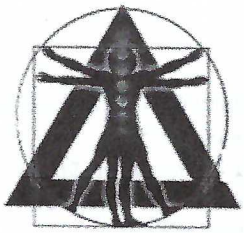

North GA Center for the
Healing Arts
11 Overview Dr Ste 21
Blue Ridge, GA 30513
706-946-5433

New Practice Member Application

Name: _____ Date: _____ Gender: M F

Address: _____ City: _____ State: _____

Phone: Home _____ Cell _____

Email Address: _____

D.O.B: _____ Age: _____ Married Single Divorced (Circle One)

Spouse's Name: _____ Childrens' Names: _____

Occupation: _____

Previous Chiropractic Care: Y N When: _____

What have you heard about chiropractic care? _____

_____

Who may we thank for referring you? _____

Primary reason for your visit today: _____

_____

Anything I should know about your spine or nervous system: _____

_____

Previous trauma, injuries or accidents: _____

_____

Previous surgeries/hospitalization: _____

_____

Any other medical conditions: _____

_____

What do you enjoy doing when you are not working? _____

_____

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Practice Member Agreement

Acknowledgement of Fees:
The practice member acknowledges that these are cash fees and no 3rd party insurance or Medicare will be billed or accepted. We do not bill patient's insurance or Medicare for any procedures performed in this office. This includes manipulation of the spine and its articulations. We charge a fee for the Applied Kinesiology examination and the doctor's time for the proper evaluation. The adjustment itself, if or when it's performed to anyone regardless of benefits, does not carry a fee. Therefore, no reimbursement through Medicare is possible. Medicare does not cover muscle testing as performed through Applied Kinesiology methods. Medicare also does not cover Functional Medicine, Functional Immunology or Nutritional Supplements. As an elective care office, we do not participate in any lawsuit, medical case, opinion or testimony unless required by law to do so. We do not accept any personal injury, slip and fall or workman's compensation cases.

Visits:
All visits are to occur during regular office hours unless a special appointment has been made in advance. Due to the special nature of the practice, it is necessary for Dr. Smith to occasionally take time away from the office for continuing educational events. The office will make a sincere effort to notify all members of any changes to the schedule in advance by phone, text or email with patients who already have a scheduled appointment.

Recommendations:
Members are recommended non-therapeutic monthly check-ups (elective care) regardless of how you may feel. Pain is not necessarily an indicator of when there is vertebral subluxation present and many other health issues that arise in the body do not always carry the symptom of pain.

This Plan is NOT Insurance:
This agreement does not constitute insurance. The care offered in this office is non-incidental, elective care provided in a non-therapeutic mode based on the practice member coming in regularly to be checked and evaluated through Applied Kinesiology muscle testing.

Release of Endorsement:
North Georgia Center for the Healing Arts has consent to send texts and emails regarding appointments, schedule changes and various events.

I have read the agreement and had the opportunity to ask questions and accept the terms:

Full Name:_____ Date Signed: _____

Signature: _____

North Georgia Center
for the Healing Arts
21 High Park Dr. St. 8
Blue Ridge, GA 30513
706-946-5433

CASE HISTORY

Today's Date:			Dr. C.I. Smith D.C., CFMP, PAK
PATIENT INFORMATION			
Patient's last name: First: Middle:	Age:	DOB:	Sex: ☐ Male ☐ Female

Are your present problems due to an injury?	☐ Yes ☐ No	☐ On the Job ☐ Auto Accident ☐ Personal Injury	☐Other:
Has the accident been reported?	☐ Yes ☐ No	☐ To Employer ☐ Auto Carrier	☐Other:
Are you now or have you ever been disabled? (Service Work)	☐ Yes ☐ No	When:	Why:
Have you retained an attorney?	☐ Yes ☐ No	Name:	Address:

List any accidents or falls and dates: ☐ Car: _____ ☐ Recreation: _____

☐ Sports: _____ ☐ School: _____ ☐ Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? ☐ Yes ☐ No, Why? _____

Have you ever had a lapse of memory? ☐ Yes ☐ No

Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No When? _____ By Whom? _____

Have you ever had an X-rays made? ☐ Yes ☐ No, When? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication – prescription or over-the-counter? ☐ Yes ☐ No List:

