

Smith Chiropractic Offices, P.C.

Name _____ Date _____
First M Initial Last

SS# _____ Male Female # of Children _____

Home Address _____
Street/P.O.Box City State Zip Code

Home Phone # _____ Work Phone# _____ Cell Phone# _____

Date of Birth ____/____/____ Age ____ Marital Status Single Married Divorced Widowed Separated

How did you hear about us? _____

Employed: Full Time Part Time Occupation: _____ Job Description: _____

Employer Business Name: _____ Years Employed _____

Employer's Address _____
Street/P.O. Box City State Zip Code

Work Status: Working Without Restrictions Working With Restrictions Not Working/Off Since _____

EMERGENCY CONTACT INFORMATION: Contact Person: _____

Phone#: _____ Relationship: _____

Are we seeing you for a specific injury? Auto Work Other **If injury please inform front desk.**

Payment Information: I Will Be Paying For The Services Myself Health Insurance

Please Give the front desk a copy of your current Driver's License and Insurance Card. Please Ask to see the "Red Flag Rule" program for more detailed information.

General Consent Form: The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from SCO. The information within this chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimum disclosure necessary as related to your care. Please ask to see the **NOTICE OF PRIVACY PRACTICES** for more detailed information. I understand that I have a responsibility to communicate honestly with the Doctors and to notify them of any changes in my health status.

Financial Awareness and Consent understand I am financially responsible, **WHETHER OR NOT MY INSURANCE COMPANY PAYS**, for all charges incurred by me. I hereby assign my major medical insurance benefits, Private Insurance and other health plans to SCO. Any overpayment will be promptly refunded. I also authorize to release any protected health information required to secure payment. Accounts over 90 days delinquent may be subject to a monthly finance charge of 1.5%, 18% Annually.

PATIENT'S SIGNATURE _____

Responsible Party's Signature (if patient minor): _____

Except in sudden emergencies, please give **PROPER NOTICE** to cancel or reschedule. **YOU WILL BE BILLED FOR A MISSED APPOINTMENT (a "No Show")**. Insurance companies will not pay for a missed visit.