Smiley Family
Chiropractic & Wellness Center

General Information

Name: _____ Age: _____ Today's Date: _____

Date of Birth: _____ Email: _____

Address: _____ City: _____ State/Zip: _____

Phone: (Home): _____ (Cell): _____

Occupation: _____

When, where and from whom did you last receive medical or health care? _____

_____

_____

Emergency Contact: (Please list 2)

Name: _____ Relationship: _____

Phone: _____ Cell: _____

Name: _____ Relationship: _____

Phone: _____ Cell: _____

How did you hear about our practice?

Clinic Website ☐ Referral from Doctor ☐ Referral from Friend/Family Member ☐

Social Media ☐ Other: _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority.

Describe Problem & rate the severity	Mild	Moderate	Severe	Prior Treatment/Approach & rate the Success.	Excellent	Good	Fair

_____

Please list any medications and/or vitamins that you are currently taking.

Name of medication	Reason

Do you have any known allergies? ☐ Yes ☐ No

IF yes, explain: _____

Lifestyle Review

Sleep

How Many hours of sleep do you get each night on average?

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

IF yes, explain: _____

Exercise

Current Exercise Program:

Activity	Type	# of Times per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g. Golf)			
Other:			

Do you feel motivated to exercise? ☐ Yes ☐ A Little ☐ No

Are there any problems that limit exercise? ☐ Yes ☐ No

IF yes, explain: _____

Do you feel unusually fatigued or sore after exercise? ☐ Yes ☐ No

IF yes, explain: _____

Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply.)*

☐ Vegetarian ☐ Vegan ☐ Allergy ☐ Elimination ☐ Low Fat ☐ Low Carb ☐ High Protein

☐ Blood Type ☐ Low Sodium ☐ No Dairy ☐ No Wheat ☐ Gluten Free

Other: _____

Do you have sensitivities to certain foods? ☐ Yes ☐ No

IF yes, list food and symptoms: _____

Nutrition *(cont.)*

Do you adversely react to: *(Check all that apply.)*

☐ Monosodium Glutamate (MSG) ☐ Artificial Sweeteners ☐ Garlic/Onion ☐ Cheese ☐ Citrus Foods

☐ Chocolate ☐ Alcohol ☐ Red Wine ☐ Sulfite-Containing Foods *(Wine, Dried Fruit, Salad Bars)*

☐ Preservatives ☐ Food Colorings ☐ Other Food Substances: _____

Are there any foods that you crave or binge on? ☐ Yes ☐ No

IF yes, what foods?

Do you eat 3 meals a day? ☐ Yes ☐ No *IF no, how many:* _____

Does skipping a meal greatly affect you? ☐ Yes ☐ No

How may meals do you eat our per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 Meals per week

Check the factors that apply to your current lifestyle and eating habits:

☐ Fast Eater
☐ Eat too much
☐ Late-night eating
☐ Dislike healthy foods
☐ Time constraints
☐ Travel frequently
☐ Eat more than 50% of meals away from home
☐ Healthy foods not readily available
☐ Poor snack choices
☐ Significant other or family members don't like healthy
☐ Significant other or family members have special dietary needs
☐ Love to eat
☐ Eat because I have to
☐ Have negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely , bored, etc.)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Confused about nutrition advice

Smoking

Do you smoke currently? ☐ Yes ☐ No

What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig

Have you attempted to quit? ☐ Yes ☐ No

IF yes, using what methods: _____

If you smoked previously: Packs per day: _____ Number of years: _____

Are you regularly exposed to second-hand smoke? ☐ Yes ☐ No

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 oz Wine, 12 oz beer, 1.5 oz spirits)*

☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 ☐ None

Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None

Have you ever had a problem with alcohol? ☐ Yes ☐ No

IF yes, when? _____

Explain the problem: _____

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

Other Substances

Are you currently using recreational drugs? ☐ Yes ☐ No

IF yes, type: _____

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

Stress

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

How much stress do each of the following cause on a daily basis? *(Rate on scale of 1-10, 10 being highest)*

Work____ Family____ Social____ Finances____ Health____ Other____

Do you use relaxation techniques? ☐ Yes ☐ No

IF yes, how often? _____

Which tequniques do you use? *(Check all that apply)*

☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other: _____

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

IF yes, describe: _____

Have you ever been abused, a victim of crime, or experienced a significant trauma? ☐ Yes ☐ No

What are your hobbies or leisure activities? _____

Environmental/Detoxification History

Do any of these significantly affect you?

