PATIENT INFORMATION

Name _____ Email Address _____

Address _____ City, State & Zip _____

Date of Birth _____ Social Security Number _____

Home # _____ Work # _____ Other # _____

Parent/Guardian Name (if under 18) _____ Sex: □ M □ F

□ Single □ Married □ Widowed □ Divorced Children: □ Yes □ No # of Children # _____

Referred By _____

EMERGENCY CONTACT

Emergency Contact _____ Relation _____

Home # _____ Work # _____ Other # _____

Medical Doctor Name _____ Office # _____

EMPLOYMENT HISTORY

□ Unemployed □ Retired □ Unemployed due to injuries

Employer Name _____ Job Title _____

Employer Address _____ City, State, Zip _____

INSURANCE INFORMATION

Insurance Company Name _____

Insurance Company Address _____

Insurance Company's Phone Number _____

Group # (Plan, Local or Policy #) _____ Insured's Id# _____

Insured's Name _____ Relationship to Patient: Self Spouse Child Other

Birth Date of Insured _____ Social Security # of Insured _____

Insured Employer _____

ASSIGNMENT/RELEASE

I hereby authorize the Doctor to treat my condition as she/he deems appropriate including but not limited to routine diagnosis procedures and medical treatment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatments or examination rendered to me.

I further authorize SMART CHIROPRACTIC to release any and all medical information which pertains or relates to my medical care. This authorization and consent is granted for the sole and limited purpose of facilitating reimbursements for services rendered to me.

I understand and agree that insurance policies are an arrangement between the carrier and me. I certify that I, and/or my dependent(s) have insurance coverage with the above named insurance and assign directly to Dr. Vargo all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature _____ Date _____

Please indicate if you have or have had any of the following by entering the appropriate date of diagnosis; month & year. If date of diagnosis is unknown, please indicate approximate age of onset

ILLNESS	DATE	ILLNESS	DATE	ILLNESS	DATE
AIDS or HIV		Epilepsy/convulsions		Mononucleosis	
Anemia		Frequent kidney or bladder infection		Mumps	
Alcoholism		Frequent lung infection		Pain – Chronic	
Allergies (other than medications)		Gallbladder disease		Pneumonia	
Anorexia/Bulimia		Gout		Psychiatric care	
Appendicitis		Glaucoma, eye disease		Rheumatic Fever	
Arthritis		Heart disease		Rubella	
Asthma		Hepatitis, Type		Sexually transmitted disease	
Cancer		High blood pressure		Stomach ulcer	
Chemical dependency		High cholesterol		Stroke	
Chickenpox		Kidney disease		Thyroid problems	
Depression		Liver disease		Tonsillitis	
Diabetes		Measles		Tuberculosis	
Emphysema		Migraine Headache		Whooping Cough	

Are you allergic to any medication? ☐ Yes ☐ No If yes, please list

MEDICATION	REACTION

Please list all medications you are currently taking (including over the counter medication.)

MEDICATION	DOSAGE	FREQUENCY	REASON

Enter full date if known

OPERATIONS	DATE	OTHER HOSPITALIZATIONS	DATE

Please list other significant illnesses or injuries:	DATE

Family History: ☐ Seizures ☐ Stroke ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Cancer

Please explain Family History (if marked): _____

_____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Are your immunizations up to date? ☐ Yes ☐ No

FOR WOMEN:

Date of last menstrual period _____ Do you have menstrual problems? ☐ Yes ☐ No

I HEREBY CERTIFY THAT THE ANSWERS TO ALL THE ABOVE INFORMATION ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY SMART BODY CHIROPRACTIC

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires all medical records and other individually identifiable health information used or disclosed by JM Chiropractic in any form, whether electronic, on paper, or orally, to be kept properly confidential. **HIPAA** gives you, the client/patient, the right to understand and control how your protected health information (PHI) is used. HIPAA provides penalties for covered entities that misuse protected health information (PHI). Each time you meet with me, a record is made which may contain your symptoms, diagnoses, treatment, a plan for future treatment, and payment-related information. This notice applies to all of the records of your care generated by Smart Body Chiropractic

Smart Body Chiropractic & Wellness Responsibilities

We at Smart Body Chiropractic are required by law to maintain the privacy of your protected health information (PHI) and to provide you with a description of our legal duties and privacy practices regarding your PHI. We are required to abide by the terms of this notice and to notify you if we make changes to this notice, which may be at any time.

How We May Use and Disclose Medical Information About You

Treatment: We may use and disclose medical information about you to provide, coordinate, and manage your treatment or services. We may disclose medical information about you to doctors, other therapists, or others who are involved in your treatment only with your explicit verbal authorization. For example, if you have been treated by, or are treating with, other health care providers (therapists, physicians, etc.), We may request permission to speak with them and obtain copies of their reports and records of their treatments rendered to you. Also, if we refer you to another health care provider, we may provide oral information and copies of various reports that should assist him or her in treating you.

Payment: We may use and disclose medical information about you in order to obtain reimbursement for services, to confirm insurance coverage, for billing or collection activities, and for utilization review. An example of this would be sending a bill for your sessions to your insurance company. **This is not typically necessary however, when you pay me directly for services rendered, as then, we do not bill insurance companies or third parties for services rendered.** You may ask me for a payment receipt that you can send into your insurance company so that you can be reimbursed for payments you've made to me for services rendered to you. In that case, your insurance company will probably request additional information from our office which we will have to provide in order for you to get reimbursed.

