Patient Intake Form

SMITH CHIROPRACTIC

Patient Name : _____Date :_____

Street : _____City : _____ State :_____Zip :_____

Cell Phone : _____Email :_____

Age : _____ Date of Birth: :_____

Occupation_____

Marital Status: Single Married Divorced Widowed

Spouse Name:_____

Children with ages :_____

Referred by :_____

Family Physician :_____

Height : _____Weight :_____Ideal Weight: _____

Previous Weight Programs:_____

Results:_____

_____

Do you consider your health an investment or an expense?

_____

Most recent car accident?_____

HSA(Health Savings) and FSA(Flex Spending) cover our services, do you have one? Yes No

Pain Indicators

☐Headaches	☐Shoulder pain	☐Upper back pain	☐Wrist pain
☐Mid back pain	☐Knee pain	☐Low back pain	☐Ankle pain
☐Neck pain	☐Hip pain	☐Radiating leg pain	☐Radiating arm pain

Body Composition

Problem areas you would like addressed:

☐ Love Handles	☐ Wrinkles/ Age Spots	☐ Flabby arms
☐ Turkey Neck	☐ Thighs	☐Back fat
☐ Cellulite	☐ Stretch Marks	☐ Mommy Tummy

Other:_____

Medical History (circle all that apply)

High cholesterol Allergies Sinuses Surgeries Cancer Significant Trauma

High Blood Pressure TMJ Heart Disease Asthma Vertigo Liver Disease Diabetes Epilepsy Anxiety Ulcers Arthritis Sleep Problems

Thyroid Disease Hepatitis Kidney Disease Fatigue ADD Weight Problems Joint Pain Liver Disease Sleep Apnea Seizures Acid Reflux Infertility

List medications/prescriptions:_____

_____

Lifestyle

- ☐ Stress
- ☐ Pain
- ☐ No exercise
- ☐ Alcohol
- ☐ Poor Snacks
- ☐ Caffeine
- ☐ Skipping meals
- ☐ Poor Sleep
- ☐ Poor liver
- ☐ Under / Over Eat
- ☐ Sugar / Bad Carbs
- ☐ Nerves
- ☐ Stress Eating

Weight Loss

How much weight have you decided to lose? _____

What methods failed to help you lose weight? _____

How many times a year do you diet? _____

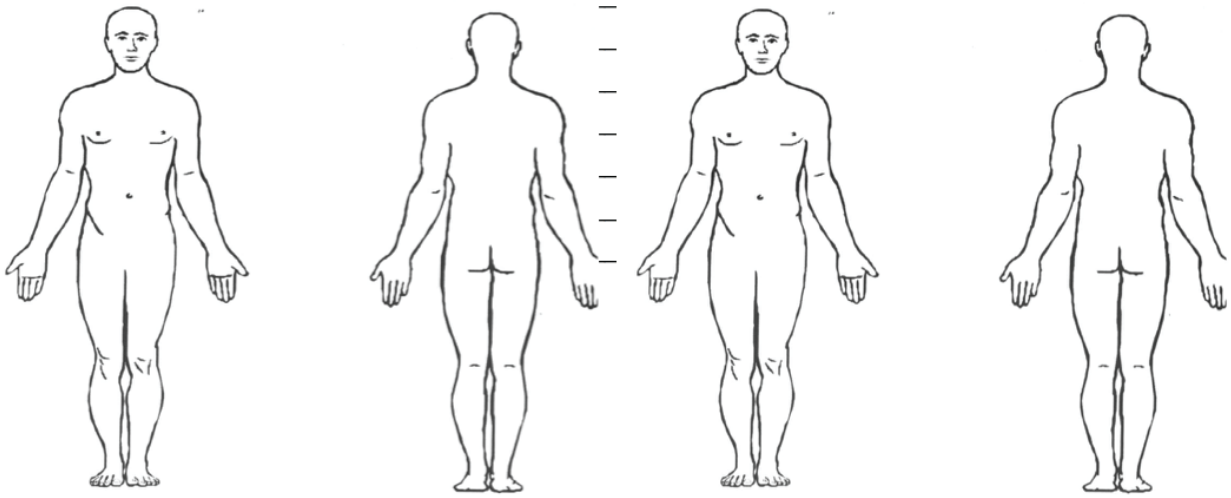
Is successful weight loss a top priority? (explain) _____

What new activities will you become involved in after losing weight? _____

How fast do you want to be thin, trim, and fit? _____

Do you feel tired, run down, and out of energy? _____

Areas Of Your Body That You Want To Change



CONTOUR LIGHT

Treatment Consent Form

Patient	Provider

This consent to treatment form explains the risks and benefits of the Contour Light treatments. Patient understands the following:

1. Results vary greatly from person to person. No result is guaranteed.
2. Contour Light is a treatment intended to be implemented in conjunction with a modification in diet and lifestyle as part of a complete protocol. The recommended diet and lifestyle is a critical part of the program and are essential in achieving the maximum results.
3. Temporary hyper pigmentation/hypo pigmentation (changes in skin color) on rare occasion may occur as a result of treatment.
4. Contour Light should not be used by patients with any of the conditions listed below.