Smoking: ☐ Yes ☐ No If so, how many packs?	☐ None ☐ Light Activity	Mother: ☐Diabetes ☐ Heart ☐ Kidney ☐ Cancer ☐Other: _____ Father: ☐Diabetes ☐ Heart ☐ Kidney ☐ Cancer ☐Other: _____
Drinking: ☐ Yes ☐ No Alcohol:	☐ Moderate Activity ☐ Active	Brother: # of: ☐ Diabetes ☐ Heart ☐ Kidney ☐ Cancer ☐Other: _____
Caffeine: ☐ Yes ☐ No If so, how many cups?	☐ Very Active ☐ Elite Athlete	Sister # of: ☐Diabetes ☐ Heart ☐ Kidney ☐ Cancer ☐Other: _____

OPERATIONS AND PROCEDURES

Date	Procedure	Date	Procedure	Date	Procedure
	Vaccinations		Tubes in Ears		Sinus
	Tonsillectomy		Appendectomy		Hernia
	Gall Bladder		Female Organs		Thyroid
	Back Operation		Rectal Surgery		Stomach
	Other:		Other:		Other:

☐ I have never had any operations/procedures/surgeries.

Pain Symptoms: 1.
(In Order of Severity) 2.
3.

Began-(Mo/YR) Previous Episodes:
Began-(Mo/YR) Previous Episodes:
Began-(Mo/YR) Previous Episodes:

Please mark the intensity of you pain today. 1st Visit
0- No Pain 10- Intense Pain

Example: NECK

1 2 3 (4) 5 6 7 8 9 10
1.

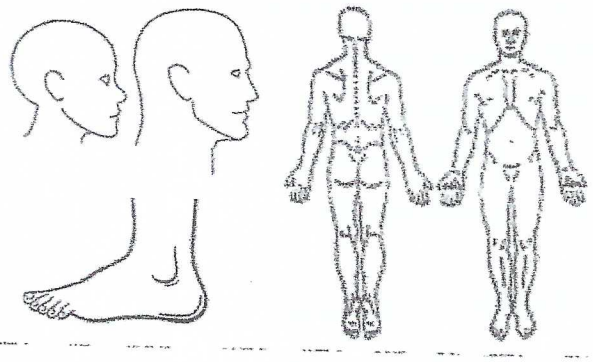
1 2 3 4 5 6 7 8 9 10
2.

1 2 3 4 5 6 7 8 9 10
2

1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawing using the codes listed

N – Numbness P – Pain T – Tingling A – Ache S – Soreness ST - Stiffness



Please mark the intensity of you pain today. 2nd Visit
1- No Pain 10- Intense Pain

Example: NECK

1 2 3 (4) 5 6 7 8 9 10
1.

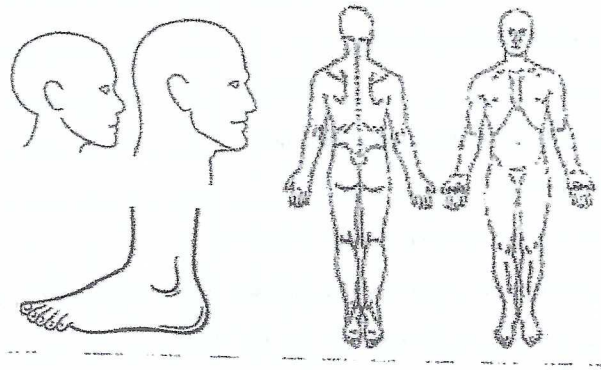
1 2 3 4 5 6 7 8 9 10
2.

1 2 3 4 5 6 7 8 9 10
3.

1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawing using the codes listed

N – Numbness P – Pain T – Tingling A – Ache S – Soreness ST - Stiffness



Doctors Use Only

Doctors Use Only

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

☐ 541 Appendicitis	☐ 280 Anemia	☐ 429.9 Heart Disease	☐ 716 Arthritis
☐ 480 Pneumonia	☐ 055 Measles	☐ 240 Goiter	☐ 345 Epilepsy
☐ 390 Rheumatic Fever	☐ 072 Mumps	☐ 487 Influenza	☐ 319 Mental Disorder
☐ 045 Polio	☐ 052 Chicken Pox	☐ 511 Pleurisy	☐ 724.2 Lumbago
☐ 011 Tuberculosis	☐ 250 Diabetes	☐ 303.9 Alcoholism	☐ 690 Eczema
☐ 033 Whooping Cough	☐ 239 Cancer	☐ 099 Venereal Disease	☐ 042 HIV Positive
☐ 493.3 Asthma	☐ 346.9 Migraine Headaches	☐ 054.9 Herpes	☐ 340 Multiple Sclerosis

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NOTICE *of* PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLAESE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR OFFICE.

