John Smith, DC, CCSP, PA
Sean Smith, DC
2926 Capital Blvd, Raleigh NC, 27604
919-878-8848

Advanced, effective solutions

- Auto, work, sports & personal injuries
- Whiplash
- Chronic headaches, neck, shoulder, arm, wrist and hand pain.
- Low back, sciatic, disc, leg, knee and ankle pain
- Pain relief for tough cases, even when other methods have failed
- Advanced treatments to improve your energy, your immune system and your overall health

A patient-centered approach

- Most insurance accepted
- Emergencies seen promptly
- Appointments that fit your busy schedule
- Major credit cards honored
- Flexible payment plans

12 convenient locations:

CARY:
1125 Kildaire Farm Rd, Ste 101 Cary, NC 27511
919-467-7797

CLAYTON:
501 Gateway Dr., Suite 103, Clayton, NC 27520
919-550-9355

DURHAM:
5007 Southpark Dr., Ste 130, Durham, NC 27713
919-572-2312
3319 Durham-Chapel Hill Blvd., Durham, NC 27707
919-383-9890

FUQUAY VARINA:
7636 Purfoy Rd., Suite 121, Fuquay Varina, NC 27526
919-577-0660

GARNER:
240 New Fidelity Ct., Garner, NC 27529
919-772-1113

RALEIGH:
2926 Capital Blvd., Raleigh, NC 27604
919-878-8848
7209 Creedmoor Rd., Ste 107, Raleigh, NC 27613
919-390-2444
7116 Six Forks Rd., Raleigh, NC 27615
919-847-3122
7116-A Six Forks Rd., Raleigh, NC 27615
919-847-3124
3700 Six Forks Rd., Raleigh, NC 27609
919-787-8883

WAKE FOREST:
1269 S. Main St, Wake Forest, NC 27587
919-556-2014

AUTO ACCIDENT INFORMATION CHECKLIST

As a courtesy, we accept Medpay and liability insurance on assignment and liens for personal injury cases. In order for us to properly file your claims for service, it is your responsibility to provide us the following information. If requested information is not provided by your third visit, payment becomes due at the time services are rendered (until information is provided).

- Copy of Police report and insurance exchange information sheet
- Your auto insurance card or policy (Medpay). You need to call your agent and report the accident.
- Liability insurance information: Company name, adjuster's name, claim number, phone number, and address in which to mail claims.

AUTO ACCIDENT INTAKE FORM

Todays's Date____________________ **(Please answer all questions thoroughly. Thank you for your cooperation.)**

Legal First Name____________________Middle Initial__________Last Name___________________________________

Address____

City____State________________________Zip Code________________

Home Phone (______)____________________________ Work Phone (______)_________________________________

Cell Phone (______)______________________________ Email ____

Date of Birth ________________Age:______ Sex: ☐ Male ☐ Female Social Sec. Number____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other Name of Spouse_____________________________

Who should we contact in case of emergency?____

Date of Accident:_________________________ Please describe how the accident happened:______________________

____

____

You were struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right side

List your painful areas in order of severity:

1. ____
2. ____
3. ____

Name and phone number of your personal auto insurance company (Medpay) __________________________________

____

Medpay adjuster's name & claim #____

Have you reported the accident to the liability and Medpay companies: ☐ Yes ☐ No

Name and phone # of responsible party's insurance (Liability)____

____

Claim #____________________________ Adjuster's name:____

Attorney's name and phone #:____

I authorize John A. Smith, D.C. to release any and all records to my insurance company, attorney, etc. I realize that I am responsible for all charges incurred in the event that my insurance company does not pay, or pays less than the total due. I authorize medical payments directly to John A. Smith, D.C. for any services or supplies.

Patient Signature:____

Or Legal Guardian if a minor:____

Please give the receptionist your driver's license, police report and insurance information to copy for your file.

Patient Name____ Date______________

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other______________________			

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular Procedure	☐ Cervical Spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar Spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic Spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Other______________________			

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other______________________

Social History: (Check all that apply to you)

Caffeine Use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐ <1 pack/day	☐ often	☐ never
Wear Seat Belt:	☐ occasional	☐ always	☐ never

Other_________________________________

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetis:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling

Other_________________________________

Occupational Activities: (Check one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment Operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive Legal	☐ Housekeeper
☐ Other__________________			

Patient Name____ **Date**______________________________

Review of Systems – (Check box if you have had trouble with any of the following. Circle NO if none.)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of Legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowell Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
Weight Loss/Gain				Sweating				Broken Bones			
Low Energy Level								Joints Replaced			
Difficulty Sleeping											

