Serenity Chiropractic and Rehab

"The Backbone of Health"

Dr. Betty Smith DC
2088 Idlewood Road #6
Tucker, Ga. 30084
Cell (404)551-7516 Office (770)557-0914 Fax 1(800)266-1446

CASE HISTORY/ PATIENT INFORMATION

Patient's Name_____ DOB_____

Address_____City_____

_____ State_____ Zip code_____ Phone #_____

Social Security #_____ Occupation_____ Office #_____

Employer_____ Duties at Work_____

Who may we thank for your referral_____ DOA_____

History or Present Illness:

Chief complaint_____

Have you ever had a similar condition_____

_____car accident _____slip and fall _____back pain _____Headache _____other

Are you pregnant or possible pregnant ___Y ___N
Do you smoke ___Y ___N Do You drink ___Y ___N
Do you have Headaches ___Y ___N
Are you taking any medicine to relieve the pain ___Y ___N

Past Medical History:

__Broken or fractured Bones __Osteoarthritis __Eating Disorder __ulcer __Alcoholism __Drug Addiction
__Circulatory Problems __Epilepsy __Coughing up Blood __High Blood Pressure __Low Blood Pressure
__Rheumatoid Arthritis __Pace Maker __Stroke __HIV Positive __Excessive Bleeding __Seizures __Cancer
__Diabetes __Tuberculosis __Asthma __Mental Illness __Depression __COPD __Kidney Disease
__Liver Disease

Major injuries, illness, fall auto /accident or Surgeries_____

Insurance:

Name of your insurance company_____ Claim #_____
Have you been contacted by an adjuster __Y __N Adjuster name_____
Other's Party Name_____ Other Party Insurance Company_____
Do you have Med Pay __Y __N
Do you have a Attorney_____ Attorney #_____

Patient Signature_____ Date_____

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Accident: Which of the following apply to you __ Driver __ Passenger __ Pedestrian __ Was in the car with you
Was someone in the car with you __Y __N
Did you require Post- Accident Hospitalization __Y __N
Were you rendered unconscious due to the accident __Y __N
Were you wearing a seatbelt __Y __N
Were you issued a traffic citation __Y __N
Did your head strike an object __Y __N
Were you braced for the impact __Y __N

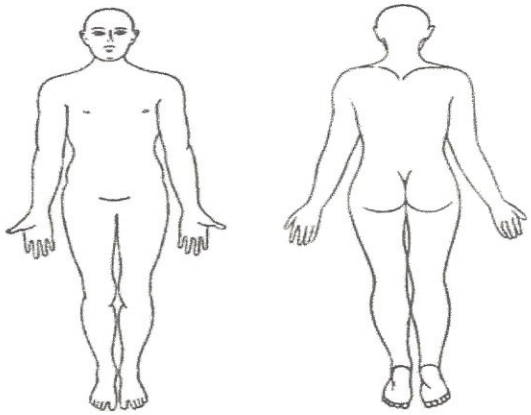
Explain the accident:

_____
_____
_____
_____

Pain Description:

***Please rate your pain on a scale 1-10. 1 indicating the least pain and 10 being more severe. (PLEASE CIRCLE)**

Headaches-	1	2	3	4	5	6	7	8	9	10
Neck Pain -	1	2	3	4	5	6	7	8	9	10
Left Shoulder-	1	2	3	4	5	6	7	8	9	10
Right Shoulder-	1	2	3	4	5	6	7	8	9	10
Left Arm-	1	2	3	4	5	6	7	8	9	10
Right Arm-	1	2	3	4	5	6	7	8	9	10
Upper Back-	1	2	3	4	5	6	7	8	9	10
Mid Back-	1	2	3	4	5	6	7	8	9	10
Low Back-	1	2	3	4	5	6	7	8	9	10
Left Hip Pain-	1	2	3	4	5	6	7	8	9	10
Right Hip Pain-	1	2	3	4	5	6	7	8	9	10
Left Leg Pain-	1	2	3	4	5	6	7	8	9	10
Right Leg Pain-	1	2	3	4	5	6	7	8	9	10
Left Knee Pain-	1	2	3	4	5	6	7	8	9	10
Right Knee Pain-	1	2	3	4	5	6	7	8	9	10
Left Foot Pain-	1	2	3	4	5	6	7	8	9	10
Right Foot Pain-	1	2	3	4	5	6	7	8	9	10



INFORMED CONSENT TO MEDICAL AND CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic and medical adjustments, including various modes and physical therapy and if necessary X-rays authorized by the doctor listed below. I have the opportunity to discuss with the doctor listed below and or other office or clinic personnel, the nature and purpose of the chiropractic adjustments and other procedures. I understand that results are not guaranteed. I further understand/informed that as in all health care practice (chiropractic), there are some very slight risk of treatment including but not limited to muscle strain, sprain, disc injuries and strokes. I do not expect the doctor to able to anticipate and explain all risk and complication and I wish to rely on the doctor to exercise judgment during the course of the procedures, at which the doctor considers at the time based upon the facts then known in my best interest.

