Dr. Troy Smith
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MOTOR VEHICLE ACCIDENT

HISTORY

Patient's name: ____________________________ Date of Birth ______Today's Date: ______ Date of Injury: ______

Address: ____

Phone: home: ( ) cell: ( ) work: ( )

Attorney's name: _________________________________ Phone: _____________ Address: __________________________

Insurance company: ______________________________ Claim #: ____

Policy #: _______________________________________ Insured person on policy: _______________________________

Claim adjuster: __________________________________ Phone: ____________ Address: __________________________

Injury History

Was the crash on – the – job? ◊ No ◊ Yes Was the seat broken? ◊ No ◊ Yes

You were the: ◊ driver ◊ front seat passenger ◊ rear seat passenger

Driver's name: ____________________________ Vehicle year: ________ make: __________ model: ______________

Your estimated speed at time of crash: _____mph; ◊ stopped ◊ slowing ◊ accelerating

Other vehicle year: _________ make: ____________________ model: _______________________________________

Estimated speed of other vehicle at time of crash:___mph; ◊ stopped ◊ slowing ◊ accelerating

Time: ◊ daylight ◊ dawn ◊ dusk ◊ dark Aware of impending crash? ◊ No ◊ Yes

Road: ◊ dry ◊ damp ◊ wet ◊ snow ◊ ice ◊ other ________________________________

Head restraint: ◊ none ◊ adjustable ◊ up ◊ down ◊ altered by crash? ◊ non – adjustable

Was the seat back altered by the crash? ◊ No ◊ Yes, how? ____________________________________

Lap Belt: ◊ Wearing ◊ Not wearing Shoulder belt: ◊ Wearing ◊ None ◊ Not wearing

Did the air bag deploy? ◊ No ◊ Yes If yes, were you struck? ◊ No ◊ Yes

Head position at time of crash: ◊ upright ◊ Looking up ◊ down ◊ left ◊ right

Hands: ◊ both on wheel ◊ one on wheel Brakes applied? ◊ No ◊ Yes

Crash description: ____

____

Crash diagram:
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During crash:

Did you strike any parts of vehicle? ◊ No ◊ Yes, describe ______________________________

Did vehicle strike any other objects after crash? ◊ No ◊ Yes, describe __________________

Wearing: ◊ hat ◊ glasses Still on after crash? ◊ No ◊ Yes

Glove box knocked open? ◊ No ◊ Yes Hit by flying object? ◊ No ◊ Yes, what? _________

Did you lose consciousness? ◊ No ◊ Yes, for how long? ______________

After the crash:

◊ headache ◊ dizziness ◊ nausea/vomiting ◊ disorientation/confusion ◊ neck pain

◊ upper back pain ◊ mid back pain ◊ low back pain ◊ arm pain ◊ leg pain ◊ jaw pain

◊ numbness ◊ tingling ◊ seizures ◊ memory loss ◊ hearing difficulties

◊ speaking difficulties ◊ vision changes *Please circle symptoms you had PRIOR to accident*

Did the symptoms occur: ◊ immediately, which ones? ____________________________________

◊ later, which ____ how long after? _______

Were the police on scene? ◊ No ◊ Yes Was a report made? ◊ No ◊ Yes

Estimated property damage to your vehicle _________________

Afterwards did you go: ◊ home ◊ hospital ◊ private Dr. ◊ by ambulance

Emergency department:

◊ x-rays ◊ CT (cat) scan ◊ MRI ◊ blood work ◊ other _________________________

◊ cervical collar ◊ medications ____

◊ follow up instructions ____

Past health history

Surgeries (dates & continued problems) ____

____

Prior motor vehicle accidents (dates & continued problems): _______________________________

____

Fractures (dates & continued problems): ____

____

Other injuries to neck & spine (dates & continued problems): _____________________________