☐ Cigarette Smoke ☐ Perfume/Colognes ☐ Auto Exhaust Fumes ☐ Other

In your work or home environment, are you regularly exposed to: *(Check all that apply)*

☐ Mold ☐ Water Leaks ☐ Renovations ☐ Chemicals ☐ Electromagnetic radiation

☐ Damp Environments ☐ Carpets or Rugs ☐ Old Paint Stagnant or Stuffy Air ☐ Smokers

☐ Pesticides ☐ Herbicides ☐ Harsh Chemicals *(Solvents, Glues, Gas, Acids, etc.)* ☐ Cleaning Chemicals

☐ Heavy Metals *(Lead, Mercury, etc.)* ☐ Paints ☐ Airplane Travel ☐ Other:

Have you had a significant exposure to any harmful chemicals? ☐ Yes ☐ No

IF yes, Chemical Name, Length of exposure, Date: _____

Do you have any pets or farm animals? ☐ Yes ☐ No

IF yes, do they live: ☐ *Inside* ☐ *Outside* ☐ *Both Inside & Outside*

Medical History: Illness/Conditions		
Injuries		
Broken Bone(s)		
Back Injury		
Neck Injury		
Head Injury		
Other:		
Surgeries		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint Replacement		
Heart Surgery		
Other:		
Hospitalizations	**Date**	**Reason**

Please list any other issues or concerns,that are not listed, you may have.

Medical History *(cont.)*

Checking YES = A condition you currently have. Check PAST = A condition you've had in the past.

Gastrointestinal	**Yes**	**Past**
Irritable bowel syndrome	☐	☐
GERD (reflux)	☐	☐
Crohn's Disease/Ulcerative Colitis	☐	☐
Peptic Ulcer Disease	☐	☐
Celiac Disease	☐	☐
Gallstones	☐	☐
Other:	☐	☐
Respiratory		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Phdumonia	☐	☐
Sinusitis	☐	☐
Sleep Apnea	☐	☐
Other:	☐	☐
Urinary/Genital		
Kidney Stones	☐	☐
Gout	☐	☐
Interstitial Cystitis	☐	☐
Frequent Yeast Infections	☐	☐
Frequent Urinary Tract Infections	☐	☐
Sexual Dysfunction	☐	☐
Sexually Transmitted Diseases	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Hypothyroidism (Low Thyroid)	☐	☐
Hyperthyroidism (Overactive Thyroid)	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Infertility	☐	☐
Metabolic Syndrome/Insulin Resistance	☐	☐
Eating Disorder	☐	☐
Hypoglycemia	☐	☐
Other:	☐	☐
Inflammatory/Immune		
Rheumatoid Arthritis	☐	☐
Chronic Fatigue Syndrome	☐	☐
Food Allergies	☐	☐
Environmental Allergies	☐	☐
Multiple Chemical Sensitivities	☐	☐
Autoimmune Disease	☐	☐
Immune Deficiency	☐	☐
Mononucleosis	☐	☐
Hepatitis	☐	☐
Other:	☐	☐

Musculoskeletal	**Yes**	**Past**
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Chronic Pain	☐	☐
Other:	☐	☐
Skin		
Eczema	☐	☐
Psoriasis	☐	☐
Acne	☐	☐
Skin Cancer	☐	☐
Other:	☐	☐
Cardiovascular		
Angina	☐	☐
Heart Attack	☐	☐
Heart Failure	☐	☐
Hypertension (High Blood Pressure	☐	☐
Stroke	☐	☐
High Blood fats (cholesterol, Triglycerides)	☐	☐
Rheumatic Fever	☐	☐
Arrythmia (Irregular Heart Rate)	☐	☐
Murmur	☐	☐
Mitral Valve Prolapse	☐	☐
Other:	☐	☐
Neurologic/Emotional		
Epilepsy/Seizures	☐	☐
ADD/ADHD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple Sclerosis	☐	☐
Parkinson's Disease	☐	☐
Dementia	☐	☐
Other:	☐	☐
Cancer		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months.