This Notice of Privacy Practice describes how
Dr. C.J. Smith D.C., CFMP, PAK @ North Georgia Center for the Healing Arts
May use and disclose your protected health information to carry out treatment, payment or heath care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Dr. C.J. Smith D.C., CFMP, PAK @ North Georgia Center for the Healing Arts
and all clinic personnel 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. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by contacting our office, via phone or e-mail and requesting that a revised copy be sent to you in the mail or asking for one at the time of your nest appointment.

1. **USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATOION**
   Your protected health information may be used and disclosed by your physician, our office personnel and other outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice. Following are examples of the types of uses and disclosures of your protected health information that **Dr. C.J. Smith D.C., CFMP, PAK @ Blue Ridge Spinal Heath** is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.
   TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and ay related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to the primary care physician that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., as specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment to your physician.

   PAYMENT: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance play may undertaker before it approves or pays for the health care 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. For example, obtaining approval for a diagnostic test, such as an MRI, may require that your relevant protected health care information be disclosed to the health plan to obtain approval for the MRI to be performed.

Please check the correct box for each item below. Check at least one box for each or symptom listed.

Never	Previously	Presently	General Symptoms
☐	☐	☐	995.3 Allergy:
☐	☐	☐	780.9 Bronchitis
☐	☐	☐	780.9 Chills
☐	☐	☐	780.39 Convulsion
☐	☐	☐	780.4 Dizziness
☐	☐	☐	780.2 Fainting
☐	☐	☐	780.79 Fatigue
☐	☐	☐	780.6 Fever
☐	☐	☐	784.0 Headache
☐	☐	☐	780.52 Loss of Sleep
☐	☐	☐	783 Loss of Weight
☐	☐	☐	799.2 Nervousness
☐	☐	☐	729.8 Neuralgia
☐	☐	☐	780.8 Sweats
☐	☐	☐	786.07 Wheezing
☐	☐	☐	311 Depression

Never	Previously	Presently	Gastro-Intestinal
☐	☐	☐	787.3 Belching/Gas
☐	☐	☐	789.0 Abdominal Pain
☐	☐	☐	564.0 Constipation
☐	☐	☐	787.91 Diarrhea
☐	☐	☐	783.6 Excessive Eating
☐	☐	☐	575.9 Gall Bladder
☐	☐	☐	455 Hemorrhoids
☐	☐	☐	782.4 Jaundice
☐	☐	☐	794.8 Liver Trouble
☐	☐	☐	787.02 Nausea
☐	☐	☐	536.8 Stomach Pain
☐	☐	☐	783.0 Poor Appetite
☐	☐	☐	536.8 Poor Digestion
☐	☐	☐	787.03 Vomiting
☐	☐	☐	578.0 Vomiting Blood
☐	☐	☐	783.5 Excessive Thirst
☐	☐	☐	536.8 Indigestion
☐	☐	☐	569.3 Rectal Bleeding

Never	Previously	Presently	Eye/Ear Noise/Throat
☐	☐	☐	493.9 Asthma
☐	☐	☐	378.9 Crossed Eyes
☐	☐	☐	389.9 Deafness
☐	☐	☐	388.70 Earache
☐	☐	☐	388.60 Ear Discharge
☐	☐	☐	388.30 Ear Noises
☐	☐	☐	240.9 Enlarged Thyroid
☐	☐	☐	460 Frequent Colds
☐	☐	☐	477 Hay Fever
☐	☐	☐	784.49 Hoarseness
☐	☐	☐	478.1 Nasal Obstruction
☐	☐	☐	784.7 Nosebleeds
☐	☐	☐	379.91 Pain in Eyes
☐	☐	☐	368.9 Poor Vision
☐	☐	☐	461.9 Sinusitis
☐	☐	☐	462 Sore Throat
☐	☐	☐	463 Tonsillitis
☐	☐	☐	786.2 Persistent Cough
☐	☐	☐	787.2 Difficulty Swallowing
☐	☐	☐	523.8 Bleeding Gums

