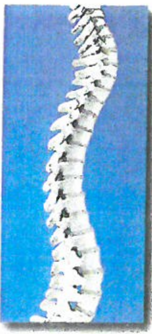

Welcome

OPTIMUM HEALTH THROUGH CHIROPRACTIC CARE

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ______________________________ Date ________ SS/HIC/Patient ID#____________
First Middle Initial Last

Address ______________________ City ______________ State ______ Zip __________

Sex: ❑ Female ❑ Male Birthdate ____________ E-mail ____________________

Home Phone (_____)__________ Cell Phone (_____)__________ Work Phone (_____)__________

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for_____years

Patient Employer/School ________________________ Occupation ______________

Employer/School Address ______________________ City __________ State ____ Zip _______

Spouse or parent's name ______________ Employer __________ Work Phone (_____) ________

Whom may we thank for referring you to us? ______________________________

Person to contact in case of emergency ____________________ Phone (_____)__________

Responsible Party

Name of person responsible for this account ______________________________

Relationship to patient ____________________ Phone (_____) ______________

Address ____________________________ City __________ State _____ Zip _______

Name of employer ________________________ Work Phone (_____) ______________

Insurance Information

Name of insured ____________________ Relationship to patient ______________

Birthdate ____________ Social Security # ______________ Date employed ___________

Name of employer ______________________ Work Phone (_____) ______________

Address ____________________________ City __________ State _____ Zip _______

Insurance Co. ____________Phone (_____) ________ Group #______ Employer # __________

Insurance Co. Address ____________________ City __________ State _____ Zip _______

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured ____________________ Relationship to patient ______________

Birthdate ____________ Social Security # ______________ Date employed ___________

Name of employer ______________________ Work Phone (_____) ______________

Address ____________________________ City __________ State _____ Zip _______

Insurance Co. ______________________Group # ____________ Employer # __________

Insurance Co. Address ____________________ City __________ State _____ Zip _______

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

CONFIDENTIAL

#65551 – © 1998 HMI 1-800-468-4144

TERMS OF ACCEPTANCE AND CONSENT FOR TREATMENT

I, the undersigned patient, parent or legal guardian, know that I (the patient) am suffering from a condition requiring chiropractic care. 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 goal. Chiropractic has only one goal. It is important for each patient to understand this goal and the method that will be used to attain it. This will prevent confusion or disappointment. "Vertebral Subluxations" are mechanical interferences, by the spinal bones, to the normal flow of mental impulses traveling over the nerve pathways. The goal of Chiropractic is to locate, analyze and correct these vertebral subluxations.

The method of correction is by specific adjustments of the spine and/or extremity joints. These adjustments are intended to reduce subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency. With a proper nerve supply restored through chiropractic adjustments, the body can begin the process of repair leading to health. In some patients this happens quickly; in others, more slowly. In some patients the repair and maintenance is complete; in others, only partial.

We do not offer to diagnose or treat any disease or condition other the subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of the health care provider who specialized in that area. Regardless of what the disease, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. Our method of treatment is the spinal or extremity adjustment of vertebral or extremity subluxations, as well as additional modalities required to facilitate this adjustment.

I hereby give consent to have chiropractic adjustments performed in a semi-open room setting. I acknowledge that closed rooms are available to me at any given time, but may result in longer wait times. I understand that a semi-open room setting does not ensure complete privacy and will inform the staff if I need to discuss any confidential information in private.

I, ______________________________ have read and fully understand the above statements.
(Print Name)

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 that basis ____
(Signature) (Date)

Complete if Patient is a minor child.

____
(Print Child's Name)

I, ____ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____
(Signature) (Date)

JENNIFER M. SMITH DC

NAME:____ **PATIENT #** ____________________

PAYMENT POLICIES

1. All first visit charges are payable when services are rendered.

2. At the completion of your first office visit you will be advised as to a time you may return for your second consultation when the doctor will inform you as to your examination results and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.

3. Method of payment you plan to use to take care of today's charges? □ Cash □Check □Visa/MasterCard

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office of Dr. Jennifer Smith will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Dr. Jennifer Smith will be credited to my account upon receipt. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize the office of Dr. Jennifer Smith to obtain a credit report if deemed necessary.

Patient's Signature ____ Date ______________

DIRECT PAYMENT AUTHORIZATION

I hereby instruct and direct payment to be made payable to and mailed directly to:

Health and Wellness Chiropractic Center
Dr. Jennifer M. Smith
1051 Town Center Drive
Orange City, FL 32763
(386)775-3600

In consideration of the services rendered I authorize and direct the payment to the above named of any sum I now or hereafter owe out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for these services. The payment will not exceed my indebtedness to the above mentioned.

A photocopy of this authorization shall be considered as effective and valid as the original. I authorize use of this form for all insurance claims.

Patient's Signature ____ Date ______________

X-RAY / MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to physicians, employers and/or insurance companies which would expedite the process of my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

I authorize the taking of photographs and x-rays to be used for treatment purposes.

I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

I have requested the release of records of (patient's name) ____________________________which are a part of the records at (facility) ____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all insurance information, copies of records and reports, including copies of x-rays, and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Patient's Signature ____ Date ______________

Guardian's Signature ____ Date ______________

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, 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 or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

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 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 a 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

Jennifer M. Smith, D.C.
1051 Town Center Drive, Orange City, FL 32763
Office: (386)775-3600 * Fax: (386)775-3602

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED INFORMATION

PATIENT NAME: ______________________ DATE OF BIRTH:________________

ADDRESS:___________________________ CITY AND ZIP:_________________

TYPE OF PRIVATE HEALTH INFORMATION TO BE RESTRICTED OR LIMITED
(PLEASE CHECK ALL THAT APPLY)

- o HOME ADDRESS
- o HOME PHONE NUMBER
- o WORK PLACE
- o VISIT NOTES
- o PATIENT HISTORY
- o OFFICE ADDRESS
- o SPOUSE'S NAME
- o SPOUSE'S OFFICE NUMBER
- o OTHER

OUR OFFICE PROMISES NOT TO RELEASE ANY INFORMATION ABOUT YOU UNLESS YOU HAVE SPECIFICALLY SPECIFIED IT BELOW TO HAVE PERSONALLY GIVEN US WRITTEN PERMISION TO DO SO.

PLEASE LIST ANY PERSON BELOW THAT WE MAY RELEASE YOUR PERSONAL INFORMATION TO.

____

____

____

PATIENT SIGNATURE OR LEGAL GUARDIAN___________________________

DATE___________