OZZIE SMITH
IMAC REGENERATION CENTER

Ozzie Smith IMAC Regeneration Center
13353 Olive Blvd.
Chesterfield, MO 63017
P: (314) 200-4955 | www.ozziesmithcenter.com

Name: _____ Birth Date: _____-_____-_____

Age: _____ ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Social Security #: _____ Driver's License State and #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Care Provider: _____ Referring Provider: _____

We're glad you're here! It helps us greatly to know how patients hear about us. Please check all that apply:

☐ Internet Search	☐ Attended an Event	☐ Work Comp/Attorney
☐ Facebook	☐ Drove by Clinic	☐ Employer
☐ Magazine/Newspaper	☐ Doctor Recommendation	☐ Ozzie Smith Center Employee
☐ TV Commercial	☐ Family/Friend Recommendation: _____	

Do you have Insurance: ☐ Yes ☐ No

Is the condition you are being seen for related to: ☐ Auto Accident; ☐ Work Injury; ☐ Liability Claim

Primary Insurance Carrier:

Name of Insurance Co: _____ Name of Insured: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Carrier:

Name of Insurance Co: _____ Name of Insured: _____

Policy Number: _____ Group Number: _____

Patient Signature: _____ **Date:** _____

HRN# _____ (office use only)

IMAC REGENERATION CENTER - Informed Consent

REGARDING: X-Rays/Imaging Studies

MALES & FEMALES: I understand the risks associated with exposure to x-rays and have had the opportunity to discuss the risks and benefits with the ordering provider.

_____ _____

Patient or Authorized Person's Signature **Date**

Witness initials: _____

In addition to this, if applicable, by my signature below I am acknowledging that the doctor and/or member of the staff has discussed with me the hazardous effects of ionization to an unborn child. After careful consideration, I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my care.

FEMALES ONLY: Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions.

The first day of my last menstrual cycle was on: ____-____-____ (date)

- ☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

_____ _____

Patient or Authorized Person's Signature **Date**

Witness initials: _____

IMAC REGENERATION CENTER - Informed Consent

REGARDING: Physical Therapy/Occupational Therapy

Physical Therapy/Occupational Therapy is a patient care service in response to a wide range of care needs for patients of all ages, regardless of gender, color, race, creed, national origin, or disability.

The purpose of Physical Therapy/Occupational Therapy is:

- To treat disease, injury, and disability by evaluation, examination, testing and use of rehabilitative procedures, manipulations, massage, mobilizations, exercise, education, and physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound in the diagnosis or treatment.
- To obtain for the physician, information needed for diagnosing and evaluation of patients.
- To prevent and minimize residual physical disability.
- To aid the patient in achieving maximum potential to within their capabilities.
- To accelerate convalescence and reduce the length of functional recovery.

The above professional practices include, but are not limited to the use of:
Therapeutic exercises and activities, ultrasound, E-stim, work conditioning, swallowing training, electromyographic (EMG) tests, Nerve conduction velocity (NVC) tests, thermography, transcutaneous electrical nerve stimulation (TENS), bed traction, Decompression therapy, application of topical medication to open wounds, sharp debridement, casting and splinting, phonophoresis, iontophoresis, and biofeedback.

All procedures will be thoroughly explained to you before you are asked to perform them.

Depending on your current condition, you may or may not experience any increase in pain. If you should experience an increase in pain or discomfort you should notify your caregiver immediately. This will enable the therapist to make the necessary adjustments to your care.

There are certain inherent risks with therapy treatment. You will be asked to exert effort and perform activities with increasing degrees of difficulty, this could increase your pain levels. The risks are small and you will be able to control any procedure by stopping if needed. The Therapist or Therapist Assistant will take precautions to ensure that you are protected from any potentially hazardous situation.

It is my choice to receive the recommended care, and I understand that I am not required to use IMAC Regeneration Center to receive this care.

_____ _____

Patient or Authorized Person's Signature **Date**

Witness initials: _____

IMAC REGENERATION CENTER - Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at IMAC Regeneration Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____

Patient or Authorized Person's Signature **Date**

Witness initials: _____

IMAC REGENERATION CENTER OFFICE POLICIES

Welcome to IMAC Regeneration Center

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care,*** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice, so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of true health. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you careabout.

- **PATIENT PRIVACY –** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

- **YOUR CARE** - When a patient seeks health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Health care at **IMAC Regeneration Center** is rendered primarily to minimize, reduce, and remove causes of symptoms, which are a major interference to the expression of the body's innate wisdom. The doctors use Chiropractic, Physical Therapy, Regenerative Medicine, or combinations of these techniques to accomplish this goal, including but not limited to corrective chiropractic techniques, physical therapeutic modalities, mobilization, stabilization, and proprioception techniques, as well as stem cell therapy, platelet therapy, trigger point injections, and various other regenerative medicine, physical therapy, and chiropractic treatments. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal, nervous system and other joint problems. Where in the past, chronic and acute structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through several distinct phases of care to make a structural correction to your body that will enable your central nervous system to function optimally, thereby improving your overall health.

- **FIRST THINGS FIRST**- Prior to receiving care at this office, a health history and examination will be completed. Imaging studies, as well as any other necessary diagnostics, may also be ordered to confirm the true nature of your condition and exact location of the cause of your condition. The results of these procedures will aid in assessing your presenting problem and your overall health. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so t**h**at you can make the best possible decision regarding your health care needs.

- **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the integrated regenerative approach that will be used to manage your health, immediately following your examination, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Patient initials: _____

Retaining page 1 of 2

IMAC REGENERATION CENTER OFFICE POLICIES

I hereby acknowledge receiving a copy of the practice's 'Office Policies' a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____	_____	_____
Patient Name	**DOB**	**HRN # (office use only)**
_____	_____	
Patient Signature	**Date**	
_____	_____	
Witness	**Date**	

IMAC REGENERATION CENTER – NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call for the corporate controller at 1-866-266-4622. If he/she is unavailable, you may make an appointment with our receptionist to see him/her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____

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IMAC REGENERATION CENTER – NOTICE OF PRIVACY PRACTICE

I have received a copy of IMAC Regeneration Center's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Patient Name	**DOB**	**HRN # (office use only)**
_____	_____	
Patient Signature	**Date**	
_____	_____	
Witness	**Date**	

In addition to the above entities, I give permission for IMAC Regeneration Center and its employees to release my private information and discuss my care with the following individuals:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Primary Care Provider: _____ Phone: _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Clinic: OZZIE SMITH IMAC REGENERATION CENTER
Address: 13353 OLIVE BLVD., CHESTERFIELD, MO 63017

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient's Signature: _____ Date: _____

PATIENT FINANCIAL POLICY

Thank you for choosing IMAC as your health care provider. We are committed to building a successful physician/therapist-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc). We will make every effort to make your treatment affordable and have payment options available.

Co-pays
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing/patient care coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Patient's Signature: _____ Date: _____

OZZIE SMITH
IMAC REGENERATION CENTER

Ozzie Smith IMAC Regeneration Center
13353 Olive Blvd.
Chesterfield, MO 63017
P: (314) 200-4955 | www.ozziesmithcenter.com

Medical Records Request

Date: _____

To: _____
(Physician's Name)

_____
Address

I hereby request that my medical records be released to:

_____at:
(Physician's Name)

Ozzie Smith IMAC Regeneration Center
13353 Olive Blvd.
Chesterfield, MO 63017
P: (314) 200-4955 | www.ozziesmithcenter.com

_____
Patient's Name (Print)

_____
Address

_____
City State Zip

Patient's Signature: _____ **Date:** _____

Witness Signature: _____ Date: _____