General	**Mild**	**Moderate**	**Severe**
Cold Hands & Feet	☐	☐	☐
Cold Intolerance	☐	☐	☐
Daytime Sleepiness	☐	☐	☐
Difficulty Falling Asleep	☐	☐	☐
Early Waking	☐	☐	☐
Fatigue	☐	☐	☐
Flushing	☐	☐	☐
Heat Intolerance	☐	☐	☐
Night Waking	☐	☐	☐
Nightmares	☐	☐	☐
Can't Remember Dreams	☐	☐	☐
Low Body Temperature	☐	☐	☐
Head, Eyes, & Ears			
Conjunctivitis	☐	☐	☐
Distorted Sense of Smell	☐	☐	☐
Distorted Taste	☐	☐	☐
Ear Fullness	☐	☐	☐
Ear Ringing/Buzzing	☐	☐	☐
Eye Crusting	☐	☐	☐
Eye Pain	☐	☐	☐
Eyelid Margin Redness	☐	☐	☐
Headache	☐	☐	☐
Hearing Loss	☐	☐	☐
Hearing Problems	☐	☐	☐
Migraine	☐	☐	☐
Musculoskeletal			
Back Muscle Spasm	☐	☐	☐
Calf Cramps	☐	☐	☐
Chest Tightness	☐	☐	☐
Foot Cramps	☐	☐	☐
Joint Deformity	☐	☐	☐
Joint Pain	☐	☐	☐
Joint Redness	☐	☐	☐
Joint Stiffness	☐	☐	☐
Muscle Pain	☐	☐	☐
Muscle Spasms	☐	☐	☐
Muscle Stiffness	☐	☐	☐
Muscle Twitches	☐	☐	☐
Around Eyes	☐	☐	☐
Arms or Legs	☐	☐	☐
Muscle Weakness	☐	☐	☐

Musculoskeletal *(cont.)*	**Mild**	**Moderate**	**Severe**
Neck Muscle Spasm	☐	☐	☐
Tendonitis	☐	☐	☐
Tension Headache	☐	☐	☐
TMJ Problems	☐	☐	☐
Mood/Nerves			
Agoraphobia	☐	☐	☐
Anxiety	☐	☐	☐
Auditory Hallucinations	☐	☐	☐
Blackouts	☐	☐	☐
Depression	☐	☐	☐
Difficulty:	☐	☐	☐
Concentrating	☐	☐	☐
With Balance	☐	☐	☐
With Thinking	☐	☐	☐
With Judgement	☐	☐	☐
With Speech	☐	☐	☐
With Memory	☐	☐	☐
Dizziness (spinning)	☐	☐	☐
Fainting	☐	☐	☐
Fearfulness	☐	☐	☐
Irritability	☐	☐	☐
Light-Headedness	☐	☐	☐
Numbness	☐	☐	☐
Other Phobias	☐	☐	☐
Panic Attach's	☐	☐	☐
Paranoia	☐	☐	☐
Seizures	☐	☐	☐
Suicidal Thoughts	☐	☐	☐
Tingling	☐	☐	☐
Cardiovascular			
Angina/Chest Pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart Attack	☐	☐	☐
Heart Murmur	☐	☐	☐
High Blood Pressure	☐	☐	☐
Irregular Pulse	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Palpitations	☐	☐	☐
Phlebitis	☐	☐	☐
Swollen Ankles/Feet	☐	☐	☐
Varicose Veins	☐	☐	☐

