Thank you for your interest in our practice!

New patients will need to make an appointment for their first visit. First visits often take longer as we will take xrays, get your medical history and take the time to get to know you. A small part of the paperwork can be printed out by you and brought into the office to save some time at your first visit. Please read the Notice of Privacy Practices, and then print out and fill out the following forms before your first visit. You will only need to print out and complete the Consent to Treat Minor form if the patient is a minor You may make an appointment by contacting the office by phone or submitting a request through the website.

Thank you and we look forward to meeting you!

Dr. Smith and Staff

Notice of Privacy Practices

Norman R. Smith, DC, LLC
615 E. Columbia Ave
Leesville, S.C. 29070

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON JANUARY 1, 2004

This Notice of Privacy Practices describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, or require additional information. Please contact our privacy contact Dr. Norman Smith at 803-532-1102.

This notice describes our practices and those of any health care professional allowed to enter information into your chart, any member of our volunteer staff that we allow to help you while you are here, and all employees of, Norman R. Smith, D.C., LLC.

All of these people follow the terms of this notice. They may also share protected health information (PHI) with each other for treatment, payment or health care operations as described in this notice.

Our Pledge Regarding Information:

We are committed to protecting information about you and your health. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of our records.

We are required by law to:

- maintain the privacy of your information
- give you notice of our legal duties and privacy practices related to your information, and
- follow the terms of the notice that is currently in effect.

How We May Use and Disclose Information About You:

- **Treatment:** We may use and disclose PHI to treat or provide services to you. For example, a chiropractor treating you for a sore neck would need to know if you have a history of neck surgery.

- **Payment**: We may use and disclose PHI so that we can bill and be paid for the treatment and services you receive from us. For example, we may need to give information about your spinal care to your insurance company so that they will pay for services.

- **Health Care Operations**: We may use and disclose PHI as needed to carry out our organizational needs. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice.

- **Organized Health Care Arrangement (OHCA):** For certain activities, we may disclose information about you to other health care providers participating in an organized health care arrangement. For example, we may share information with other health care providers in order to improve quality of care.

- **Those Involved in Your Care:** We may release relevant PHI to a friend, family member, or anyone else you designate who is involved in your care or payment related to your care. We may also disclose PHI to those assisting in disaster relief efforts so that your family can be notified about your condition, status, or location.

- **Other**: We may use or disclose PHI for the following purposes:
  Appointment reminders
  Health related products and services
  As required by law
  To avert a threat to health or safety
  Workers' Compensation
  Public health activities
  Health oversight activities
  Lawsuits and disputes
  Government functions
  Custodial law enforcement
  To other health care providers to facilitate referrals for tests and/or treatment.

Your Rights Regarding Your Information

You have the following rights regarding information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and obtain a copy of the PHI contained in your medical record. You must submit your request in writing to the office staff. In some cases, we may deny your request. There may be a fee for the costs of copying, mailing, or supplies associated with your request.

Right to Amend: You have a right to request an amendment of your PHI. You must submit your request along with the reason for the amendment in writing to the medical records department.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of our disclosures of your PHI except any made (l) to you, (2) prior to April 14, 2003, (3) as a result of your specific written permission, or (4) for Treatment, Payment, Health Care Operations, OHCA, Those involved in your care, Directory, for national security, intelligence purposes, or to correctional institutions or law enforcement officials. You may submit your request in writing to our Privacy Officer. The request must include the time period (not longer than six years) for the disclosures you wish to be listed. The first list you request will be free. We may charge you for the costs of providing other lists within a 12-month period.

Right to Request Restrictions: You have the right to request restrictions on the PHI we use or disclose about you as described in the sections for Treatment, Payment, Health Care Operation, OHCA, Those Involved in Your Care and Directory. In some cases, we may not agree to your request. You must submit your request for restrictions in writing.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain way or at certain location. You must submit your request for confidential communications in writing. We will honor reasonable requests.

Right to Paper Copy of This Notice: You have the right to a paper copy of this notice at any time. To obtain a paper copy of this notice, contact our Privacy Officer.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact us at 803-532-1102. You will not be penalized for filing a complaint.

Other Uses and Disclosures of Information

Other uses and disclosures of PHI not covered by this notice will be made only with your written authorization. You may also revoke the authorization at any time by sending a written notice to the medical records department.

We reserve the right to change the terms of this notice, and apply any changes to all PHI that we maintain. If the terms do change, you may receive a revised Notice by contacting our Privacy Contact.

We will post a current copy of this notice in our office.

