 533-0974

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____ Patient Birth Date: _____

We at Smith Chiropractic LLC are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

By signing below, I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patients parent/guardian if minor Date

_____
Printed Name of Patient or patients parent/guardian if minor

_____
Relationship to Patient

SMITH CHIROPRACTIC LLC

1417 N. Brown St.
El Paso, TX 79902
Telephone (915) 533-2225
Fax (915) 533-0974
Email drsmithsoffice@sbcglobal.net
HIPPA Compliance Officer: Mary Chacon

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

State laws that have stricter limits:

Add any special notes here such as "Upon request, we will give you a copy of your records within 15 days of the request. State board and HIPAA Rules allow us to charge a reasonable fee for these records. If you would like a copy of your records in electronic format, we recommend that you purchase an encrypted thumb drive."

Or, "Our EHR system allows patients direct access to their medical records at no cost."

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.