Never	Previously	Presently	Respiratory
☐	☐	☐	786.50 Chest Pain
☐	☐	☐	786.2 Chronic Cough
☐	☐	☐	786.09 Difficulty Breathing
☐	☐	☐	786.3 Spitting Blood
☐	☐	☐	786.4 Spitting Phlegm

Never	Previously	Presently	Genito-Urinary
☐	☐	☐	788.36 Bed Wetting
☐	☐	☐	599.7 Blood in Urine
☐	☐	☐	788.4 Frequent Urination
☐	☐	☐	788.3 Lack of Bladder Control
☐	☐	☐	590.9 Kidney Infection
☐	☐	☐	788.1 Painful Urination
☐	☐	☐	601.9 Prostate Trouble

Never	Previously	Presently	Muscle/Joints/ Bones
☐	☐	☐	724.5 Backache
☐	☐	☐	719.7 Foot Trouble
☐	☐	☐	550 Hernia
☐	☐	☐	719.1 Pain between Shoulders
☐	☐	☐	724.6 Painful Tail Bone
☐	☐	☐	723.9 Stiff Neck
☐	☐	☐	781.9 Spinal Curvature
☐	☐	☐	719.0 Swollen Joints
☐	☐	☐	781.0 Tremors/ Twitching
☐	☐	☐	782 Arm Trouble

Never	Previously	Presently	Cardio-Vascular
☐	☐	☐	401.9 High Blood Pressure
☐	☐	☐	458.9 Low Blood Pressure
☐	☐	☐	786.51 Pain Over Heart
☐	☐	☐	785.9 Poor Circulation
☐	☐	☐	438 Previous Heart Trouble
☐	☐	☐	785.0 Rapid Heart
☐	☐	☐	427.89 Slow Heart
☐	☐	☐	436 Stroke
☐	☐	☐	719.7 Swelling Ankles
☐	☐	☐	454 Varicose Veins

Never	Previously	Presently	Skin or Allergies
☐	☐	☐	680.9 Boils
☐	☐	☐	924.9 Bruising Easily
☐	☐	☐	701.1 Dryness
☐	☐	☐	691.8 Eczema
☐	☐	☐	708.9 Hives or Allergy
☐	☐	☐	698.9 Itching
☐	☐	☐	782.0 Sensitive Skin
☐	☐	☐	782.1 Skin Eruptions

Never	Previously	Presently	For Woman ONLY
☐	☐	☐	625.3 Cramps or Backaches
☐	☐	☐	626.2 Excessive Flow
☐	☐	☐	627.2 Hot Flashes
☐	☐	☐	626.4 Irregular Cycle
☐	☐	☐	634.9 Miscarriage
☐	☐	☐	625.3 Painful Periods
☐	☐	☐	623.5 Vaginal Discharge
☐	☐	☐	611.79 Lump in Breast
☐ Yes ☐ No			Pregnant at this time?
☐ Yes ☐ No			Have you had a mammogram?

All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office at the time of service. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collections become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat me as deemed appropriate with the use of natural chiropractic methods, and I give authority for these procedures to be performed. I am the responsible party for payment of any treatment received or incurred during the visit. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis. The purpose of this doctor is to facilitate healing to the body by supporting its normal physiology through chiropractic, functional medicine, applied kinesiology, or nutrition.

Patient's/Guardian's Signature X: _____ Date: _____

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of Chiropractic students, Professional Applies Kinesiology students, Professional Neurologist students, licensing, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that preform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains 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. You may contact our office to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for future appointments and or concerns regarding your care

Other Permitted and Required Uses and Disclosure That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

REQUIRED BY LAW: WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO THE EXTENT THAT THE USE OR DISCLOSURE IS REQUIRED BY LAW. THE USE OR DISCLOSURE WILL BE MADE IN COMPLIANCE WITH THE LAW AND WILL BE LIMITED TO THE RELEVANT REQUIREMENTS OF THE LAW. YOU WILL BE NOTIFIED, IF REQUIRED BY LAW, OF ANY SUCH USES OR DISCLOSURES.