I have been informed that it is not uncommon for the patient to have some increased discomfort after an adjustment. If that happens, I will apply ice or heat to the area and rest it. If I am concerned about the discomfort of develop any new symptoms, I can call the clinic where I am being seen during office hours. If I am out of town or unable to contact the doctor, I can present myself to the emergency-room. If any test were performed outside (laboratorey, MRI or other diagnostic procedures). I understand the doctor will notify me of the results at my next scheduled appointment

Open room authorization: I give Serenity Chiropractic and Rehab permission to perform my therapies in an open room , where other patients are also being treated. The doctors and staff at Serenity Chiropractic and Rehab will do all that is in their power to protect my personal health information but due to the physical conditions, I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private the doctor will provide a room for these conversations.

I understand that part of a promotional campaign, I am receiving a free consultation. All other treatment including but not limited to an examination, X-Ray, adjustments and all other therapies and other investigation into my health conditions, will be charged according to the standard fee schedule used by Serenity Chiropractic and Rehab. By signing, I understand the promotion and choose to continue treatment with Serenity Chiropractic and Rehab.

I have read the above consent, with the doctor as indicated by our initials. I have also had an opportunity to ask questions about its content and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment.

Patient's Name:_____ Date:_____

Patient's Signature_____

Doctor's Signature:_____ Date_____

Serenity Chiropractic and Rehab

Notice of Doctor's Lien/ Assignment of Benefits

Date:_____ Date of accident:_____

Patient's Name:_____ Medical payment Insurance: Yes___ No_____

Patient's Address:_____ _____ County:_____

Patient's City, State & zipcode:_____

At fault Insurance Company and claim #:_____

Medical Pay insurance Company and Claim #:_____

Serenity Chiropractic and Rehab INVOICE Amount: $_____

I do hereby authorize Serenity Chiropractic and Rehab to furnish you, _____(insurance company) a full report of my examination, diagnosis, treatment, prognosis etc. of myself in regards to the accident in which I was recently involved. I also acknowledge that such doctor of her representative(s) may provide further consideration in exchange for this Lien/ Assignment; including deposition of testimony and request of report(s).

I hereby authorize and direct you, my current and any successor attorney(s); together with any responsible insurance company, to pay directly to Serenity Chiropractic and Rehab such total sums as are currently due and may become due and owing her in the future for all chiropractic and related services rendered me bother by reason of this accident (and by reason of any other bills) that are due at this office and to further withhold such total sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said doctor (Dr. Betty Smith- Weldon/Serenity Chiropractic and Rehab) and such total sums. I hereby further give a lien or assignment of my potential benefits on my pending/prospective case to said doctor against any and all insurance benefits referenced below and proceeds of my settlement, judgment, court order or verdict which may be paid to you, my attorney or myself as a result of the injuries or illness for which I have been or will be treated from a chiropractic scope of care perspective in connection with such accident, including any unpaid to you attorney or myself as a result of the injuries or illness for which I have been or will be treated from a chiropractic scope of care perspective in connection with such accident; including any unpaid services for chiropractic care provide prior to such accident.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by her for services rendered me and that this agreement is made for Serenity Chiropractic and Rehab/Dr. Betty Smith- Weldon additional protection and in consideration of her awaiting payment and other services provided by her, as referenced above. I further understand that such payment is not contingent on any settlement, judgment, court order or verdict by which I may eventually recover said fee ant that my chiropractor/doctor may take appropriate and timely action to enforce payment against me for all such outstanding chiropractic bills.

I agree to promptly notify said doctor (Dr. Betty Smith-Weldon/Serenity Chiropractic and Rehab) prior to any change of additional of attorney(s) used by me in connection with this accident and I instruct my present attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s). I further acknowledge and agree that this executed lien/Assignment shall be binding upon any subsequent or additional attorney(s) regardless of whether this written document is expressly acknowledged by such attorney.

