RICHMOND CHIROPRACTIC NEUROLOGY

Mark S. Smith, DC, DABCN
Board Certified Chiropractic Neurologist
1807 Huguenot Road, Suite 105
Midlothian, VA 23113

804.897.9194 Office
804.423.1599 Fax
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www.richmondchironeuro.com

Welcome to our office and thank you for completing this brief, but necessary, paperwork.

Patient Registration

Name: _____ DOB: / /
Street Address: _____ Age: _____
PO Box: _____ Gender: M F
City/State/Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
SSN: _____ Occupation: _____
Marital Status (circle one) S M D W Email Address: _____
Employer _____
Address: _____
Phone: _____ Best time to call: _____

Spouse Or Parent's Name: _____
Employer: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Billing & Insurance Information

Name of Responsible Party: _____
Insurance Company Name: _____
Policyholder's Name: _____
Insurance Co. Phone Number _____ POLICY ID# _____

Please provide us with your insurance card to be copied

Emergency Contact Name: _____ Phone #: _____
Relationship to Patient: _____

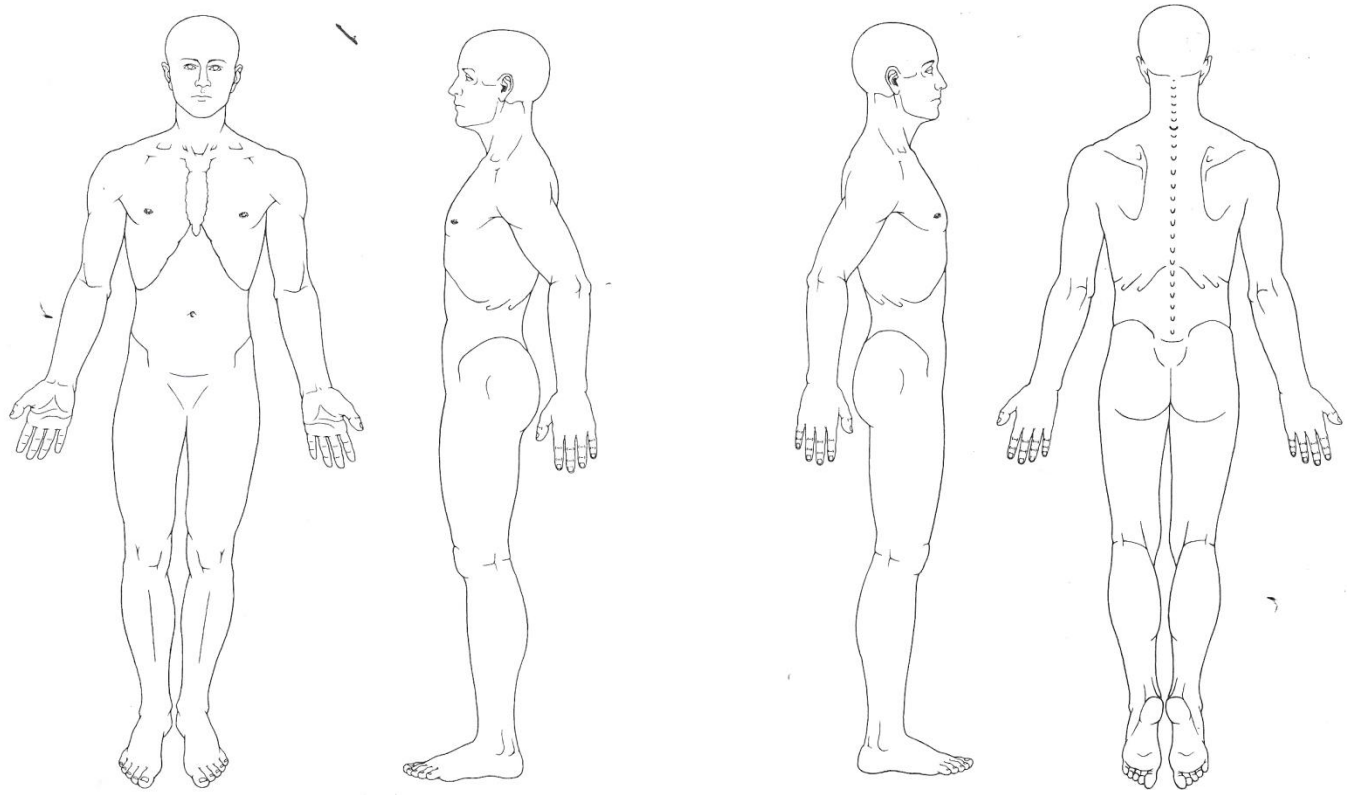
Patient authorization, assignment and lien:
I authorize the release of medical information to insurance carriers and/or their agents. I also authorize payment of medical benefits to the physician or supplier for services rendered. I certify that the information that I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the requesting party. I further understand that I am fully responsible for all services rendered by Mark S. Smith, DC, PC chiropractic services and that I am fully responsible for all services and that if my account is turned over for collection, that I am responsible for 33% attorney fees plus cost.