PUBLIC HEALTH: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR PUBLIC HEALTH ACTIVITIES AND PURPOSES TO PUBLIC HEALTH ATHORITY THAT IS PREMITTED BY LAW TO COLLECT OR RECEIVE THE INFORMATION. FOR EXAMPLE, A DISCLOSURE MAY BE MADE FOR THE PURPOSE OF PREVENTING OR CONTROLLING DISEASE, INJURY OR DISABILITY.

COMMUNICABLE DISEASES: WE MAY DISCLOSE YOUR PROTECTED INFORMATION, IF ATHORIZED BY LAW, TO A PERSON WHO MAY HAVE BEEN EXPOSED TO A COMMUNICABLE DISEASE OR MAY OTHERWISE BE AT RISK OF CONTRACTING OR SPREADING THE DISEASE OR CONTITION.

HEALTH OVERSIGHT: WE MAY DISCLOSE PROTECTED HEALTH INFORMATION TO A HEALTH OVERSIGHT AGENCY FOR ACTIVITIES AUTHORIZED BY LAW, SUCH AS AUDITS, INVESTIGATIONS, AND INSPECTIONS. OVERSIGHT AGENCIES SEEKING THIS INFORMATION INCLUDE GOVERNMENT BENEFIT PROGRAMS, OTHER GOVERNMENT REGULATORY PROGRAMS AND CIVIL RIGHTS LAWS.

ABUSE OR NEGLECT: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMAITON TO A PUBLIC HEALTH AUTHORITY THAT IS AUTHORIZED BY LAW TO RECEIVE REPORTS OF CHILD ABUSE OR NEGLECT OR ELDERLY ABUSE OR NEGLECT. IN ADDITION, WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION IF WE BELIEVE THAT YOU HAVE BEEN A VICTIM OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE TO THE GOVERNMENTAL ENTITY OR AGENCY AUTHORIZED TO RECEIVE SUCH INFORMATION. IN THIS CASE, THE DISCLOSURE WILL BE MADE CONSISTENT WITH THE REQUIREMENTS OF APPLICABLE FEDERAL AND STATE LAW.

FOOD AND DRUG ADMINISTRATION: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO A PERSON OR COMPANY REQUIRED BY THE FOOD AND DRUG ADMINISTRATION FOR THE PURPOSE OF QUALITY, SAFETY, OR EFFECTIVENESS OF FDA-REGULATED PRODUCTS OR ACTIVITIES INCLUDING, TO REPORT ADVERSE EVENTS, PRODUCT DEFECTS OR PROBLEMS, BIOLOGIC PRODUCT DEVIATIONS, TO TRACK PRODUCTS; TO ENABLE PRODICT RECALLS; TO MAKE REPAIRS OR REPLACEMENTS, OR TO CONDUCT POST MARKETING SURVEILLANCE, AS REQUIRED.

LEGAL PROCEEDINGS: WE MAY DISCLOSE PROTECTED HEALTH INFORMAITON IN THE COURSE OF ANY JUDICIAL OR ADMINISTRATIVE PROCEEDING, IN RESPONSE TO AN ORDER OF A COURT OR ADMINISTRATIVE TRIBUNAL (TO THE EXTENT SUCH DISCLOSURE IS EXPRESSLY AUTHORIZED), OR IN CERTAIN CONDITIONS IN RESPONSE TO A SUBPOENA, DISCOVERY REQUEST OR OTHER LAWFUL PROCESS.

LAW ENFORCEMENT: WE MAY ALSO DISCLOSE PROTECTD HEALTH INFORMATON, SO LONG AS APPLICABLE LEGAL, REQUIREMENTS ARE MET, FOR LAY ENFORCEMENT PURPOSES. THESE LAW ENFORCEMENT PURPOSES INCLUDE (1) LEGAL ROCESSES AND OTHERWISE REQUIRED BY LAW, (2) LIMITED INFORMATION REQUESTS FOR IDENTIFICATION AND LOCATION PURPOSES, (3)

PERTAINING TO VICTIMS OF A CRIME, (4) SUSPICION THAT DEATH HAS OCCURRED AS A RESULT OF CRIMINAL CONDUCT, (5) IN THE EVENT THAT A CRIME OCCURS ON THE PREMISES OF OUR PRACTICE, AND (6) MEDICAL EMERGENCY (NOT ON OUR PRACTICE'S PREMISES) AND IT IS LIKELY THAT A CRIME HAS OCCURRED.