____

Serious illnesses: ____

MEDICATIONS & SUPPLEMENTS

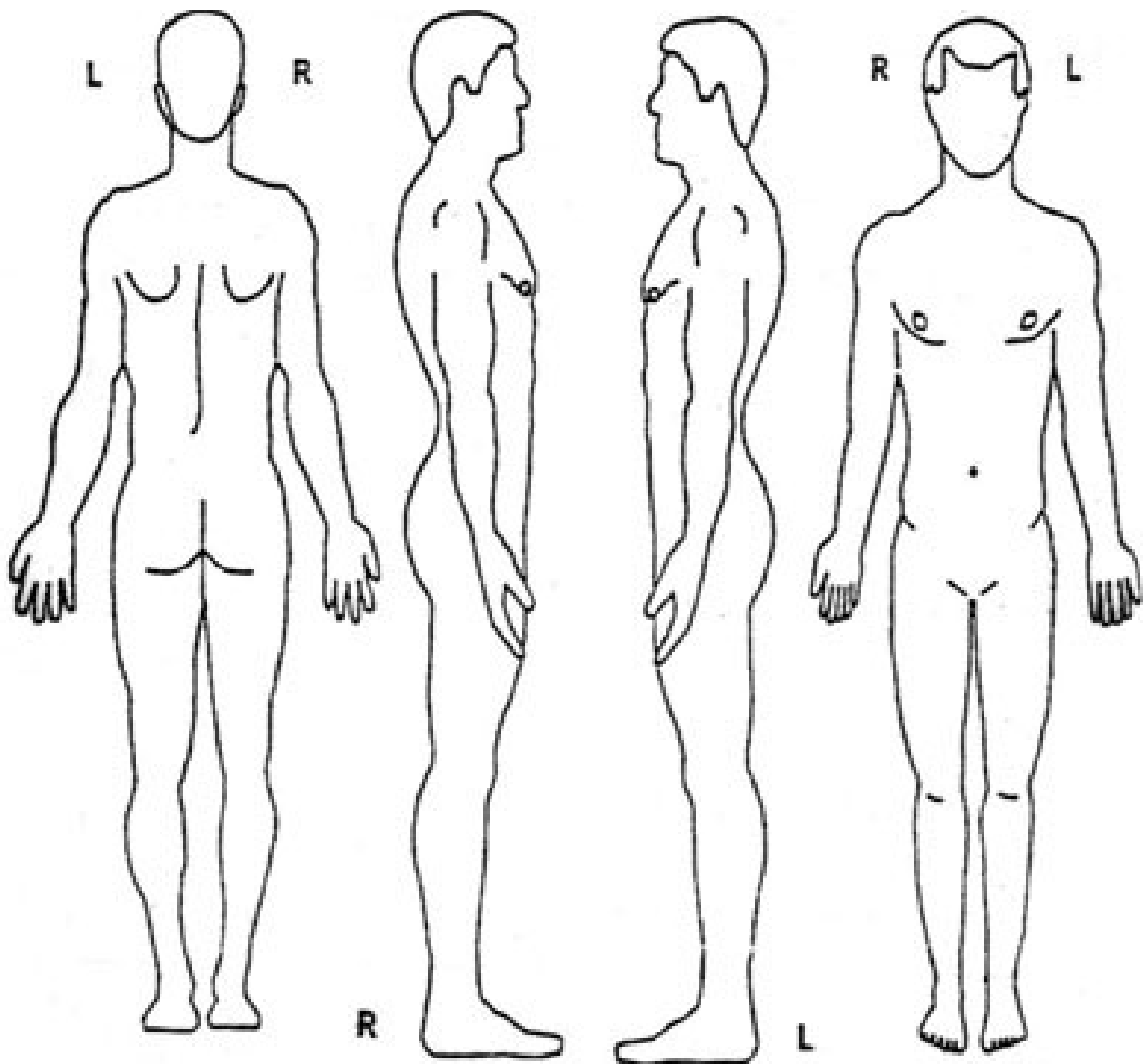
Please include current medications as well as medications that you are no longer taking, but have taken for 1 year or more.

