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 _____