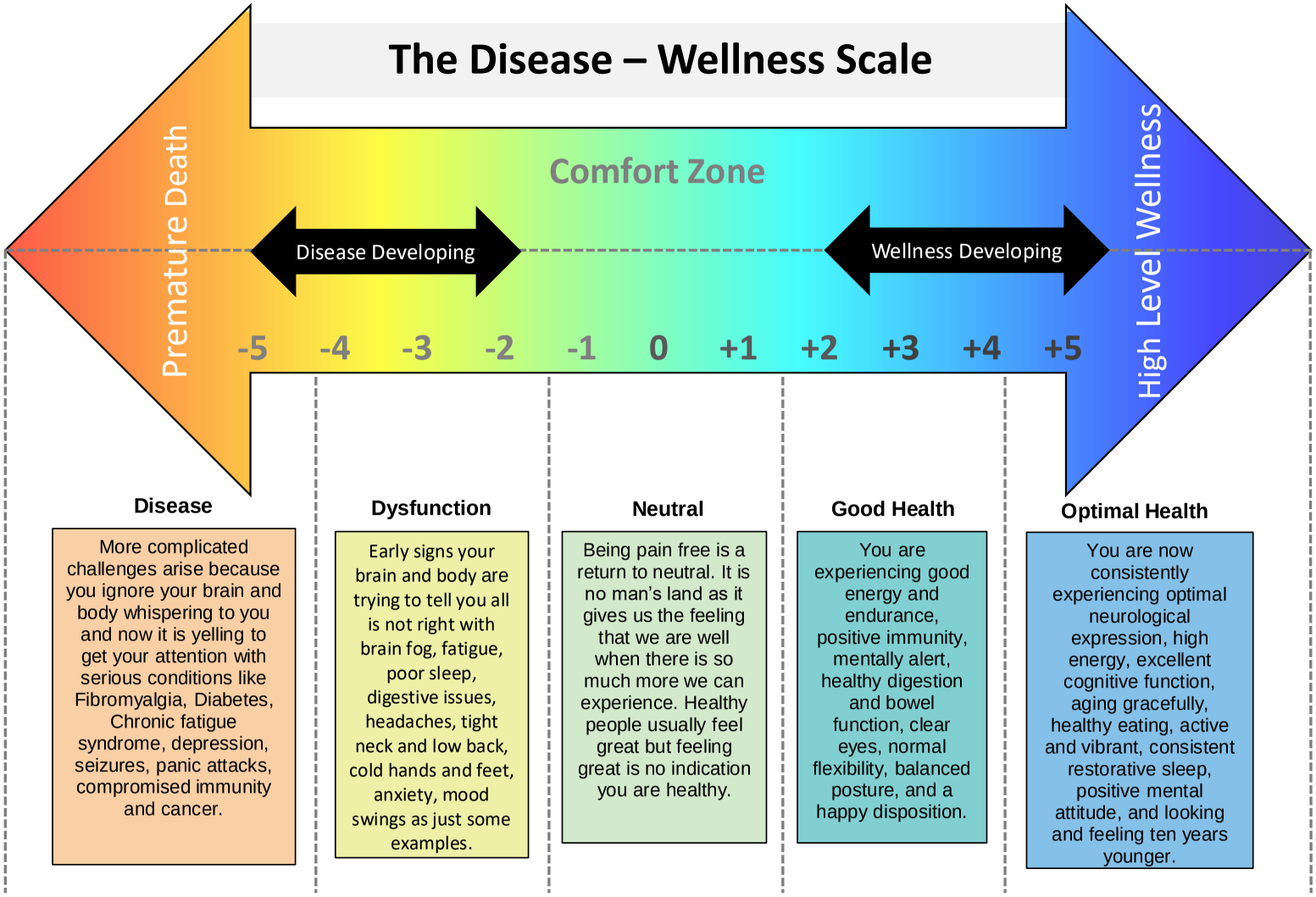
Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months.

Urinary	**Mild**	**Moderate**	**Severe**
Bed Wetting	☐	☐	☐
Hesitancy	☐	☐	☐
Infection	☐	☐	☐
Kidney Disease	☐	☐	☐
Kidney Stones	☐	☐	☐
Leaking/Incontinence	☐	☐	☐
Pain/Burning	☐	☐	☐
Urgency	☐	☐	☐
Digestion			
Anal Spasms	☐	☐	☐
Bad Teeth	☐	☐	☐
Bleeding Guns	☐	☐	☐
Bloating of:	☐	☐	☐
Lower Abdomen	☐	☐	☐
Whole Abdomen	☐	☐	☐
Bloating After Meals	☐	☐	☐
Blood in Stool	☐	☐	☐
Burping	☐	☐	☐
Canker Sores	☐	☐	☐
Cold Sores	☐	☐	☐
Constipation	☐	☐	☐
Cracking at Corner of Lips	☐	☐	☐
Dentures w/Poor Chewing	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Dry Mouth	☐	☐	☐
Farting	☐	☐	☐
Fissures	☐	☐	☐
Foods "Repeat" (Reflux)	☐	☐	☐
Lower Abdominal Pain	☐	☐	☐
Mucus in Stools	☐	☐	☐