Name ___________________________________

Name of Medicine/Supplement:	Condition Prescribed For:	Dose:	How Long:

PAIN DRAWING

Name: ____ **Date:** ______________________________



Mark as follows:

A - Ache **B - Burning** **N - Numbness** **P - Pins & Needles** **S - Stabbing**

O - Other - Describe

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 – Pain Intensity
A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 – Personal Care
A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting
A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4 – Walking
A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting
A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

SECTION 6 - Standing
A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 - Sleeping
A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than n one quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 - Social Life
A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 - Traveling
A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain
A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

COMMENTS:____

NAME:________________________________DATE:__________ SCORE:_________

NECK DISABILITY INDEX

Date______________ Patient's Name ____

PLEASE READ: Answer each of the 10 sections by marking the ONE BOX that most applies to your NECK PAIN.

SECTION 1: Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2: Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3: Lifting
- ☐ I can lift heavy weights without extra neck pain.
- ☐ I can lift heavy weights but it gives extra neck pain.
- ☐ Neck pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Neck pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4: Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all because of the pain in my neck.

SECTION 5: Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

SECTION 6: Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7: Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

SECTION 8: Driving
- ☐ I can drive my car without any neck pain at all.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all because of the pain in my neck.

SECTION 9: Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10: Recreation
- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some pain in my neck.
- ☐ I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly engage in any recreational activities because of pain in my neck.
- ☐ I cannot engage in any recreational activities at all because of pain in my neck.

How Strong is Your Pain?

Please place an "X" on the line below at the point which you feel represents your pain right now.

No Pain ____ Excruciating (the worst possible)

Source: © 1992, Vernon/Hagino, modified from Fairbanks *et al*., Physiotherapy 1960. Rev. 3/98

Headache Disability Index

NAME: ________________________ DATE: ________ AGE: ________ *Scores Total: ______; E____; F____*
(100) (52) (48)

instructions: Please CIRCLE the correct response:

I have headaches: [1] 1 per month [2] more than 1 but less than 4 per month [3] more than one per week
My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.			
F2. Because of my headaches I feel restricted in performing my routine daily activities.			
E3. No one understands the effect my headaches have on my life.			
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.			
E5. My headaches make me angry.			
E6. Sometimes I feel that I am going to lose control because of my headaches.			
F7. Because of my headaches I am less likely to socialize.			
E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.			
E9. My headaches are so bad that I feel I am going to go insane.			
E10. My outlook on the world is affected by my headaches.			
E11. I am afraid to go outside when I feel that a headache is starting.			
E12. I feel desperate because of my headaches.			
F13. I am concerned that I am paying penalties at work or at home because of my headaches.			
E14. My headaches place stress on my relationships with family or friends.			
F15. I avoid being around people when I have a headache.			
F16. I believe my headaches are making it difficult for me to achieve my goals in life.			
F17. I am unable to think clearly because of my headaches.			
F18. I get tense (e.g. muscle tension) because of my headaches.			
F19. I do not enjoy social gatherings because of my headaches.			
E20. I feel irritable because of my headaches.			
F21. I avoid traveling because of my headaches.			
E22. My headaches make me feel confused.			
E23. My headaches make me feel frustrated.			
F24. I find it difficult to read because of my headaches.			
F25. I find it difficult to focus my attention away from my headaches and on other things.			

SIMPLE SHOULDER TEST QUESTIONNAIRE

NAME____ **DATE**________ **AGE**________ **SCORE**________

OCCUPATION: __________________ Dominant Hand: Right / Left / Ambidextrous; Shoulder eval. L / R

____

Answer each question below by checking "Yes" or "No"

	Yes	No
1. Is your shoulder comfortable with your arm at rest by your side?		
2. Does your shoulder allow you to sleep comfortably?		
3. Can you reach the small of your back to tuck in your shirt with your hand?		
4. Can you place your hand behind your head with the elbow straight out to the side?		
5. Can you place a coin on a shelf at the level of your shoulder without bending your elbow?		
6. Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?		
7. Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow?		
8. Can you carry twenty pounds at your side with the affected extremity?		
9. Do you think you can toss a softball under-hand ten yards with the affected extremity?		
10. Do you think you can toss a softball over-hand twenty yards with the affected extremity?		
11. Can you wash the back of your opposite shoulder with the affected extremity?		
12. Would your shoulder allow you to work full-time at your regular job?		
TOTALS		

