SMITH CHIROPRACTIC CENTER P.A.
P.O. BOX 587 7 NOBLE STREET
SMITHFIELD, NC 27577
919-989-9559

Last Name _____ First Name _____ Middle Int. _____

Home Phone (___)_____ Mobile (___)_____

Street Address _____

Mailing Address (If Different)_____

City, State, and Zip _____ E- Mail _____

Age _____ Date of Birth _____ Social Security No. _____

Circle One: Male Female Married Single Widowed Divorce # of Children_____

Employer _____ Employer's Phone (___)_____

Name of Insurance _____ Primary Insured Name _____

Name of person responsible for payment _____
Would like for us to file insurance for you? YES NO Have you met your deductible? YES NO

Driver's License #_____ State_____

Emergency Contact _____ Phone _____

Please list your family physician, location (city and state) and Medications you are currently taking

_____

_____

Are you pregnant? YES NO Date of Last menstrual period_____

Have you ever been treated by another chiropractor? YES NO

If yes, Physician's Name_____ Dates_____

Please list your complete surgical history (dates and type of surgery) _____

_____

REFERED BY: Circle one PATIENT TV YELLOW PAGES LETTER NEWSPAPER OFFICE SIGN INTERNET

Family History: Please circle if any family member has suffered from:

Tuberculosis	Gout	Mental Illness	High Blood Pres.
Diabetes	Heart Attacks	Arthritis	Other _____
Migraines	Spinal Disorder	Epilepsy	
Kidney Disease	Allergy	Cancer	

Have you ever had any serious falls or injuries? If yes give dates and treatment.

_____

_____

Please describe your pain beginning with the most severe: (such as neck, low back, mid back, etc)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

When did these conditions begin? _____ Is condition getting: __Better __Worse __Same

What is the cause of your condition (s)? _____

Have you experienced this before? ____Yes ____No

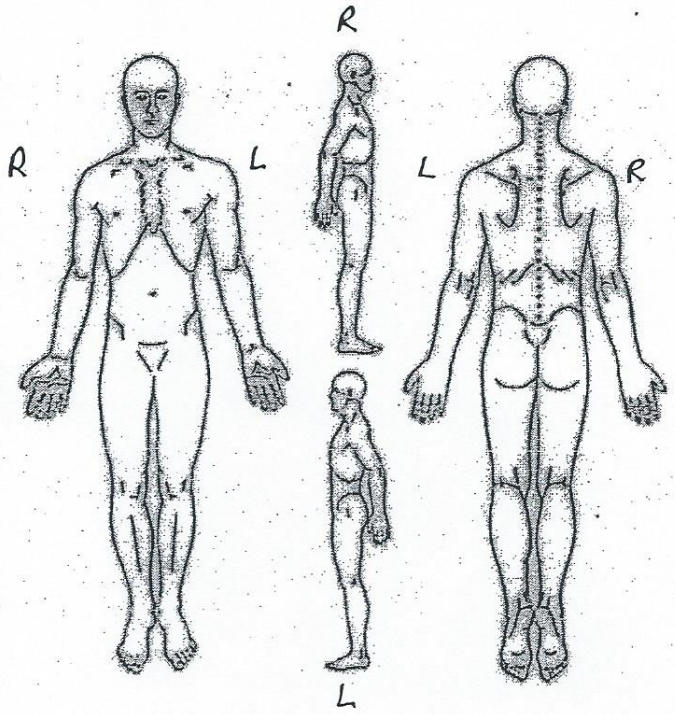
What makes your condition feel better? _____Worse_____

Have you seen any other physician or chiropractor for this condition? ___Yes ___ No

If yes: Physician's name: _____ Dates of visits: _____

If you are experiencing any of the following conditions, Please indicate on the diagrams below.

A = Ache B = Burning N = Numbness
P = Pain S = Stabbing O = Other



Please check the spaces below for symptoms you are currently having.

_____SLEEPING PROBLEMS
_____ANXIETY
_____HEADACHES
_____NECK PAIN/STIFFNESS
_____SHOULDER PAIN
_____PAIN ACROSS SHOULDER BLADES
_____UPPER BACK PAIN
_____MID BACK PAIN
_____LOW BACK PAIN
_____HIP OR BUTTOCK PAIN
_____LEG OR FOOT PAIN
_____ARM OR HAND PAIN
_____ARM OR LEG WEAKNESS
_____NUMBNESS OR TINGLING
_____MUSCLE SPASM OR CRAMPING
_____CHEST PAIN
_____DIFFICULTY BREATHING
_____DIZZINESS
_____EAR NOISES
_____EYES LIGHT SENSITIVE
_____FATIGUE
_____COLD HANDS
_____DIARRHEA
_____CONSTIPATION
_____LOSS OF MEMORY
_____VISION PROBLEMS
_____ALLERGIES

I hereby authorize Smith Chiropractic Center to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to Smith Chiropractic Center from my insurance company, and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. I understand that the first day fees are due and payable at the time of service.

BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO SMITH CHIROPRACTIC CENTER FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

_____(SEAL)
SIGNATURE OF PATIENT/GUARDIAN AUTHORIZING CARE

_____
DATE

SMITH CHIROPRACTIC CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

SMITH CHIROPRACTIC CENTER

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4-11-03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Eric L. Smith, D.C.

Telephone: (919) 989-9559 Fax: (919) 989-9552

E-mail:

Address: 7 Noble Street, Smithfield, NC 27577