Please list all current medications being taken____

____

____

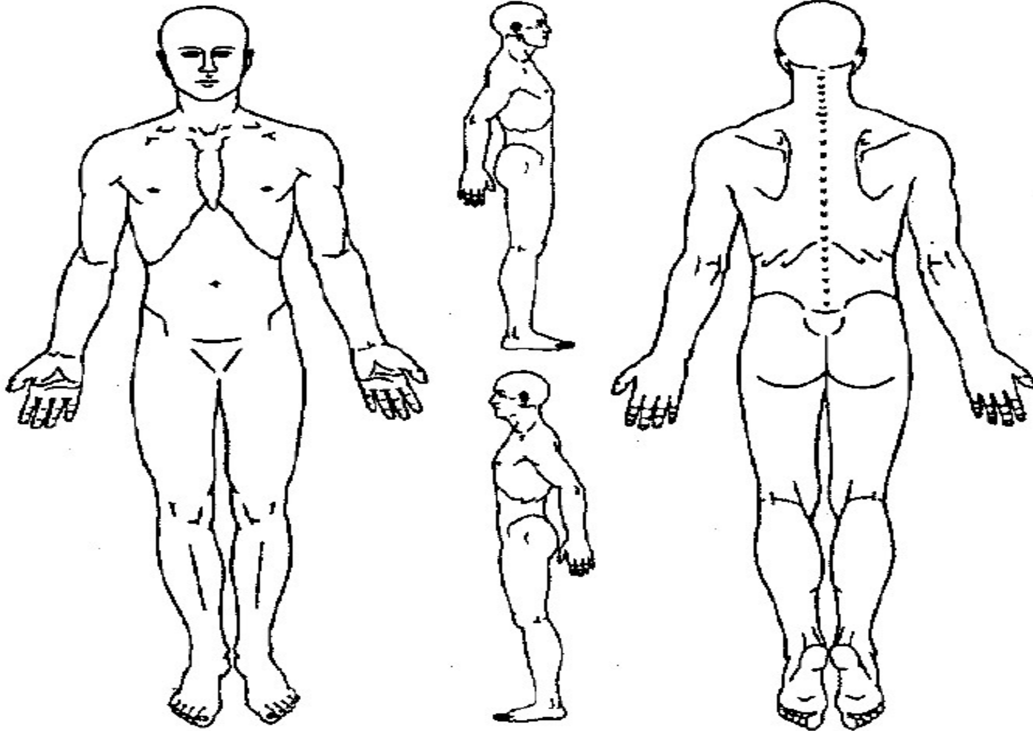
____

Are you pregnant? ☐ **Yes** ☐ **No** ☐ **N/A**

Patient Name____ **Date**__________________________

By using the key below, indicate on the diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Stabbing** **T=Tingling** **A=Dull Ache**



Describe your symptoms in order of severity, with worse symptom being #1:___________________________
____
____
____

When did your symptoms begin? **Month**_________________ **Day**__________________ **Year**_________________

Are your symptoms a result of? ☐ **Motor Vehicle Accident** ☐ **Work Related Accident** ☐ **Other**__________

How did your symptoms begin?
____
____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting
☐ Burning ☐ Tingling ☐ Stabbing ☐ Other____________

How are your symptoms changing?

☐ Getting better ☐ Getting worse ☐ Not changing

Patient Name ____ **Date** ____________________________

Payment/Insurance Information:

Who is responsible for your bill? mark appropriate box(es)

☐ Self ☐ Health Insurance ☐ Spouse ☐ Worker's Comp
☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other___________________________

Personal Health Insurance Carrier_____________________________ Insurance Card ID #__________________________

Policy Holder's Name____Group #____________________________________

Policy Holder's Date of Birth______/______/_______ Primary Care Physician_________________________________

Policy Holder's Employer____

Please give your license and insurance card to the receptionist for copy and verification. Thank you.

NOTICE:

How will you be paying for today's charges? ☐ Visa ☐ Mastercard ☐ Debit ☐ Check ☐ Cash

I authorize Chiropractic Partners to release any and all information to my insurance company, my attorney, or my insurance adjuster. I realize that I am ultimately responsible for all charges incurred in the event that my insurance does not pay. I authorize medical payments directly to Chiropractic Partners for any services or supplies.

Patient Signature:____Date:___________________

Legal Guardian's Signature:____Date:___________________

Attending Doctor's Signature:____Date:___________________

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. This includes various modes of physical therapy and diagnostic radiographs, on me or on the patient named below, for whom I am legally responsible. I further understand that this may be performed by Dr. John A. Smith and/or other licensed Doctors of Chiropractic who now or in the future treat me. This will include those employed by, working for, or associated with other Chiropractic Partners offices.

I have had an opportunity to discuss with Dr. John A. Smith and/or with other offices or office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some inherent risks to treatment, including, but not limited to, fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and complications. Further, I wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based upon the facts then known, are in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the above-named procedures. I intent this consent to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment.