Office Use Only

Diagnosis: DJD, RA AVN, IMP RCT FS, TUBS AMBRII Other: ______________________________

Dx Confirmed? _________ Pt # _______ Physician ____

SST: Initial / Pre-op / Follow-up: 6 mon 1 yr 18 mon 2 yr 3 yr 4 yr 5 yr Other: ______

Initial SST Date: ___/___/___ Rx: ______________________

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FINANCIAL POLICY

All payments are due at the time of service (TOS), unless special arrangements have been agreed upon prior to visit. This arrangement offers patients a 10% discount on my usual and customary charges for prompt payment at time of service. Although prices may vary with treatment needed, typical new patient exams are $72.00 [usual and customary (U&C) = $80.00], and typical office treatments are $50.00 (U&C = $55). (*Medicare not included).* This includes active treatment of up to two areas. Established patient exams for new problems and re-examinations will typically vary between $35 and $58 (U&C = $39 and $65) depending upon the complexity of the exam. Any exams or treatments, such as electrotherapy, nutritional evaluation, therapeutic exercise instruction, and other therapies vary from these prices, and will be explained by the doctor prior to commencing. All supplements/herbs, lab work, supports and other supplies must be paid for at the time they are received. Additional pre-pay discount plans and financial hardship plans are also available. For detailed information on these, please speak directly with Dr. Smith or Holly. For a detailed fee schedule (travel card), please inquire at the front desk, and one will be provided to you.

Insured patients
All insurance benefits and reimbursement will be directed to you. You will receive a superbill that you can submit to your insurance company. Please keep in mind, that most insurance companies do not pay for maintenance or wellness care. If there are any discrepancies between you and your insurance company, we will gladly assist you in rectifying the matter once it is brought to our attention.

Workers Compensation Claims
All workers compensation cases will be billed directly to the insurance company, providing the appropriate paper work has been filled out and a claim is filed. If the claim is denied, we will bill your private insurance carrier, if you have coverage. Please keep in mind that if your claim is denied, then you are responsible for prompt payment of your account.

Personal Injury/Motor Vehicle Accidents
Personal injury auto accident cases will be billed to your auto insurance company, providing that a claim and the appropriate paper work has been filed. Keep in mind we do not bill third party insurance companies. If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service. You are responsible for any outstanding fees not reimbursed by your insurance company.

Medicare.
Medicare fees for treatments to the spine are set by the federal government. Additional treatments (which you may decline) can cause an increase in charges which may vary between treatments. These prices are listed on the Advanced Beneficiary Notice that you have received. Hence, 15 minute appointments may vary between $31and $45 and 30 minute appointments may vary between $51 and $80. Dr. Smith and/or Holly will review these policies with you, if you like.

24 hour Cancellation Policy
In order to maintain schedule availability for all of our patients, we ask that any appointment cancellations are given at least 24 hours in advance. Multiple late cancellations and/or missed appointments will result in a full charge for the scheduled time.

Records and & Report Requests
Please allow us 2 weeks notice to prepare these time intensive documents for you. If you need them sooner, we will charge $75 for reports, and $30 per copied chart.

I have read, understand, and agree with the above financial policy.

____   ________________
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Patient/Guardian Signature Date

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result. I give my permission and consent to the procedure or treatment.

____________________________________ ______________________
Patient Signature Date

Please read the following carefully and **initial each statement**.

_________ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with Dr. Smith, because it may affect care.

_________ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Dr. Smith reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

Portion Below Used If Additional Information Requested & Received

I requested and received, in substantial detail, further explanation of the procedure or treatment. I was also given information about material risks of the procedure or treatment, and other alternative procedures or methods. I give my permission and consent to the procedure or treatment.

____________________________________ ______________________
Patient Signature Date

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.