Health Care Operations: We may use and disclose, as needed, your protected health information (PHI) in order to support our business activities, including quality assessment, licensing, marketing, legal advice, and customer service. For example, we may call you by name in the waiting area when we are ready to see you for your appointment.

Other Uses and Disclosures:

We may use and disclose your PHI in an emergency situation to prevent harm to yourself or others. An example would be mandated reporting of abuse to children, the elderly, a disabled person, or when a judge orders the release of information. Only the minimum amount of information relevant to your health care would be disclosed. We may create and distribute de-identified health information by removing all references to individually identifiable details. We may ask you to provide us with testimonials to help us with marketing Smart Body Chiropractic & Wellness and practice related products. We would only use your protected health information with your written permission. We may contact you to provide appointment reminders, or to offer information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures would be made only with your written authorization. You have the right to revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

Your Rights

You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to us, Smart Body Chiropractic & Wellness.

- The right to request restrictions on certain uses and disclosures of protected health information (PHI), including those related to disclosures to family members, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from me upon request.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the federal government at the address below, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201.
Phone: (877) 696-6775

If you have any questions about this notice, please contact Denise Vargo, D.C. by email or phone:
Email: smartbodychiro@yahoo.com
Phone: (281) 997-1333

By signing below, I acknowledge that I have reviewed a copy of the Notice of Privacy Practices. I also acknowledge that I consent to the use and disclosure by Smart Body Chiropractic of my protected health information (PHI) for purposes of treatment, payment and health care operations.

Patient or Guardian Signature: _____

Printed Name: _____ **Today's Date:** _____

Smart Body Chiropractic & Wellness
2723 Manvel Rd
Pearland, TX 77584

Patient Name: _____ Date: _____

CANCELLATION/MISSED APPOINTMENT POLICY

Your appointment time has been set aside for you. This time is unavailable to other patients. Therefore, we require at least **24 hours** in advance notice if you need to cancel your appointment. For all missed or cancelled appointments with **less than 24 hours notice**, you will be charged a **$25 cancellation fee**. Appointment reminder texts are a courtesy. Should you receive a reminder text, it is still your responsibility to remember your appointment.

I have read and understand the cancellation appointment policy

_____.
(Patient signature)

If patient is a minor, please provide parent or guardian's information.

Name _____ Relationship _____

Parent or Guardian signature _____

Informed Consent Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.
Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to inter vertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.
Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

• Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

• Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

• Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

• Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Informed Consent

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____

Print Name

_____

Signature

_____

Date

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Smart Body Chiropractic & Wellness as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving medical services from Smart Body Chiropractic & Wellness ("Smart Body"), you agree:

1. You acknowledge and agree to the established policies and procedures of Smart Body, including but not limited to this PATIENT FINANCIAL RESPONSBILITY STATEMENT, in effect from time to-time ("Policies"). You may request a copy of the current Policies from the Business Office Staff. These Policies may be changed from time to time by Smart Body, without notice. If there is any conflict between another policy or procedure of Smart Body and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, this Statement shall control.
2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our Policies, which are not otherwise covered by supplemental insurance.
3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Smart Body, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Smart Body are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Smart Body; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

4. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be re-scheduled by Smart Body.
5. By signing below, you authorize Smart Body to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign to Smart Body, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize Smart Body and associated physicians, staff, and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your

treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Smart Body does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.
6. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to Smart Body until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize Smart Body to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

7. We accept payment by check, cash, credit cards or Zelle.

a. **Payment by Check**. If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $25.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution.

b. **Payment by Credit Card**. You may pay with a credit card, **(NOT A DEBIT CARD).** Your payment with a credit card may be made in person or by telephone.

c. **Zelle.** You may send by Zelle to Smart Body at 346-673-5567.

8. **Managed Care (HMO, PPO, etc.).** All managed care co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a primary care physician, you are responsible for presenting this at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.
9. **Medicare.** Smart Body is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. By signing below, you request that payment of authorized Medicare benefits be made on your behalf to Smart Body for any services furnished to you by Smart Body.
10. **Workers' Compensation Cases.** Charges for services incurred as a result of a verified work related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier as a courtesy. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance carrier. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due within thirty (30) days.

11. **Third Party Liability Injuries.** If you receive treatment as a result of a third party liability injury (for example: motor vehicle accidents, premises liability, or other general liability claims against third parties), a courtesy payment of $30 will be due in full at the time of the service. We will accept a letter of protection from an attorney as a guarantee of payment or assignment of third party insurance payments. We may agree to bill a third party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide us all necessary information to confirm coverage for these payments with the auto/third-party carrier. We will also collect information about your personal medical insurance in case the auto/third-party carrier denies your claim. Regardless of whether we submit your claim to third-party insurance, as the patient, you are ultimately responsible for payment.

Acknowledgement

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the Smart Body Chiropractic & Wellness PATIENT FINANCIAL RESPONSIBILITY STATEMENT upon request; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to Smart Body for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered;

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____ _____ _____

Patient/Responsibility Party/Guardian Date Date of Birth

_____ _____ _____

Patient/Responsibility Party/Guardian Date Date of Birth