To be completed by the patient:

____
Print Patient's name

____
Signature of Patient

____
Date

To be completed by the patient's representative, if necessary, e.g. If the patient is a minor or is physically or mentally incapacitated

____
Print Name of Patient

____
Print Name of Representative

____
Signature of Representative

____
Date

John A. Smith, DC, CCSP, PA | Sean W. Smith, DC
2926 Capital Blvd., Raleigh NC 27604
P: 919-878-8848 | F: 919-878-8863
W: www.chiropartners.com

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

Disclosures of Protected Health Information

There are several reasons for which we may have to use or disclose your PHI (Protected Health Information):

- We may have to disclose your PHI to another healthcare provider or hospital should we refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your PHI and/or billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our practice for quality control or other operational purposes.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI, we respectfully request that you submit these restrictions in writing. With your right to restriction, you also have the right to revoke your authorization or consent to us at any time. Again, this change of authorization must be requested in writing before your file status will be changed.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communications, such as reminders of appointment times, follow-up of health care, insurance coverage/benefits issues, or any other information that only the patient will personally be able to answer.

________________________________ Printed Name	___________________________________ Authorized Representative
________________________________ Signature	___________________________________ Date
________________________________ Date	

JOHN A. SMITH, D.C. , CCSP, PA
2926 Capital Blvd., Raleigh, NC 27604
(919) 878-8848

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Chiropractic Partners to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to *Chiropractic Partners* any proceeds or compensation that I am or may be entitled to receive as a result of injuries that occurred on ____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to *Chiropractic Partners*, from any disability benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums are due or may become due to *Chiropractic Partners* for its services rendered.

I appoint Chiropractic Partners as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named a payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with *Chiropractic Partners*.

I authorize Chiropractic Partners to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to *Chiropractic Partners* for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If *Chiropractic Partner*s is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse *Chiropractic Partners* for its costs of recovery, including reasonable attorney's fees.

____	__________________	________________________________
Patient	Date	Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Chiropractic Partners hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Chiropractic partners hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Chiropractic Partners agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

CHIROPRACTIC PARTNERS

By: ____
John A. Smith, D.C., CCSP, PA

MOTOR VEHICLE ACCIDENT

You may choose one of the following options to handle your auto accident case:

A) Liability Insurance and MedPay combination – Upon verification of benefits from both sources, we will file all insurance claims to the MedPay portion of your auto insurance policy which will be filed weekly throughout care, and to the liability insurance company of the person responsible for the accident which will be filed upon your dismissal from care. Filing claims to both sources assures coverage of your services, and any/all overpayments will be refunded to you after all insurance processing has been completed. It is your responsibility to provide us with any/all MedPay and third party payor (Liability) information by your third visit. In order for us to file on your behalf, a signed lien and assignment of benefits will be remitted to both companies to assure that payment will be made in full, directly to our office. If any payments are mailed directly to the patient they are to be forwarded to our office upon receipt. (Please initial)___________________

B) Personal Health Insurance – If option A is not possible, we will file to your insurance company if they do not have the right of subrogation (the right to request a refund of any monies paid if Liability/MedPay has paid), and benefits have been verified. You will be responsible for any/all portions not covered by your insurance company up to our full fees (any contract or agreement between us, the provider, and your insurance company to reduce fees will be waived, as this is a third party liability case). (Please initial)_______________

C) Patient Pays For Care – If options A or B are not possible, you will be responsible to pay for services as rendered or to make payment arrangements based on our payment plan options. (Please initial)_______________

D) Attorney Representation – If represented by an attorney, we will file to your MedPay carrier if available, and hold a signed lien on any remaining balance (up to our full fees). If a settlement has not been made within 9 months after your dismissal from care, or if our fees for service are reduced in the settlement, the remaining balance (up to our full fees) becomes your responsibility, and we will discuss payment options available ast said time. (Please initial) _________________

Please Note:

Receipts for services or account statements will only be provided to a patient upon payment of all services either by the insurance company or patient.

I have chosen the above-circled/initialed option, and I understand and fully agree to the terms and conditions as stated above. I have signed the required Assignment of Benefits and/or lien (if applicable).

____   ________________________________

Patient Signature   Witness

Chiropractic Partners
RESTORING HEALTH AND WELLNESS

Election Not to File Health Insurance Claims
(Personal Injury/Accident)

The chiropractor(s) at this clinic are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

IF you elect NOT to file claims on your health insurance:

1. The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. You will be required that your bill will be paid by sources other than your health insurance. You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payors to the extent necessary to satisfy your bill.
2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.
3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.
4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.
5. None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.
2. You will be responsible for paying to the clinic the cost of any non-covered services you elect to receive, and your payment will be due at the time services are rendered.
3. If you health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.

4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.

2. I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third – party payors who are potential sources of payment.

3. I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.

4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payors; subject only to any contractual obligation the clinic may have to my health benefit plan.

___________________________________ Printed Name of Patient	___________________________________ Printed Clinic Representative
___________________________________ Signature of Patient (or parent/legal guardian, as applicable)	___________________________________ Signature of Clinic Representative
___________________________________ Date:	___________________________________ Date:

A complete copy of this executed agreement must be maintained in the patient's health care record, and a copy must be provided to the patient.