If you have any questions about this notice, please contact **the designated privacy official, Dr. Troy Smith,** of our office at **(805) 489 - 8592 530 Traffic Way, Arroyo Grande, CA 93420**

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.
We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a low back condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the bottom of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal

requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law: We will disclose health information about you when required to do so by federal, state or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, medical supplies or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent we* may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to **our designated privacy official, Dr. Troy Smith** in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health

information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to **our designated privacy official, Dr. Troy Smith**. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for
purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to **our designated privacy official, Dr. Troy Smith**. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically).

We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request: If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical* Information to **our designated privacy official, Dr. Troy Smith**.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the *Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication* to **our designated privacy official, Dr. Troy Smith**. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact **our designated privacy official, Dr. Troy Smith**.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact **our designated privacy official, Dr. Troy Smith**., **(805) 489 -3714**. You will not be penalized for filing a complaint.

I acknowledge having received a copy of this Notice of Privacy Practices

Patient Name: ________________________________ Signature: __________________________________ Date: ______________

Relationship to Patient (if other than self): _________________________

Dr. Troy Smith
2 James Way, Ste. 108, Pismo Beach, CA 93449
T: 805.489.8592 F: 805.489.9509
www.pbfamilywellness.com
pbfamilywellness@gmail.com

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Rescission of Assignment of Benefits (1)

Patient's Name:____
Insured:____
Date of Injury:____
Claim #:____
Insurance Adjuster:____
Phone #: (____)____
Fax #: (____)____
Insurance Company:____
Address:____
____

I, being the insured on this claim, specifically direct you, my insurance company, to rescind and cancel any assignment given to you by any third-party, including my attorney. I direct you to send payment for my bills, for chiropractic treatment, to my doctor of chiropractic as follows:

Name:_____________________________________
Address:___________________________________
City:_______________________, CA Zip:___________

Under the terms of my policy contract as owner and beneficiary of this policy, I direct reimbursement for all chiropractic services be paid DIRECTLY to my doctor of chiropractic, the provider of services. No other third-party, including my attorney, should receive payment for these treatments. This direction is for the remainder of this claim.

Thank you for your cooperation.

____
Print Patient/Insured's Name

_____________________________________ ____________________
Patient/Insured Signature Date
~~~~~~

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www.pbfamilywellness.com
pbfamilywellness@gmail.com

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Rescission of Assignment of Benefits (2)

Patient's Name:____
Insured:____
Date of Injury:____
Claim #:____
Insurance Adjuster:____
Phone #: (____)____
Fax #: (____)____
Insurance Company:____
Address:____
____

I, being the insured on this claim, specifically direct you, my insurance company, to rescind and cancel any assignment given to you by any third-party, including my attorney. I direct you to send payment for my bills, for chiropractic treatment, to my doctor of chiropractic as follows:

Name:____
Address:______________________________________
City:________________________, CA Zip:____________

Under the terms of my policy contract as owner and beneficiary of this policy, I direct reimbursement for all chiropractic services be paid DIRECTLY to my doctor of chiropractic, the provider of services. No other third-party, including my attorney, should receive payment for these treatments. This direction is for the remainder of this claim.

Thank you for your cooperation.

____
Print Patient/Insured's Name

____ ____________________
Patient/Insured Signature Date
~~~~~~

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pbfamilywellness@gmail.com

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Rescission of Assignment of Benefits (3)

Patient's Name:____
Insured:____
Date of Injury:____
Claim #:____
Insurance Adjuster:____
Phone #: (____)____
Fax #: (____)____
Insurance Company:____
Address:____
____

I, being the insured on this claim, specifically direct you, my insurance company, to rescind and cancel any assignment given to you by any third-party, including my attorney. I direct you to send payment for my bills, for chiropractic treatment, to my doctor of chiropractic as follows:

Name:____________________________________
Address:__________________________________
City:______________________, CA Zip:__________

Under the terms of my policy contract as owner and beneficiary of this policy, I direct reimbursement for all chiropractic services be paid DIRECTLY to my doctor of chiropractic, the provider of services. No other third-party, including my attorney, should receive payment for these treatments. This direction is for the remainder of this claim.

Thank you for your cooperation.

____
Print Patient/Insured's Name

____________________________________ ________________
Patient/Insured Signature Date
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