CONFIDENTIAL PATIENT INFORMATION

DATE ___/___/____

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME_____ DATE OF BIRTH ___/___/____ AGE ___ Male☐ Female☐

ADDRESS_____ APT#_____ SSN _____-____-_____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (_____)_____

ALTERNATE PHONE (CELL): (_____)_____ EMAIL ADDRESS: _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE ____ ZIP _____

WORK PH. # (_____)_____ EXT._____ DATE SYMPTOMS BEGAN: ____/____/____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT _____PHONE_____

Dr. Norman R. Smith
615 East Columbia Avenue
Leesville, SC 29070
803-532-1102

Acknowledgement of Receipt of Notice of Privacy Practices

Name: _____

Address: _____

Telephone: _____ Chart Number: _____

I have received a copy of the Notice of Privacy Practices.

_____

Signature of Patient/Authorized Person Date

If there is any person we may speak with regarding medical records and/or any information regarding this patient, please indicate below:

_____ _____ _____

Others with which information may be discussed Relationship to individual

NORMAN R. SMITH D.C., LLC

DATE_____
NAME_____ DATE OF BIRTH_____

CURRENT SYMPTOMS

REASON FOR CONSULTING THIS OFFICE

_____
_____
_____
_____
_____

HOW DID YOUR CONCERN BEGIN? ___Unknown ___Suddenly ____Gradually

WHAT HAPPENED TO CAUSE OR RE-AGGRAVATE THE CONDITION?

____Cause not known ____Work Accident/Injury ____Personal Injury

____Auto Accident ____Home Accident ____Sports Injury

____Other – Describe _____

HOW WOULD YOU RATE YOUR OVERALL PAIN TODAY? (Please Circle)

No pain 1 2 3 4 5 6 7 8 9 10

WHEN ARE YOUR SYMPTOMS WORSE?

Morning____ Afternoon____ Evening____ Night____ Always the Same____

WHAT MAKES YOUR CONDITION BETTER?

Nothing____ Stretching____ Heat____ Rest____ Exercise____ Ice____
Sitting____ Standing____ Medications____ Other_____

HAVE YOU HAD ANY RECENT TREATMENT FOR YOUR CONDITIONS OUTSIDE OF THIS OFFICE?

Yes____ No____ If yes, list dates, treatments and Doctors

_____
_____

MEDICAL HISTORY

HAVE YOU EVER BEEN TO A CHIROPRACTOR? ___Yes ____No

DO YOU HAVE A FAMILY PHYSICIAN? ____Yes ____No

Date of Last Physical Exam:_____
Physician's Name: _____
Address: _____

HAVE YOU EVER HAD SURGERY? ___Yes ___No

Date, Reason, Results of Surgery:_____
_____
_____

HAVE YOU EVER HAD A SERIOUS ACCIDENT/INJURY ____Yes ____No

List Date & Describe Injury:
Auto:_____
Work Related: _____
Personal: _____
Sports Injury:_____
Other: _____

TO YOUR KNOWLEDGE, ARE YOU PREGNANT? ____Yes ____No

PLEASE INDICATE IF YOU NOW HAVE OR HAD IN THE PAST ANY OF THE FOLLOWING ILLNESSES

ILLNESS OR CONDITION	CURRENTLY HAVE	HAD IN PAST	ADDITIONAL INFORMATION
Cancer/Tumor			
Diabetes			
Heat Trouble			
Stroke (please list date)			
Osteoporosis			
Spinal Disc Disease			
Bone Fracture (please list bone & date)			
Abnormal Weight Loss			

OCCUPATIONAL INFORMATION

HOW DO YOU RATE YOUR PHYSICAL ACTIVITY AT WORK?

___Seated more than 50% of workday
___Manual Labor: ___Light __Light to Moderate ___Moderate ___Moderate to Heavy ___Heavy

DO WORK ACTIVITIES AGGRAVATE YOUR PRESENT COMPLAINTS?

___Yes ___No
If Yes, Explain: _____
_____
_____

____ I HAVE NO PRESENT SYMPTOMS AND AM REQUESTING WELLNESS BASED CHIROPRACTIC CARE

IS THERE SOMEONE WE CAN THANK FOR REFERRING YOU TO OUR OFFICE FOR CARE?
_____

_____ _____
PATIENT'S SIGNATURE DATE

Consent to Treatment of Minor Child

Dr. Norman R. Smith

615 East Columbia Avenue

Leesville, SC 29070

I hereby authorize Dr. Norman R. Smith to administer treatment as he deems necessary to my son/daughter:

_____

(Child's Name)

Date:_____

Parent's Signature:_____

Witness:_____