CORNOERS, FUNERAL DIRECTORS, AND ORGAN DONATION: WE MAY DISCLOSE PROTECTED HEALTH INFORMATION TO CORONER OR MEDICAL EXAMINER FOR IDENTIFICATION PURPOSES, DETERMINING CAUSE OF DEATH OR FOR THE CORONER OR MEDICAL EXAMINER TO PREFORM OTHER DUTIES AUTHORIZED BY LAW. WE MAY ALSO DISCLOSE PROTECTED HEALTH INFORMATION TO A FUNERAL DIRECTOR, AS AUTHORIZED BY LAY, IN ORDER TO PREMIT THE FUNERAL DIRECTOR TO CARRY OUT THEIR DUTIES. WE MAY DISCLOSE SUCH INFORMATION IN REASONABLE ANTICIPATION OF DEATH. PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED FOR CADAVERIC ORGAN, EYE OR TISSUE DONATION PURPOSES.

RESEARCH: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO RESEARCHERS WHEN THEIR RESEARCH HAS BEEN APPROVED BY AN INSTITUTIONAL REVIEW BOARD THAT HAS REVEIWED THT RESEARCH PREPOSAL AND ESTABLISHED PROTOCOLS TO ENSURE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION.

CRIMINAL ACTICITY: CONSISTENT WITH APPLICABLE FEDERAL AND STATE LAW, WE MAY DISCLOSE YOUR PROCTED HEALTH INFORMATION, IF WE BELIEVE THAT THE USE OR DISCLOSURE IS NECESSARY TO PREVENT OR LESSEN A SERIOUS AND IMMINENT THREAT TO THE HEALTH OR SAFETY OF A PERSON OR THE PUBLIC. WE MAY ALSO DISCLOSE PROTECTED HEALTH INFORMATION IF IT IS NECESSARY FOR LAW ENFORCEMENT AUTHORITIES TO IDENTIFT OR APPREHEND AN INDIVIDUAL.

MILITARY ACTIVITY AND NATIONAL SECURITY: WHEN THE APPROPRIATE CONDITIONS APPLY, WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION OF INDICIDUALS WHO ARE ARMED FORCES PERSONNEL (1) FOR ACTICITIES DEEMED NECESSART BY APPROPRIATE MILITARY COMMAND AUTHORITES; (2) FOR THE PURPOSE OF A DETERMINATION BY THE DEPARTMENT OF VETERANS AFFAIRS OF YOUR ELIGIBILITY FOR BENEFITS, OR (3) TO FORGEIN MILITARY AUTHORITY IF YOU ARE A MEMBER OF THAT FOREIGN MILITARTY SERVICE. WE MAY ALSO DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO AUTHORIZED FEDERAL OFFICIALS FOR CONDUCTING NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES, INCLUDING FOR THE PROVISION OF PROTECTIVE SERVICES TO THE PRESIDENT OR OTHER LEGALLY AUTHORIZED.

WORKERS' COMPENSATION: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION AS AUTHORIZED TO COMPLY WITH WORKERS' COMPENSATION LAWS AND OTHER SIMILAR LEGALLY-ESTABLISHED PROGRAMS.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made ONLY with written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health 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 physician may, use professional judgement to determine whether the disclosure is in your best interest.

OTHER INVOLVED IN YOUR HEALTH CARE OR PAYMENT FOR YOUR CARE: UNLESS YOU OBJECT, WE MAY DISCLOSE TO A MEMBER OF YOUR FAMILY, A RELATICE, A CLOSE FRIEND OR ANY OTHER PERSON YOU IDENTIFY, YOUR PROTECTED HEALTH INFORMATION THAT DIRECTLY RELATES TO THAT PERSON'S INVOLVEMENT IN YOUR HEALTH 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 IN OUR PROFESSIONAL JUDGEMENT. WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMAITON TO NOTIFY OR ASSIST IN NOTIFYING A FAMILY MEMBER, PERSONAL REPRESENTATICE 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 USES AND DISCLOSURES TO FAMILY OR OTHER INDIVIDUALS INVOLVED IN YOUR HEALTH CARE.

