# Welcome Smithfield Chiropractic

## Patient Information

Date: _____

Patient: _____

Address: _____

_____

City State Zip

□ Single □ Married □ Divorced □ Widowed

Birthdate: _____ Sex: □ M □ F

Ethnicity: □ Hispanic or Latino □ Other

Race: □ White □ American Indian/Alaskan Native

□ Asian □ Black/African American □ Pacific Isl.

Language: □ English □ Spanish □ Other: _____

Home Phone: _____

Cell Phone: _____

Patient SS#: _____

E-mail Address: _____

Height: _____ Weight: _____ BP: ____/____

Smoking Status : □ Every Day □ Some Days

□ Former Smoker □ Never Smoked

Occupation: _____

Employer: _____

Employer Address : _____

_____

Work Phone: _____

Spouse's Name: _____

Birth Date: _____

Prescribed Medications (Name/ Strenth/ Instructions)

_____

_____

_____

_____

Medication Allergies

_____

_____

_____

Diagnosed With: □ Asthma □ Diabetes

Would you like electrolic access to health records?

□ Yes □ No

Whom may we thank for referring you? _____

_____

## Insurance

### INSURACE OR CASH PATIENT

Primary Insurance: _____

Policy #: _____

Policy Holder's Name: _____

Secondary Insurance: _____

Policy #: _____

Policy Holder's Name: _____

### ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise, the balance is due payable, by me, for services rendered. I understand that I am financially responsible for all charges independent of insurance payments. I clearly understand and agree that all services made to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

## Emergency Contact

IN CASE OF EMERGENCY, CONTACT:

_____

Name Relationship

_____

Home Phone Work or Cell Phone

# Smithfield Chiropractic
## CONSENT TO TREAT & DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

**We are very concerned with protecting your privacy.** While the law requires us to give you this disclosure, please understand we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment.
- We may have to disclose your health care information and billing record to another party if they are potentially responsible for the payment of your services.
- We may have to use your health care information within our practice for quality control or other operational purposes.
- We may need to use your personal information to remind you of your appointments, send you a birthday card, send you a thank you note for your referrals, send you a welcome to the office information letter, invite you to participate in a patient appreciation days, send you an office news letter, or send promotional information.

**We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent from.** We reserve the right to change our privacy practices as described in the notice. You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions, however, we will try to respect your concerns.

I hereby authorize the doctor to treat my condition as he deems appropriate through the use of chiropractic adjustments and procedures including various modes of physical therapy and diagnostic X-rays. It is understood and agreed that the amount paid to the doctor for X-rays is for examination only. The X-rays will remain the property of this office. When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of known benefits, risks, and alternatives.

**Chiropractic** is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

**Subluxations** are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Furthermore, I understand and agree that the doctor and Clinic will not be held responsible for any pre-existing medically diagnosed conditions, not any medically diagnosed conditions, not any medical diagnosis. I do not expect the doctor to be able to anticipate and explain all risks and/or complications. I wish to rely on the doctor to exercise judgment during the course of treatment. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I have read and understood this agreement and by my signature below agree to all herein.

Patient's Authorizing Signature: _____ Date: _____

For Patient's Under 18: Consent to treat a Minor Child

I hereby authorize the doctor to administer chiropractic care as deemed necessary to my SON/DAUGHTER

Parent or Guardian's Signature: _____ Date: _____