



Dr. Troy Smith
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WELCOME

The doctor of the future will give no medicine, but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease.” - Thomas Edison

Patient Information

Thank you for choosing our practice for your chiropractic care. Please answer to the best of your ability and check all that apply. If you have any questions or concerns, do not hesitate to ask. We will be happy to help. (Please Print)

Name _____ Date _____ email _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Home Phone (____) _____ Cell Phone (____) _____

Married Widowed Single Minor Divorced

How did you learn about us? _____

Person to contact in an emergency _____ Phone _____

Employer _____ Phone _____

Responsible Party

Person responsible for account _____ Relationship to patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insurance: PPO None Medicare HMO Other _____

Additional Health Care Providers

Name _____ Specialty _____ City _____ Phone _____

Name _____ Specialty _____ City _____ Phone _____

Name _____ Specialty _____ City _____ Phone _____

Date of last exams _____

Please check here if you prefer that health information is not shared between Dr. Smith and your other providers
(Women) Are you pregnant Yes No Nursing Yes No Taking birth control pills Yes No

Symptoms

Reason for visit: _____

Where specifically is the problem located? _____

Do you have pain, numbness, tingling, or weakness radiating into the arms, hands, legs, or feet? _____

Are your symptoms the result of a: motor vehicle accident injury at work other _____

When did you first notice your symptoms? _____

Are your symptoms staying the same worsening or improving?

Do the symptoms come and go or are they constant?

If your symptoms come and go, how many times per day/week/month do you notice them? _____

For what percentage of the day do you notice your symptoms? _____

Would you describe your symptoms as dull/achey sharp/shooting burning throbbing other _____

Place a mark on the line below that indicates the severity of your symptoms

No pain/symptoms 0 1 2 3 4 5 6 7 8 9 10 The worst pain/symptoms imaginable

What activities of your daily life does your condition effect, or prevent you from doing as you normally would?

What makes your condition worse? _____

What makes your condition better? _____

What other symptoms do you feel are associated with your condition? _____

Health History

Check only those conditions which you have or have had in the past:

- | | | | | |
|--------------------------------------|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Depression | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Fractures | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, growths |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Measles | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Other _____ |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

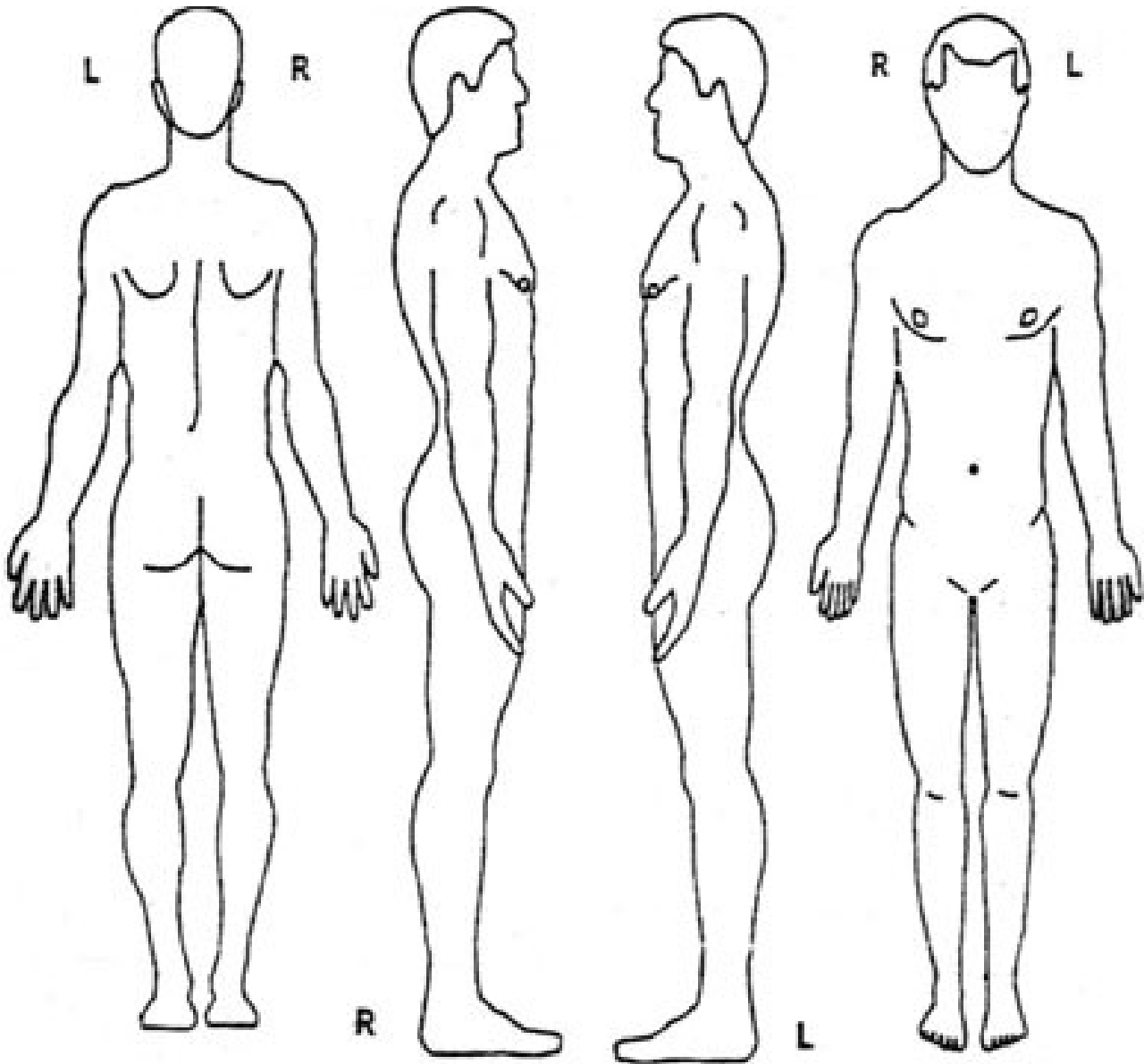
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature of Patient/Guardian

Date

PAIN DRAWING

Name: _____ Date: _____



Mark as follows:

A - Ache

B - Burning

N - Numbness

P - Pins & Needles

S - Stabbing

O - Other - Describe



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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 \$31 and \$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.

 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.

8

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:

9

- 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): _____