Signature: _____ Date: _____ (COMPLETE BACK PAGE)
(If minor child, please have legal guardian sign above.)

Please tell us whom we can thank for referring you to our office: _____

Reason for visit: Please briefly describe your health condition(s) for which you are seeking care:

If applicable, please mark the area(s) where you have pain.



Please mark the areas where you have pain or discomfort using the following key:

X = Stabbing O= Burning M=Aching Z= Tingling ///=any other pain type

OR, use the pain scale below to indicate severity.

Minimal	1	2	3	4	5	6	7	8	9	10	Disabling
Ex: lower leg					*X*						

Authorization For and Consent to Manipulation or Special Procedures

Dr. Smith has determined that you are a candidate for a trial of manipulative therapy, which may also be called an adjustment. From the examination findings, there is a reasonable possibility that you will benefit significantly from such treatment. Adjustment includes procedures such as:

- The pushing, pulling or turning of the spine and related articulations
- The pulling or application of traction to the head, arms or legs
- The massaging of areas of muscle spasm, tender points and/or trigger points

These procedures are performed using the hands or arms of the doctor while the patient is in a relaxed position. During these procedures, it is not uncommon to hear a “popping” or “cracking” noise as the movement is restored to the articulation.

The purpose of an adjustment is to relieve pain, increase motion, relax muscles and reduce spasms, influence intervertebral disc disease, stimulate trigger points, stimulate the nervous system in a specific context and in other ways improve the biomechanical and neuromuscular function of the spine and related articulations. These changes will hopefully lead to relief of symptoms and improvement in function.

Explanation of Risks

Like most forms of medical treatment there are possible complications and risks of which you should be aware. Spinal adjustments are considered one of the safest methods available for the treatment of many pain syndromes, spinal and joint disorders. However, some of the complications of receiving adjustments are as follows:

- The most common adverse effect is a temporary aggravation of symptoms that usually lasts only a short period and occurs in only a small percentage of patients.
- Other unlikely but possible complications could be stretch injuries to muscle, tendons and soft tissues; fracture or displacement of bones; injury to discs; complications in addition to these do exist, however it is not possible to advise you of every imaginable complication, including the remote possibility of stroke. Also, the exact incidence of serious complications from adjustments is unknown, but the risks of such complications are described as rare or very rare.

Dr. Smith is a licensed doctor of chiropractic and every reasonable precaution has and will be taken to reduce the risks of adverse effects from this and any treatment.

Statement of Request

The purpose and nature of adjustment therapies, possible alternative methods of treatment, ancillary procedures, the risks involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the adjustment and other therapies and that I have been given the opportunity to ask questions. I hereby request that Dr. Smith administer a trial on adjustment therapy and appropriate ancillary therapies to me.

Patient (Guardian) Signature: _____ Date: _____
Patient Name (Print) _____ (COMPLETE BACK PAGE)
Guardian Name (Print) _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Mark S. Smith, DC, PC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Mark S. Smith, DC, PC. I understand that diagnosis or treatment of me by Mark S. Smith, DC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Mark S. Smith, DC, PC is not required to agree to the restrictions that I may request. However, if Mark S. Smith, DC, PC agrees to a restriction that I request, the restriction is binding on Mark S. Smith, DC, PC and Mark S. Smith, DC

I have the right to revoke this consent, in writing, at any time, except to the extent that Mark S. Smith, DC or Mark S. Smith, DC, PC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Mark S. Smith, DC, PC 's Notice of Privacy Practices prior to signing this document. The Mark S. Smith, DC, PC 's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Mark S. Smith, DC, PC. The Notice of Privacy Practices for Mark S. Smith, DC, PC is also provided at our office at 1807 Huguenot Road, Suite 105, Midlothian, VA 23113 and on Mark S. Smith, DC, PC's website at www.richmondchironeuro.com. This Notice of Privacy Practices also describes my rights and the Mark S. Smith, DC, PC 's duties with respect to my protected health information.

