NEW PATIENT INFORMATION

Patient Name:	Social Security #
Address	Drivers License # State
City, State, Zip	Birth Date Age
Marital Status (check) ❑ Married ❑ Single	Home phone
Employer	Work Phone
Address	Cell Phone
City, State, Zip	E-Mail
	Occupation
Spouse or Guardian Information	
Name	Social Security #
Address	Drivers License # State
City, State, Zip	Birth Date
Employer	Home Phone
Address	Work Phone
City, State, Zip	Occupation
Patient for Guardian - Nearest Relative not living with you	
Name	Phone
Address	Relationship
Reason for this visit: (check one) ❑ Auto Accident ❑ Accident at work ❑ Other Injury ❑ Gradual	
Name of Primary Care Physician, Orthopedist, Physical Therapist, Acupuncturist	
Name:	
Address	
City, State, Zip	
Major area of complaint:	
Have you been in an accident or had an injury in the last twelve months? (check) ❑ Yes ❑ No	
Have you had x-rays before? (check) ❑ Yes ❑ No Approx. Date:	
Females only: Are you pregnant? (check) ❑ Yes ❑ No	
Do you have health Insurance? (check) ❑ Yes ❑ No	
Name of insurance company:	
Address	
City, State, Zip	
Policy number	
Who referred you to our office?	
PLEASE NOTE: This office will gladly prepare Insurance forms however we cannot render services on the assumption that our charges will be paid by an Insurance company. All fees are charged directly to the patient or guardian, therefore basic responsibility for payment is yours.	
I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT:	
Signature of Patient/Guardian	
Staff: Checked by:	
Copy of Insurance card	
Minors form signed	

Steven L. Smith, D.C.

Initial Consultation Form

Patient's Name: ____ Date: ________________

Primary Complaint(s): ____

____

____

Please check the appropriate responses:

Overall Frequency of Complaint: (check one please)

❑ **Constant**-100% of the time ❑ **Frequent**-75% ❑ **Intermittent**-50% ❑ **Occasional**-25%

Overall Intensity of Complaint: (check one please)

❑ **Minimal** (An annoyance but no effect on activity) ❑ **Moderate** (Tolerable with marked impairment of activity)
❑ **Slight** (Tolerable with some impairment to activity) ❑ **Severe** (Intolerable and cannot perform any activities)

Is your problem affecting any other area of your body? If yes, explain:

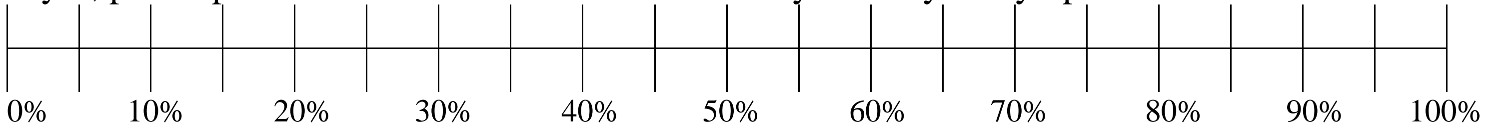
____

____

Does it interfere with your normal daily activities (Family, recreation, sports)? ________________
How? ____

____

Does your symptoms increase while performing your normal work duties? (Check) ❑ Y ❑ N
If yes, please place an "X" at the amount below that you feel your symptoms increase at work:



0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What aggravates the problem? ____

____

What relieves the problem? ____

____

If this went without being taken care of, how do you think it would affect you? ________________

____

Any questions or concerns? ____

____

______________________________ ______________________________
Patient's Signature Date

PATIENT NAME:__________________________ **DATE**: ____________________________

HABITS

What kind of exercise do you do? ____

____

What condition is your mattress in? ____

Any lumps, bumps, dips, depressions? ____

How is your work station? ____

Any ergonomic stresses? ____

Are you undergoing any personal turmoil or emotional stress right now? ___________________

____

Do you drink? ____________ How Much? ____

Do you smoke? ___________ How Much? ____

Do you sleep well? ____

How many hours? ____

Do you feel rested when you wake up? ____

Is your energy level normal for you? ____

Any recent weight gain/loss? ______ how Much? ____________________________________

FAMILY HISTORY

Any family history of rheumatoid disease, diabetes, arthritis? _____________________________

____

Is you father alive? ______________

How old? ______________________

How is his health? _______________

Is your mother alive? _____________

How old? ______________________

How is her health? ____

How many brothers and sisters? ____

Are they healthy? ____

Are there any birth defects in your family? ____

Any family history of back pain? ____

PAST MEDICAL HISTORY

Any serious accidents or injuries? ____

____

Any serious illnesses? ____

____

Any hospitalizations? ____

____

Are you currently taking any medicines? ____

____

Are you currently under any medical treatment for any reason? ___________________________

____

Do you have any chronic illnesses or disease? _______________________________________

____

WHAT SUPPLEMENTS DO YOU CURRENTLY TAKE?

____

____

____

____

Smith Chiropractic
131 N. El Molino Ave., #180
Pasadena, CA 91101
626-792-1221

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Smith Chiropractic.

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

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the doctor or intern, affiliated with Smith Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

________________________________ ________________
Patient's Name (please print) **Date**

____
Patient or Guardian's Signature

Steven L. Smith, D.C.
131 N. El Molino Ave., #180
Pasadena, CA 91101
626-792-1221

NOTICE OF PRIVACY PRACTICES

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have necessary medical and PHI to provide the highest quality medical care possible. Patients should not be afraid to provide information to our practice and its doctors and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its doctors and staff will:

-Adhere to the standards set forth in the Notice of Privacy Practices.

-Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our Practice and its doctors and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc., without an authorization from the patient.

-Use and disclose PHI to remind patients of their appointments only with their consent.