I request that my attorney(s) and any applicable insurance company acknowledge this lien/Assignment by signing below and returning to the doctor's office. The undersigned agrees that a copy of this lien may forwarded to third parties responsible for payment to the patient and that such third parties can act directly in protecting such lien/Assignment. Such insurance benefits shall include any coverage provided to the patient(s) for liability, disability, medical payments coverage, no fault, health accidents, workers compensation and any other applicable benefits. Such insures are directed and authorized to withhold and reimburse to Dr. Betty Smith-Weldon/Serenity Chiropractic and Rehab such amount as necessary to satisfy the total sum owed by me for chiropractic services

This agreement shall be binding upon the patient heirs, successors, personal representatives or assigns

Date:_____ ***Patient signature(or Guardian)***_____

The undersigned for the above patient (and or insurance company's representative), does herby acknowledge receipt of this notice and herby to honor and comply with all the terms of the above agreement and agrees to protect adequately or otherwise withhold such sums from any settlement, judgment, court order or verdicts may be necessary to adequately protect and fully compensated said doc above named. Attorney and/or insurer further acknowledge that in the event the enforceability and/or appropriate amount subject to this lien/assignment is litigated, the prevailing party will be awarded attorney's fees and cost. This agreement shall be binding upon and successor, agent, representative, employee or substituted and/or added attorney(s) of the patient with the same force and effect

Date:_____ ***Attorney/Insurance Representative signature***:_____

Date:_____ ***Serenity employee signature***_____

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Authorization for release/disclosure of protected medical records

Patient Name _____ Date of Birth _____

Receiving Party: _____

Phone Number: _____ Fax Number: _____

Address: _____

Phone number- (404) 551- 7516 Fax Number- 1 (800) 266-1446

At the request of the undersigned, you are hereby authorized, requested and directed to disclose protected health information about me as described below for the purpose of evaluation and/or treatment with a Doctor at Serenity Chiropractic and Rehab.
the following specific person or class of persons or facility is authorized to make the requested disclosure: any and all medical doctors, hospitals, emergency treatment center, private health care facilities, Chiropractors, Physical therapists or any other persons of facilities who have provided any health-related treatment diagnosing testing or test analysis on behalf of the undersigned or who maintain any documentation pertaining to the physical and or mental condition of the undersigned.

1. Serenity Chiropractic and Rehab may receive disclosure of protected health information about me.
2. The specific information that should be disclosed Is: documentation pertaining to the physical and mental condition of the undersigned, including patient history, examination, diagnosis, treatment, prognosis, opinion, X-ray, and complete treatment file. I understand that this disclosure may include psychiatric, drug/alcohol and HIV testing results and or AIDS related information. You are further authorized, requested and directed to discuss any relevant knowledge you may have related to any of the above referenced information with the Doctor of Serenity Chiropractic and Rehab.
3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulation.
4. I may revoke this authorization by notifying Serenity Chiropractic and Rehab in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed and my revocation will not affect those actions. I understand that any medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization. This authorization shall remain in effect regardless of the lapse of time unless revocation is submitter to Serenity Chiropractic and Rehab in writing as stated above
5. This authorization and /or request to release information from my protected health information (PHI) is fully understood and is made voluntarily on my part and includes faxing of my PHI to/from Serenity Chiropractic and Rehab.

Parent/Guardian Signature _____ Date _____

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Serenity Chiropractic and Rehab Media Release Form

Representatives from **Serenity Chiropractic and Rehab** will Photograph, Videotape, and or interview patients in connection with **Serenity Chiropractic and Rehab** treatment, and or events for printed/ online publications, newsletters, news releases, websites stories, videos, social media, and other publication with **Serenity Chiropractic and Rehab.** Photos/ videos/interviews taken by media personnel are the organizations' property and may be posted publicly.

This form allows patients the option to allow or not allow **Serenity Chiropractic and Rehab** to take photos /videos of themselves. To exercise this option, check the box above and provide the information requested as soon as possible.

NOTE: If opted in or out, a patient remains active throughout his/her course at **Serenity Chiropractic and Rehab.** To change this status, patient must notify the front office with a new agreement form.

Check only DO or Do NOT:

_____ **DO** photograph, videotape, and/or interview patient for publication in public or **Serenity Chiropractic and Rehab** Media.

_____ **DO NOT** photograph, videotape, and/or interview patient for publication in public or **Serenity Chiropractic and Rehab** Media.

Patient Signature_____ Date_____

Patient (Printed Name)_____

Serenity employee signature_____