Mark S. Smith, DC, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Mark S. Smith, DC, PC**'**s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative’s Authority

Mark S. Smith, DC, DABCN: Board Certified Chiropractic Neurologist
Health Consultant/ Functional Medicine
1807 Huguenot Road, Suite 105, Midlothian, VA 23113 Ph # 804.897.9194

Name: _____ Date: _____

Please take several minutes to answer these questions so Dr. Smith can help you get better faster. (**Please circle as many that apply**)

1. How have you taken care of your health in the past?

a. Medications
b. Emergency Room
c. Routine Medical
d. Exercise
e. Nutrition/Diet
f. Holistic Care
g. Vitamins
h. Chiropractic
i. Other (please specify): _____

2. How did the previous method(s) work out for you?

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

3. How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-esteem
f. Sleep
g. Time
h. Finances
i. Freedom

(COMPLETE BACK PAGE)

5. Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (Time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

What would be different/better without this problem? Please be specific.

What do you desire most to get from working with us?

What is that worth to you?

OFFICE POLICIES AND GUIDELINES

A. INTRODUCTION

We believe that a clear definition of our office policies will allow both you, the patient, and us, the doctor's office, to concentrate on the big issue—REGAINING AND MAINTAINING YOUR HEALTH. Therefore, please carefully read the information below and sign at the end of this document confirming that you understand and agree with the covered information. Please notify the staff if you have any questions for it is imperative you understand the information covered below.

B. APPOINTMENT POLICY

Depending on your case, you may or may not be asked to schedule a block of visits at a time. This method of scheduling (multiple scheduling) is primarily utilized to create the best possible therapeutic results, and for your convenience, to minimize waiting time and to facilitate the incorporation of these appointments into your daily routine. This multiple scheduling method is especially important due to the necessity of the regular scheduled treatments to improve or alleviate your health problems.

Regardless of how many visits are scheduled for you each week, please note that it is the frequency of the visits that counts towards achieving optimal results, and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. In the best interest of your health, it is important for you to make up the missed appointment as soon as possible after the day of the cancellation.

This office reserves the right to charge for missed appointments and those cancelled without a minimum 24 hours notice.

The current charge is the full fee per each missed appointment. We realize that sometimes schedule changes are necessary, therefore this missed appointment fee will be waived if a missed appointment or a "less-than-24-hours-notice" appointment is rescheduled and successfully kept the next day of business of this office. Special consideration will be made in emergency situations and will be handled on a case-by-case basis.

I have read the above Appointment Policy **_____(patient initials)**

C. FINANCIAL POLICY

1. It is our office policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments, regardless of whether or not this office accepts insurance assignment.
2. All payments determined to be owed by you are expected at the time of service unless restricted by this office's contract with your insurance company.
3. Balances over 30 days may be subject to collection fees and interest charges of 1½% per month.
4. **Returned/NSF checks will be automatically subject to an additional fee of $20.00.** Once this office receives a returned check and the patient has been notified, immediate payment in the form of cash or a money order is expected. This payment is to include the original amount of the check, the returned-check fee of $20.00 (per check), and, if applicable, the entire amount of any discount given at the time of service. If your returned or NSF check is not paid within ten (10) days, along with the additional fee of $20.00 and the entire amount of any discount given at the time of service, you agree to pay all attorney's fees; court costs; treble damages; investigation costs; collection costs and the cost of all office employees and Dr. Smith to attend court to collect on the bad check, in addition to any other remedies allowed by Virginia law.
6. As discussed in "Appointment Policy" section above, the charge for each missed appointment and each appointment cancelled **without at least 24 hours notice is the full fee normally charged at the visit.**
7. Payment for services can be in the form of cash, check, Visa, MasterCard, American Express, Discover card payments as well as any credit arrangement with medical credit arranged through this office.
8. If your account is referred to an attorney for collection, as of the day of referral of your account to the attorney, you agree to pay all collection costs and ATTORNEY'S FEES incurred by this office.

I have read the above Financial Policy **_____(patient initials)**

D. FINAL AGREEMENT

I have read and understand the above written office policy and guidelines and I agree with and agree to follow the above office policies and guidelines of Mark S. Smith, DC, PC.

Patient's Signature:_____ Date:_____

All Forms of Electronic Communication Including Email and Texting Consent Form

Richmond Chiropractic Neurology (Mark S. Smith, DC, PC and staff) offers out patients the ability to communicate with us via email. However, you should be aware that electronic forms of communication, such as email, are not always the most secure and confidential way of communicating. That being said, due to HIPAA regulations, we require the consent of our patients before we are able to send or receive any emails, including but not limited to: chart notes, ledgers, appointments, intake and history information, x-ray or imaging information or results, questions, updates, lab results or any communication, etc…

Turn-around time and other pertinent information related to electronic communications:

- These forms of communication are not the primary form of communication and are not monitored 24/7.
- It can take up to 48 to 72 hours, or longer (depending on the Holiday situation) to respond to an email or text over the weekend or during holidays.
- During normal business hours you can expect a reply within 24 hours.
- Therefore, this method of communication should not be used for emergencies or for any request needing immediate attention. If you are in an emergency situation, contact your nearest emergency room or call 911.
- We recommend that you do not communicate with us via text or email if your situation requires a prompt response.
- Issues that are complex or require substantial information transfer are not suitable for email and you should contact the office as soon as possible.
- Issues that are short and can be answered with a brief response are appropriate.
- Cell phones and tablets are considered at high risk for loss, theft, disposal or unauthorized access and it is recommended that you do not store personal health information on them.
- Communications are archived in a password protected and virus protected source.