Digestion *(cont.)*	**Mild**	**Moderate**	**Severe**
Nausea	☐	☐	☐
Periodontal Disease	☐	☐	☐
Sore Tounge	☐	☐	☐
Strong Stool Odor	☐	☐	☐
Undigested Food in Stool	☐	☐	☐
Upper Abdominal Pain	☐	☐	☐
Vomiting	☐	☐	☐
Eating			
Binge Eating	☐	☐	☐
Bulimia	☐	☐	☐
Can't Gain Weight	☐	☐	☐
Can't Loose Weight	☐	☐	☐
Carbohydrate Craving	☐	☐	☐
Carbohydrate Intolerance	☐	☐	☐
Poor Appetite	☐	☐	☐
Salt Cravings	☐	☐	☐
Frequent Dieting	☐	☐	☐
Sweet Cravings	☐	☐	☐
Caffeine Dependency	☐	☐	☐
Respiratory			
Bad Breath	☐	☐	☐
Bad Odor in Nose	☐	☐	☐
Cough-Dry	☐	☐	☐
Cough-Productive	☐	☐	☐
Nasal Stuffiness	☐	☐	☐
Nose Bleeds	☐	☐	☐
Post Nasal Drip	☐	☐	☐
Sinus Fullness	☐	☐	☐
Sinus Infection	☐	☐	☐
Snoring	☐	☐	☐
Sore Throat	☐	☐	☐
Wheezing	☐	☐	☐
Winter Stuffiness	☐	☐	☐

Mark where you feel that you currently are on the Health scale.



Health Goals

What do you hope to achieve through care in our office?

When was the last time you felt well?

What do you feel needs to happen for you to get better?

Please rank on a scale of 0 *(unwilling)* to 5 *(very willing)* for the following:

In order to improve your health, how willing are you to:

Significantly modify your diet?	0	1	2	3	4	5
Take nutritional supplements each day?	0	1	2	3	4	5
Modify your lifestyle? (e.g. work demands, sleep habits)	0	1	2	3	4	5
Engage in regular exercise?	0	1	2	3	4	5
Receive regular chiropractic care?	0	1	2	3	4	5

Our Purpose:

To serve courageously, Love Empathetically

& Facilitate healing when all Hope has been lost.

Terms of Acceptance

This document serves to inform you about potential risks that can be associated with care in our office. Please read and ask questions as needed.

Dr. Jessica Smiley, Dr. Brittany Steward, and Dr. Sara Wiatrek are licensed Chiropractors in the state of Tennessee. Our doctors have completed postgraduate courses in Neuroscience, Functional Medicine, and Neuro Emotional Technique. Dr. Smiley is board certified by the American Veterinary Chiropractic Association in animal chiropractic. With that being said, please read each statement accordingly:

Smiley Family Chiropractic and Wellness Center will not claim to treat or cure any medical conditions, but rather will attempt to restore balance and function to your health and wellness. This process may include examinations, chiropractic adjustments, functional neurology assessments and therapies, music/ acoustic therapy, color / light therapy, vestibular rehab, physical therapy exercises, muscle work(muscle stripping, massage, stretching, rehab), supplemental recommendations, diet alteration, blood chemistries, stool samples, saliva samples, various intake forms, and other methods and modalities may be used as well.

If any dietary or supplemental recommendations are made at Smiley Family Chiropractic and Wellness Center, we advise you to bring these recommendations to your medical providers before beginning. Any recommendations made are not intended to diagnose, treat, cure, or manage any medical condition. Chiropractic, Functional Medicine, and Functional Neurology comprise various methods of establishing balance within one's body. The methods that Smiley Family Chiropractic and Wellness Center utilizes should not replace that of traditional medical approaches, and it is always advised that anyone under our care should follow up with their medical providers to discuss any care recommendations. At times, an adjustment/manipulation/fast stretch may be performed to help improve your function and eliminate the effects of vertebral subluxation. As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains and sprains. There are very rare occurrences when stroke has been linked to an adjustment - many studies have been performed on this topic, some try to demonstrate a very weak association, but most studies show that chiropractic manipulations are not directly linked to this type of injury. The methods that our doctors utilize minimizes all the above-mentioned risks. Historically, Chiropractic is a very safe and effective means to achieve a more optimal state of health and wellness. In this practice our doctors will need to perform an exam prior to commenting on the state of your health and prior to making any recommendations.