Conditions that Prevent Treatment

Patient agrees (by initialing) that all of the following are true:

_____ I am over the age of 18

_____ I do not have and never had any of the following medical conditions:

- Cancer (active or within 1 Year of remission)
- HIV/AIDS
- Hepatitis C or D
- Uncontrolled High Blood Pressure

_____ I am not pregnant or breastfeeding

_____ I do not have a pacemaker

SIGNATURE

By signing below, patient agrees that provider listed above may perform the Contour Light procedure for the purpose of body contouring. Patient understands and accepts the risks listed above and agrees that all information provided on this form is true and correct to the best of patient's knowledge.

Patient Signature _____ Date _____

DISCLOSURE TO THIRD PARTIES (OPTIONAL)

By signing below, patient agrees to permit provider and third parties authorized by provider to use patient's name, photos and/or videos in the marketing of the Contour Light system and procedure. Absent a signature, provider will not disclose patient's identity to any third party except as required by law.

Patient Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

Dale F. Smith, D.C. **Carol A. Wright Smith, D.C.**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. 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, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answer machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open setting with other patients where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used if we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency. In addition we may occasionally video tape our front desk or open adjustment area for training purposes.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have written contract terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not to be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

NOTICE OF PRIVACY PRACTICE

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact:

Dr. Dale Smith & Dr. Carol Wright-Smith
7981 Dexter Road, Suite 101, Cordova, TN 38016
Phone: (901) 794-0876 Facsimile: (901) 794-0854

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Dale F. Smith, D.C. & Carol A.Wright Smith, staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

"You May Refuse To Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14. 2003

Printed Name: _____ Date: _____

Signature: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Revised M.C. version 12-20-04

CONTOUR LIGHT

Pre-Treatment Instructions

CONTOUR LIGHT

Client instructions for best results

1. Eat lightly and drink water

A minimum of 64 ounces of water per day will help flush the fat from your system. Divide your body weight by 2 and this is the number of ounces you should be drinking. Stay hydrated before your treatment and after! The red and infrared light is attracted to well- hydrated cells.

2. Food limitations

Eat only a light meal or nothing 2 hours before or after your scheduled appointment.

3. Wear comfortable clothing.

4. Do cardio following treatment

Burn 350 calories following your treatment. Walking, jogging, stair master, etc. This will burn the fat exactly where you want to! Contour Light is the best personal trainer you'll ever hire! We generally recommend use of a full body vibration plate followed by an energetic cardio workout. The average fat loss is between 40 and 60 Grams which translates into 300 to 500 calories that need to be worked off to maximize your results. The exercise does not have to follow immediately but could be done later the same day

5. Follow a low fat and low carb diet

6. Avoid alcohol

Alcohol turns into fat and will work against this treatment and will lessen your results. For best results refrain from alcohol the day before, as well.

CONTOUR LIGHT

7. Decrease Caffeine

Caffeine will dehydrate you which will decrease your results. Only drink the caffeine you need in the morning to avoid the “caffeine headache”. Completely eliminate caffeine if possible.

8. The small print

Our recommended plan is an initial treatment plan of at least 9-15 visits to get the results as seen in the before and after pictures. If your response to the treatment is favorable, you will have an opportunity to purchase more visits at a discounted rate.

Your first visit will be approximately 30 minutes and will consist of a consultation and an evaluation . We will strive to accommodate your scheduling needs to the best of our ability.

Don’t forget to ask us about our referral program.

CONTOUR LIGHT

Simple Dietary Suggestions

Dietary Suggestions:

Undergoing red light therapy is not a license to increase your food intake. On the contrary, it is recommend that you go on a low-fat diet. This allows your kidneys, liver and lymphatic systems to more effectively purge the excess fat as it is converted to energy.

It is recommended that you utilize a diet consisting of five meals per day totaling 1200 calories and follow these simple guidelines:

1. Avoid all sugars - (sweet tea, sodas, sweets, or any items containing sugar or high fructose corn syrup)
2. Avoid all fats - (including all fried foods), and avoid carbohydrates (pasta, potatoes, dried beans). Steamed rice is okay, without sauce. Salads and green vegetables are great (spritz is okay, but no dressings with fat and calories). Lean meats and fish are fine.

The important take-away is that the goal is to shrink your fat cells. To keep them reduced in size, you need to maintain a good diet and limit each day's caloric intake to balance with the number of calories that you burn each day

CONTOUR LIGHT

Rules To Optimize Treatment Results

1. Keep your regular appointments. Make up your appointment if you miss it. Red light is cumulative and the most significant results appear during the last 25% of treatments.
2. Drink plenty of water. 8-10 glasses a day.
3. Reduce caloric intake by 500 to 800 calories a day.
4. Eat only a light meal or nothing 2 hours before treatment and 2 hours after.
5. Avoid alcohol during the course of your treatment.
6. Do 12 minutes of interval exercise after the Contour Light session.
7. Do 10 minutes on the whole body vibration plate after the Contour Light session.
8. Use a liver detox supplement during the course of your treatments.