Please initial BOTH of the following:

_____I understand that all emails are not 100% secure and that Richmond Chiropractic Neurology (Mark S. Smith, DC, PC and staff) will not be held liable in any case that electronic communication confidentiality is breached in any way.

_____I give my consent to communicate by email, text or other electronic means with Richmond Chiropractic Neurology (Mark S. Smith, DC, PC)

Email: _____ Cell # (text msg.) _____
Cell Provider Name _____
Ex.: Verizon, Sprint, etc.

Signature:_____ Date**:**_____

Thank you for your understanding, trust and support.

OTHER SERVICES OFFERED BY RICHMOND CHIROPRACTIC NEUROLOGY

As part of our overall treatment plan, we ***may*** suggest in-house therapies, outpatient lab procedures and/or diagnostic test kits.
Most insurance plans cover services they consider medically necessary and/or reasonable and customary. Many of our services (such as nutritional consultations, low level light therapy, pulsed electromagnetic field therapies, and others) are often not considered by insurance companies to be necessary based upon their own internal criteria.
The patient is further notified that some tests, or all, may not be covered by their insurance company. The patient assumes full responsibility for the costs of non-covered tests and we do not assume responsibility for costs incurred regarding non-covered and/or potentially-covered services, including procedures, laboratory tests (blood, urine, saliva, etc.) and consultation. By signing this form you accept full financial responsibility for all non-covered services; including consultations, blood and other laboratory tests and procedures.
Please be advised that there may be a “Records Review Fee” charged should the doctor review medical records, lab results and/or test results from another practitioner.
It is the responsibility of the patient to follow-up with our office for results of all testing and laboratory procedures. It should not be assumed on the part of the patient that if they are not contacted by us, or if the patient does not schedule or keep a consultation, that test results are normal (or without abnormalities), and may not require further medical treatments or advice. Health/medical recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations.

I have read and understand the above information.

_____ _____

Patient Signature Date

RICHMOND CHIROPRACTIC NEUROLOGY

Office policies related to missed appointments, late arrival, and failing to cancel or re-schedule within 24 hours:

At Richmond Chiropractic Neurology, we strive to provide you with the utmost professionalism and excellent services. Our commitment to your well-being and health is basic to our mission and we take it seriously.

We sincerely care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the recommended care program you need. Your faithfulness to the recommended program is absolutely key to ensuring optimal results. With the exceptions of emergencies, it is vital that you keep your appointments. We have reminder cards, as well as text messaging services and phone calls provided to assist you.

No-show and rescheduling policies:

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our others in need (this could be you one day). You may also reschedule your appointment at that time.

All no-show and same day (less than 24 hours) cancellations/rescheduling are subject to a $35 (or more, depending on the length of time that was scheduled, for example: a 15 minute appointment @ $35, a 30 min. or more appointment at $75.) fee. Please call and **do not email** us if you need to cancel and/or reschedule.

After the first no-show appointment or failure to cancel within 24 hours, you will receive a phone call to remind you of the missed appointment and to reschedule your appointment.

After the second no-show you (not your insurance company) will be charged $35 (or more) for your time slot when you were a no-show or same-day cancellation.

The third no-show and/or same-day cancellation will again be charged $35 (or more) as well as require a discussion with you to ascertain your ability to carry out the recommended treatment program. Perhaps this program is not right for you at this particular time and it would be better for you to re-examine your ability to participate. Perhaps you need more information or something else, however, if you decide to continue with our recommendations and continue to no-show or fail to provide 24 hour notice, you will likely be asked to find another provider.

Exceptions may be made with reasonable consideration of circumstances, including an unforeseen illness or emergency.

Late Arrivals:

When you arrive late for an appointment, if the schedule allows, we will see you. Please realize that you will have limited time and we will only be able to do some basic, but essential, things that visit. There may be a short or a lengthy wait however, as we will see all on time patients first. If there is not any flexibility in that day's schedule, you may be asked to reschedule or to wait if it is for urgent care.

I understand and agree to the above policies:_____

Name:_____ Date:_____

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