Smiley Family Chiropractic and Wellness Center may use various types of photobiomodulation during your appointments. This will involve the use of a laser / light. Laser therapy has been heavily researched and proven safe and effective for many different conditions over the past several decades. We do not claim to treat, cure, manage, or diagnose any medical condition with photobiomodulation. We are simply improving the overall function of your body via the various proven effects of the laser / light therapy.

Smiley Family Chiropractic and Wellness Center acknowledges the scope of Chiropractic in the state of Tennessee is very limited and we will stay within this scope of practice. All therapies and procedures performed will be geared toward the following goals: to reduce the effects of the vertebral subluxation complex via various reflexogenic systems, to establish balance within your body, and to improve your overall health and wellness. If you have any concerns or reservations prior to care with Smiley Family Chiropractic and Wellness Center, please do not hesitate to ask. If you ever experience something that causes any concern, please discuss the matter with us immediately.

By signing below, you acknowledge that you have fully read or have had the chance to read all information contained within this document and have had an opportunity to ask any about any questions or concerns and agree with these terms and information.

_____ _____

Signature Date

_____ _____

Parent or legal guardian (If under the age of 18) Date

New Member Intake and Financial Policies – Consents

Contact
I authorize Smiley Family Chiropractic & Wellness Center to contact me via phone, text, or email. Contact purposes are typically, but not limited to being informative in nature – appointment reminders and/or info about closings and important dates. On occasion I may send notifications about current research or goings on in the field of chiropractic, Functional Medicine, Functional Neurology, Functional Endocrinology, or health in general. Dr. Jessica Smiley, Dr. Brittany Steward, and/or Dr. Sara Wiatrek will also use these contacts to follow up when that is necessary. Your contact info will never be sold or solicited. I authorize Smiley Family Chiropractic & Wellness Center to utilize smileyfamilychiropractic@msn.com and/or drsmiley_sfcwc@hotmail.com, or (423)442-2100 and/or (423)295-4406 to contact me when needed.

- I agree

Insurance and Billing
I understand that Smiley Family Chiropractic & Wellness Center, will not in any way bill my insurance, nor will they give billing codes for reimbursement from insurance for any services outside of Chiropractic (Chiropractic services include: examinations, X-rays, re-evaluations, and adjustments) . I understand that I am responsible for full payment for any service at the time of service, unless otherwise agreed upon. I agree that if an invoice is emailed or mailed after the service that I will submit payment within 30 days of receiving the invoice, unless otherwise agreed upon. If payment is not received within 30 days Smiley Family Chiropractic & Wellness Center may begin collection procedures if deemed necessary and/or begin to add a late fee of 10% of the total owed or a past due fee of $10, whichever one is greater to the uncollected balance per month from the date of service.

- I agree

Cancellation Policy
I fully acknowledge that Smiley Family Chiropractic & Wellness Center will enforce a cancellation policy if I fail to cancel my appointment less than 24 hours in advance for Functional Neurology or Functional Medicine appointments and more than 7 days for Intensive Functional Neurology appointments. The policy is as detailed below:

- If a Functional Neurology or Functional Medicine appointment is not cancelled within 24 hours 50% of the scheduled appointment will be collected.
- If an Intensive Functional Neurology appointment is cancelled between 8-14 days before the appointment, 50% of the scheduled appointment will be collected. If an appointment is cancelled within 0- 7 days a 100% of the scheduled appointment will be collected.

If you do not show up to your scheduled appointment, your card will be charged for 100% of the scheduled appointment fee.

- I am aware of the cancellation policy, and I agree

HIPPA
I have read or been given the chance to read over the HIPPA guidelines (posted on the website/form)

- I agree

Medical Information
I agree to allow Smiley Family Chiropractic & Wellness Center to obtain and/or send medical information as deemed medically necessary for my care. I also agree to allow Smiley Family Chiropractic & Wellness Center to consult with providers that I am seeing or have seen as needed for my care.

