Pediatric Intake Form (12 Year Old and Under)

1. First Name: _____ Last Name: _____ DOB: _____

2. MRN #: _____

3. **Home Address**

Address 1 _____ Address 2 _____

City _____ State _____ Zip Code _____

4. **Contact Information**

Mobile Phone _____ Home Phone _____

Primary Email Address _____ Social Security Number _____

5. **Demographic Information**

Sex:
○ Male ○ Female

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed ○ Other

6. **Personal Information**

Height - Feet: _____ Height - Inches: _____

Weight (in pounds): _____

7. **Do you have Blue Cross Blue Shield?**

○ Yes ○ No

8. **Insurance Payer**

Insurance Payer _____

9. **Insurance Policy Information (BCBS only):**

Insurance Plan Name _____ ID/Policy Number: _____ Group Number: _____

Relationship to Patient:
○ Self ○ Spouse ○ Parent ○ Employer ○ Caregiver ○ Other

Insured's First & Last Name: _____ Insured's Date of Birth: _____

10. **Insurance Card Upload**

11. **Emergency Contact Information**

Emergency Contact Name: | Contact Phone Number: | Relationship to Patient:

12. Referral Information

Referring Physician: | Referring Patient:

How did you hear about us?

○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Other:

Child's History

13. Have you ever received a formal diagnosis?

○ Yes ○ No

If yes, please specify:

14. Chief complaint in order of importance 1-5

	Complaint
1	
2	
3	
4	
5	

15. Pregnancy and Delivery Complications:

○ Yes ○ No

If yes, please specify:

16. Has formula ever been supplemented?

○ Yes ○ No

17. Any issues early on with the following?

☐ Sucking ☐ Latching ☐ Illnesses

☐ Eczema ☐ Collic ☐ Reflux (excessive spitting up)

☐ Other ☐ None

18. Breastfed?

○ Yes ○ No

19. Age when food was introduced?

20. Does the child consume any of the following:

- ☐ Dairy
- ☐ Gluten
- ☐ Corn
- ☐ High Sugar
- ☐ High Carbohydrates
- ☐ Artificial Dyes and Colorings
- ☐ None

21. Does the child have any adverse reactions to any of the listed above? Are there any known food sensitivities or allergies?

- ☐ Yes
- ☐ No

If yes, please specify:

_____

22. Please check any of the following that have applied throughout childhood until present:

- ☐ Eczema
- ☐ Asthma
- ☐ Allergies
- ☐ Infections
- ☐ Chronic Ear Infections
- ☐ Strep Infection
- ☐ Raised Bumps on Skin
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Sinus Infections
- ☐ Other
- ☐ None

If other, please specify:

_____

23. How frequently do they have bowel movements?

_____

24. Any sleeping issues from infancy to present?

- ○ Yes
- ○ No

If yes, please specify:

_____

25. Parent Relationship:

- ☐ Married
- ☐ Divorced
- ☐ Seperated
- ☐ Live Together

26. Occupation

	Job
Father	
Mother	

27. Developmental Milestones

	Age
Sit Up	
Roll Over	
Crawl	
Walk	
Talk	

28. How many words do they speak?

- ○ 1-5
- ○ 5-20
- ○ 20-50
- ○ 50+
- ○ Non Verbal

29. Does this child make eye contact?

- ○ Yes
- ○ No

30. Do they look in a mirror?

- ○ Yes
- ○ No

31. Do they recognize or know body parts?

- ○ Yes
- ○ No

32. Do they care about their appearance? Clothes, etc?

- ○ Yes
- ○ No

33. Do they have friends?

- ○ Yes
- ○ No

34. Do they play with other kids?

- ○ Yes
- ○ No

35. Where are they in school and what grade?

	Answer
Location	
Grade	

36. Do they know the following:

- ☐ Letters
- ☐ Numbers
- ☐ Colors
- ☐ Shapes

37. Do they read at all?

- ○ Yes
- ○ No

38. Can they do math?

- ○ Yes
- ○ No

39. Can they do any of the following:

- ☐ Write
- ☐ Color
- ☐ Draw

40. Is there any learning disability in school?

- ○ Yes
- ○ No

If yes, please specify:

_____

41. What are the most difficult subjects?

_____

42. What are the child's best subjects?

43. Are there any emotional issues, tantrums, etc.?

○ Yes ○ No

If yes, please specify:

44. Are there any major sensory issues, hyper/hyposensitivities?

○ Yes ○ No

If yes, please specify:

45. Do they feel pain?

○ Yes ○ No

46. Are they a picky eater?

○ Yes ○ No

47. Do they have any food preferrences?

○ Yes ○ No

If yes, please specify:

48. What do they drink?

49. Have you eliminated any of the following from their diet?

☐ Gluten ☐ Dairy ☐ Soy
☐ Other

If other, please specify:

50. Do they have a sense of smell or taste?

○ Yes ○ No

51. Please describe their muscle tone:

○ High ○ Low ○ Within Normal Limits

52. Describe their motor skills?

☐ Gross ☐ Fine

_____ _____

53. What is their hand dominance?

○ Right ○ Left ○ Ambidextrous

54. Do they have any issues with the following?

	Yes	No
Balance		
Motion Sickness		
Afraid of High Places		
Dizziness		

55. Do they spin themselves?

○ Yes ○ No

56. Do they have any stims or tics?

○ Yes ○ No

If yes, please specify:

_____

57. Do they have any OCD behaviors?

○ Yes ○ No

If yes, please specify:

_____

58. Do they have any unusually strong skills, such as the following?

☐ Early Reading ☐ Early Speech ☐ Memorizing Songs
☐ Memory for Details ☐ Memory for Locations ☐ Other

If other, please specify:

_____

Daily Activities

59. What does the child prefer for playtime?

_____

60. How much daily screen time?

_____

61. Do they prefer to be indoors or outdoors?

_____

Familial Health History

62. Does either parent have any chronic health issues?

○ Yes ○ No

If yes, please specify:

_____

63. Is there anyone in your immediate family who has experienced the following? If yes, please select and indicate who.

	Mother	Father	Brother(s)	Sister(s)	Child 1	Child 2	Child 3	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother	Other
Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Autoimmune Disease												
Arthritis												
Kidney Disease												
Thyroid Problems												
Seizures/Epilepsy												
Psychiatric Disorders												
Anxiety												
Depression												
Asthma												
Allergies												
Eczema												
ADHD												
Autism												
Irritable Bowel Syndrome												
Dementia												
Substance Abuse												
Genetic Disorders												
Other												

Supplements

64. Please list regularly used supplements as well as dosage and frequency for each

	Supplement	Dosage / Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

65. Have you ever had any of the following test ran?

- ☐ Blood Test
- ☐ MRI
- ☐ Gentetic
- ☐ Stool Testing
- ☐ EEG
- ☐ Allergy
- ☐ Other

If other, please specify:

_____

66. Has the child received any other treatment? Were they beneficial? Did you notice any improvement and which was the most effective?

_____

Parent / Legal Guardian

_____

Signature

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: _____

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(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.

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(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: _____

Smiley Family
Chiropractic & Wellness Center

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