2. **YOUR RIGHTS**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact our office if you have questions about access to your medical records.

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 of the purpose of treatment, payment or health care operations. 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 purposed 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 physician is not required to agree to a restriction that you may request. If your physician 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. With this in mind, please discuss any restrictions you wish to request with your physician.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATICE MEANS OR AT AN ALTERNATIVE LOCATION: We will accommodate reasonable requests. We also may condition this accommodation by asking you for information as to haw payment will be handled or specifications of an alternative address or other method of contact. We will not request an explanation form you as to the basis for the request. Please make this request in writing to our office.

YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORMATION. This means you may request an amendment of protected health information about you in a designated record set for so 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 is and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our office if you have questions about amending your medical records.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMAITON. This right applies to disclosures for purposed other than treatment, payment or health care operations as described in this Notice of Privacy Practice. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposed, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

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.

3. **COMPLAINTS**

You may complain to us or use 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 office of your complaint. We will not retaliate against you for filing a complaint.

You may contact our office at 706-946-5433 for further information about the complaint process.

Print Name: _____

Signature: _____ **Date:** _____

North Georgia Center
for the Healing Arts
21 High Park Dr. St. 8
Blue Ridge, GA 30513
706-946-5433

Terms of Acceptance/ Consent to Treat:

When a person seeks the services of a Chiropractor or Applied Kinesiologist, it is essential he/she fully understands the objectives of that chiropractor.

Chiropractic as it applies to this office has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the application of a gentle and specific force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine and its vertebra.

Vertebral Subluxation: A misalignment of one of the 24 vertebra in the spinal column that causes alteration of nerve function and interference to the transmission of neuronal impulses, resulting in a decrease of the functionality of what that nerve root innervates (muscle, tissue, organ etc.)

We do not offer to diagnose or treat or cure any disease or medical condition other than vertebral subluxation. Nor do we offer advice regarding treatment prescribed by other medical healthcare providers. **THE ONLY PRACTICE OBJECTIVE** is to eliminate structural interference of the body's spinal column and facilitate the body's natural healing. Our method is specific adjusting to correct vertebral subluxations as found through manual muscle testing.

HIPAA Privacy Practices

Your private healthcare information will not be shared with anyone unless you have a signed form to release your records that is signed by you, or your legal guardian, or if required by law to do so. I authorize North Georgia Center for the Healing Arts to use a telephone or email to use my name, address and phone number for the limited purpose of contacting me to notify me of pending office related communications. I also authorize my chiropractic provider to disclose to third parties (i.e. family members at home etc.) who may answer my phone to leave a reminder message with them or on my voice mail system and/or answering machine if necessary.

I, _____ have read and agree to the above terms. I have also had the opportunity to ask questions about any content in the Terms of Acceptance/ Consent to Treat. I therefore accept the chiropractic assessments and consent to treat on this basis.

Signature: _____ Date: _____

Consent to evaluate and adjust a minor child (if necessary)

I, _____ being the parent or legal guardian of

_____

_____

_____ Date: _____

Please read and sign

As of September 1st 2024 our pricing will be changing, so please note the changes below.

Fees

Office visits are always based on time spent. New patient visits are 1 hour. After the initial visit they are based on 20 minute units.

Each unit of time is 20 minutes at $90.00

So a new patient visit is 3 units or 1 hour at $270.00

All other visits are based on that unit of time.

(Ex. A 2-hour appointment would be $540.00 and so on)

Schedule changes

Sometimes life happens and we have to cancel and or reschedule. There is a 24 hour cancellation policy in effect on the Jane app scheduling software. If something comes up between then, cancellations have to be made directly with Dr. Smith via text message. I am almost always understanding in this, but no shows without a call or text will be assessed a fee for the visit, because this is a waiting list practice.

Fees Con't

All card purchases will be assessed a fee of 2.75%. Please be aware. Most businesses charge 3% or more.

I understand and agree to these terms and conditions.

Print name:_____

Sign name:_____

Date: _____