- I agree

Media Release
I authorize Smiley Family Chiropractic & Wellness Center to use various photos and videos as deemed necessary for educational and academic purposes. Mediums that these photos and videos may be used for includes but is not limited to; lectures and social media (Smiley Family Chiropractic & Wellness Center's Facebook Page and

Instagram). Due to the nature of what we do in the office it is important that people see and understand this new form of healthcare. Our goal with any information shared is to further the understanding of functional neurology, laser therapy, chiropractic, and other modalities or methods utilized. All photos and videos will be tactful.

- I agree
- I disagree

Non-Refundable Deposit

I understand that for scheduling intensive appointments, the office will request a nonrefundable deposit of $1,000 to hold the appointments. I understand that the deposit amount will go toward the full cost of the intensive and is non-refundable and non- transferable.

- I agree

Acknowledgement

By signing below, you acknowledge that you have fully read or have had the chance to read all information contained within this document and have had an opportunity to ask any questions or concerns and are in agreement with these terms and information.

- I agree

_____ Date____/_____/_____

Signature

_____ Date____/_____/_____

Parent or legal guardian (if under the age of 18)

Smiley Family Chiropractic & Wellness Center
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY. *This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated.*

NO CONSENT REQUIRED - The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

(b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Practice may also use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations –
(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER - The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a postcard mailed to you at the address provided by you; and telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG - The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS - The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:
(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure. (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

PRACTICE'S REQUIREMENTS - The Practice:

- is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- is required to abide by the terms of this Privacy Notice.
- reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- will distribute any revised Privacy Notice to you prior to implementation.
- will not retaliate against you for filing a complaint.

YOUR RIGHTS - You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and obtain a copy of your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

(e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy).

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Receive notice of any breach of confidentiality of your PHI by the Practice.

(i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

(j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(k) Request copies of your PHI in electronic format.

To obtain more information on or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Dr. Jessica Smiley, at **423-442-2100** or via email at **drsmiley@sfcwc@hotmail.com**.

QUESTIONS AND COMPLAINTS - You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below that is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer Dr Jessica.

You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE - This Notice is in effect as of 6/29/2022

_____ (Patient) _____ (Date)

Smiley Family
Chiropractic & Wellness Center

Financial Policy

1. It is the policy of this office that all services rendered be ultimately the responsibility of the patient, including those that are not reimbursed by third party payers.

2. All payments/co-payments/deductibles are payable when services are rendered or at the beginning of each week or month as credit to your account with no exceptions, unless prior arrangements have been made. If you choose to pay in advance you will be saving time at the front desk. If you are prepaid and pre-scheduled no wait is necessary, you can return your chart to the front desk counter and leave.

3. This office does not promise that an insurance company will reimburse for the usual and customary charges submitted by this office. We will honor what they communicate to us at the time of benefit verification, but as they do not guarantee benefits until claim is processed and released, neither can we.

4. This office will accept payment from secondary insurance but will not file with a secondary insurance and cannot guarantee charges will be reimbursed. Unpaid balances older than **60 days** will become patient's responsibility automatically.

5. Since we do not own your policy and occasionally we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying a situation on any of your bills older than **30 days**. 30 days after your acknowledgment we send you a bill.

6. SFCWC will NOT enter into a dispute with an insurance company over the amount of reimbursement.

7. It is the patient's responsibility to communicate to this office any changes in status of his/her insurance company policy, or new information on auto accident and worker's compensation. Failure to do so will result in patient being responsible for bills up to the date of our acknowledgment.

8. Returned checks will be subject to an additional $35.00 collection fee. All balances over 30 days will be subject to a late fee of **10% of total owed every 30 days or a past due fee of $10, whichever one is greater**.

9. All accounts not paid within **90 days** will automatically be turned over to SFCWC's Attorney. If SFCWC must file a lawsuit for unpaid balances, Patient agrees to cover all Attorney fees and Court costs.

10. All patients whose visitation schedule is once per month (or longer) will not be eligible for insurance assignment; since that frequency constitutes a well visit, insurances will not cover maintenance care.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions in regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for a mutual benefit.

I HAVE READ, UNDERSTOOD, AND AGREED WITH THE ABOVE **FINANCIAL AGREEMENT.**

Patient Signature: _____ Date: ____/____/_____

I HAVE READ, UNDERSTOOD, AND AGREED WITH THE **OFFICE AND APPOINTMENT POLICIES** explained to me of which I hold the original copy.

Patient Initials: _____