-Recognize that PHI collected about our patients must be accurate, timely, complete, and available when needed. Our Practice and its doctors and staff will:

- Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its doctors and staff respect the patient's individual dignity at all times. Our practice and its doctors and staff will respect patient's privacy in order to provide the highest quality care possible and to efficiently administer TPO.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its doctors and staff will:

    - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
    - Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

DR. STEVEN L. SMITH

CHIROPRACTOR

131 N. El Molino Ave., Suite 180
PASADENA, CALIFORNIA 91101
626-792-1221

Patient Consent for Use and Disclosure of Protected Health Information

The Purpose of this form is to comply with the federal government mandate to protect patient privacy.

With my consent, Steven L. Smith D.C. may use and disclose protected health information (PIH) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Steven L. Smith D.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Steven L. Smith reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Steven L. Smith D.C. 127 N. Madison Avenue Suite 101 Pasadena, California 91101.

With My Consent, Steven L. Smith D.C. may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With My Consent, Steven L. Smith D.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and correspondence.

Signed ______________________________ **Date** __________________________

Steven L. Smith, D.C.
131 N. El Molino Avenue #180
Pasadena, CA 91101
(626) 792-1221

To our patients: January 2, 2012

Regarding Finances:

We have recently surveyed Doctors offices in our area and have discovered that many of them are not dealing with insurance companies at all. They simply collect full fees from their patients, give them a bill and have them deal with their insurance companies on their own. Our decision after this survey is as follows:

If you do not have insurance that covers chiropractic care your office visit/manipulation charge remains the same, $60.00. Plus any and all physical therapy same day will remain the same at $15 totaling the usual $75.00 fee. (New Patient fees are not included herein)

If you have insurance we will be happy to bill it for you.
Your office visit/manipulation will remain the same at $60.00.
Your physical therapy charge will be either $23 for routine therapy or $26 for ultrasound whichever is the higher fee. If you receive more than one therapy you will only be charged for the one of the higher value.

On the day you receive your "at home care" exercises or stretches there will be an additional charge of $50 or $25 depending on the time spent. If we administer kinesio (athletic) tape for rehab purposes the cost will be $15 - $25. Our goal is to get you better and onto home care as soon as possible – this keeps your costs down and usually gives us a very satisfied patient!

We no longer can afford to accept any managed care policies. (Except for Blue Shield, at this time) We will work individually with you to make sure you totally understand your financial responsibility in our office. Your responsibility will now be your deductibles and any portion your insurance company will not pay.

It is our goal to continue to provide you with the standard of care you have been accustomed to. And by changing our policies regarding how we deal with insurance we will hopefully remain in business another 33 years to enjoy serving you.

Please sign that you have read and understood this notice.

____

Signature

INSTRUCTION AND ASSIGNMENT FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

PATIENT:____
INSURED:____
EMPLOYER:____
GROUP:____
SSN/ID#____

I hereby instruct and direct the __________________________ ***insurance company to Pay by check or draft made out and mailed to:***

Steven L. Smith, D.C.
131 N. El Molino Avenue, #180
Pasadena, CA 91101

Or

if my current policy prohibits direct payment to the Doctor, then I hereby instruct and direct you to make out the check to me and mail it in care of as follows:

Steven L. Smith, D.C.
131 N. El Molino Avenue, #180
Pasadena, CA 91101
Phone: (626)792-1221

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward my charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** ***This payment will not exceed my indebtness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.***

A PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at Steven L. Smith, D.C. Pasadena, CA this _____ day of _______________ in the year of __________.

___________________________________ ______________________________

Signature of Policyholder ***Witness***

____

Signature of Claimant if other than Policyholder

Smith Chiropractic

Please provide us with your Family Medical Doctor's information so that we may update our records.

Patient Name: ___________________________
(You're Name Here)

M.D. Name: ____________________________

Phone: _________________________________
MD Phone)

Fax: ___________________________________
(MD Fax)

Address:
(MD Address)

____

____

Please turn this form into the front office.

Thank You!

PATIENT EVALUATION

All comments will be held confidential.

MY DOCTOR'S NAME IS: ______________________________

	Inadequate	Fair	Good	Excellent
Seating Availability	❑	❑	❑	❑
Seating Comfort	❑	❑	❑	❑
Reception Area Appearance	❑	❑	❑	❑
'Treatment Room Appearance	❑	❑	❑	❑
Examination Room Appearance	❑	❑	❑	❑
Rest Room Appearance	❑	❑	❑	❑

STAFF (NOT DOCTOR) COURTESY & EFFICIENCY

Receptionist Politeness	❑	❑	❑	❑
Receptionist Accuracy	❑	❑	❑	❑
Receptionist Efficiency	❑	❑	❑	❑
Ins/Cash Billing Personnel's Politeness	❑	❑	❑	❑
Ins/Cash Billing Efficiency	❑	❑	❑	❑
General Experience of Staff	❑	❑	❑	❑

The explanation of your financial obligation was communicated: ❑Poorly ❑Confusingly ❑Adequately ❑Clearly

DOCTOR'S COURTESY & EFFICIENCY

Your doctor's explanation of your health	❑	❑	❑	❑
Your doctor's explanation of how chiropractic works	❑	❑	❑	❑
Your doctor's answers to your questions	❑	❑	❑	❑
Your doctor's concern for you as a person	❑	❑	❑	❑
How adequately your doctor takes care of your health needs	❑	❑	❑	❑
Your doctor's professional conduct	❑	❑	❑	❑
Your doctor's rapport with you	❑	❑	❑	❑
Your doctor's understanding of your needs	❑	❑	❑	❑
Your doctor's dedication to the chiropractic profession	❑	❑	❑	❑

Would you refer other people you know to our office? ❑Yes ❑No

Why?/Why not? ______________________________