Morgan Smith, LLC

Patient Information

Patient Name:

Last Name: _____First_____Middle_____

Gender: Male ⬭ Female⬭ Other⬭ Date of Birth_____/_____/_____ Age_____

Eligible for Medicare part B ⬭(if so, you will be required to fill out an Advanced Beneficiary Notice)

Height:_____ Estimated Weight:_____ SSN:_____-_____-_____

Home Address: _____

City: _____ State: _____ Zip: _____

Best Contact Number: _____ (Home ⬭ Work ⬭ Cell ⬭)

Email: _____

Please Note: you will receive emailed confirmations and reminders of appointments from a third party. Any requested emailed receipts will be send directly from the merchant services company.

Communication:

We request that no text messages be sent to the office. Any electronic communications will need to be sent through your patient portal account. Any requested documents or necessary communication outside of the portal will be in the form of encrypted emails sent through a third party.

Please initial to indicate that you understand and agree to our communication policy: _____

Emergency Contact:

Emergency Contact Name: _____ Number: _____

Relation to patient: _____

Certification:

I certify that the above information is correct and I request services.

X_____ _____

Signature of patient or Guardian *Date*

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Medical and Health History

Date_____ Patient Name _____Date of Birth_____

Main Problem

What pain/problem brings you to the office? _____

What caused this pain? _____

When did this pain start? _____

How long does this pain usually last? _____

Is it related to an accident? Yes ○ No ○ If yes ,is it an auto accident ○ Work Related ○ or ○ Other:

_____

How bad is this pain? (1=mild, 10=worst possible) ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Mark the word(s) that best describes the pain:

Cramping ☐ Aching ☐ Dull ☐ Sharp ☐ Shooting ☐ Bright ☐ Diffuse ☐ Lightening-like ☐

Throbbing ☐ Nagging ☐ Burning ☐ Deep ☐ Stinging ☐ Pressure-like ☐

How often does the pain occur? (Circle one) Occasional Frequent Constant

Does the pain travel to any other areas? _____

What makes the pain better? _____

What makes the pain worse? _____

What else have you done to treat this pain? _____

_____

Are there any other symptoms that occur with the pain? Stiffness, weakness, cramping, muscle spasms, swelling, other: _____

Other Problem

Please describe any other problems that you would like to have addressed today:

_____

_____

_____

_____

_____

_____

_____

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Lifestyle and Medical History

Do you smoke? Yes ⬭ No ⬭ If yes, how often? _____
Do you drink? Yes ⬭ No ⬭ If yes, how often? _____

Do you exercise regularly? Yes ⬭ No⬭ What do you do for exercise? _____

Are you Pregnant? Yes ⬭ No ⬭ If yes how far along are you? _____

Are you aware of any food sensitivities? _____

How would you describe your average level of stress? Low/None ⬭ Moderate ⬭ High ⬭ Severe ⬭

How is your overall health? _____

List past illnesses: _____

Do any serious medical problems run in your family? _____

Past Surgeries/Hospitalizations/Injuries: _____

_____

Current Medications-Purpose: _____

_____

(use other side if necessary)

X_____ _____

Signature of patient or Guardian *Date*

Privacy Protection

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan, coordinate, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payors; and Conduct normal healthcare operations such as quality assessments and accreditation.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by the Clinic to ensure the privacy of my personal health information.

Please initial to indicate that you understand and agree to our privacy policy X: _____

Financial Policy:

Payment in full is expected at time of visit. Upon your request, claims will be filed on your behalf. Please be aware that we are out of network with all insurers.

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Morgan Smith, LLC

If you would like claim submitted, please indicate your carrier: _____

and provide the office with a copy of your insurance card. Please initial to indicate that you understand and agree to our financial policy X: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. 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, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

*X*_____ _____

Signature of patient or Guardian *Date*

Morgan Smith, LLC

Assumption of Risk, Responsibility and Liability Waiver

I agree as follows:

Assumption of Risks

I understand while I am visiting Sports Chiropractic & Massage, which is owned and operated by Morgan Smith LLC (the "Clinic") and while I am receiving treatments, I may be in unfamiliar surroundings and may be exposed to risks to my person and possessions. I understand that I may suffer physical injury, sickness or death, or damage to my property as a result of my participation during my office visit. I freely and voluntarily accept and assume all such risks, dangers, and hazards. Accordingly, I understand that the Clinic is not able to ensure my complete safety at all times and from such risks and damages.

Assumption of Responsibility

I understand that it is my responsibility to abide by all Clinic policies and applicable laws, and to ensure that I have adequate medical, personal health, dental, and accident insurance coverage, as well as protection of my personal belongings from loss. Injuries of any kind are covered by my own insurance coverage or will be remedied at my own cost and expense.

I understand that due to the nature of the treatments provided I may be required to disrobe and/or remove my jewelry. I recognize that it is my responsibility to take reasonable measures to keep my clothing and personal items collected during my office visit and to maintain them such that they are within my control at all times. I understand it is my responsibility to gather and account for all of my personal belongings and clothing prior to leaving the Clinic. Neither Dr. Smith nor the Clinic will be responsible for lost or stolen items.

I agree to be accountable in all respects for my own actions and will not hold Dr. Smith, the Clinic or its representatives responsible for the consequences thereof. My signature below is given freely in order to indicate my understanding of the risks and my responsibilities described herein.

Liability Waiver

I release and hold harmless Dr. Smith, the Clinic, and any of its representatives from any and all liability for any loss, damage, injury or expense that I may suffer as a result of my chiropractic/massage visit(s) including, but not limited to, accidents, damage or loss of my belongings, acts of God, war, civil unrest, sickness, transportation, scheduling, government restrictions or regulations, and any and all expenses which I may incur while participating in the chiropractic/massage visit(s).

In the event one or more of the provisions of the waiver is deemed invalid, illegal or unenforceable in any respect under applicable law; the validity, legality, and enforceability of the remaining provisions hereof shall not in any way be impaired thereby.

This waiver is effective while I am a patient and participating in the chiropractic/massage visit(s) or visiting the Clinic for any reason. I understand that this agreement cannot be modified or interpreted except in writing by Dr. Smith and that no oral modification or interpretation shall be valid.

I have read this document carefully and acknowledge my responsibility and the effect of this liability waiver.

X_____ _____

Signature of patient or Guardian *Date*

05/02/2017