SUMMIT VIEW HEALTH CENTER, LLC / Dr. Jeff Gray
1227 West 9000 South, Suite G, West Jordan, Utah, 84088, (801) 748-0140

PATIENT INFO FORM 2021

DATE: _____ PATIENT NAME: _____ ACCNT:_____

PATIENT INFORMATION
First Name: _____ Middle: _____ Last Name: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: _____ Age: _____ Sex: ☐ M ☐ F Marital Status: S M D W SS#: _____
Spouse's Name: _____ How did you learn of our office? _____ **Email:** _____
Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed Student Status: ☐ Full Time ☐ Part Time
Employer: _____ Employer's Phone: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
In an Emergency Contact: _____ Phone: _____
Who is your primary care physician? _____ Phone: _____

RESPONSIBLE PARTY
First Name: _____ Middle: _____ Last Name: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

INSURANCE
Primary Insurance: _____ Insured's ID#: _____ Group #: _____
Insured's Full Name: _____ Insured's Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Insured's SS#: _____ Insured's DOB: _____ Relationship to You: _____
Secondary Insurance: _____ Insured's ID#: _____
Insured's Full Name: _____ Insured's Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Insured's SS#: _____ Insured's DOB: _____ Relationship to You: _____

OTHER INSURANCE
Are your present symptoms or conditions related to or the result of an auto accident, work related injury or other personal injury *someone else might be legally liable for*? ☐ Yes ☐ No Your initials: _____ If yes, please fill out accident specific form.
Automobile Accident Coverage: ☐ Yes ☐ No Claim #: _____ Date of Injury: _____
Auto Ins. Name/Address: _____ Phone Number: _____
Adjustor's Name: _____ Adjustor's Phone: _____
Workman's Compensation Coverage: ☐ Yes ☐ No Claim #: _____ Date of Injury: _____
Work Comp Ins. Name/Address: _____ Phone Number: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Summit View Health Center, LLC and Dr. Jeff Gray all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Patient / Guardian Date

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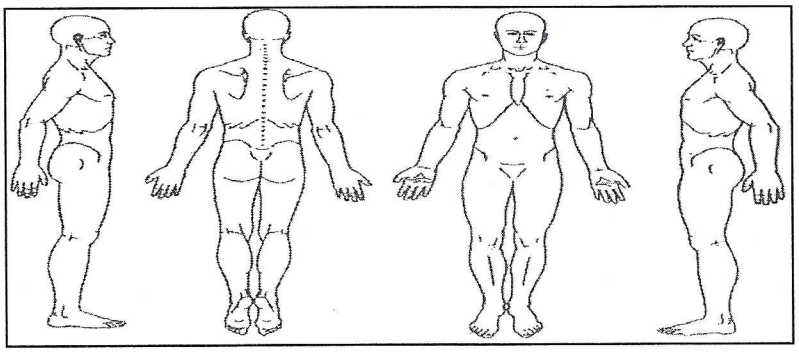
PATIENT INFORMATION FORM – CASE HISTORY

DATE: _____ PATIENT NAME: _____ ACCNT:_____

MARK AREAS OF PAIN ON DIAGRAM



SEVERITY OF PAIN: List region of pain and circle severity number. (1 = least, 10 = greatest)

ex._____*neck*_____
1 2 3 4 5 6 7 8 9 10

Chief Complaints:

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

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

When did you experience your symptoms? _____

How did your symptoms start? _____

What makes your symptoms worse? _____

What make your symptoms better? _____

Who else have you seen for your problem? _____

How long have you had this problem? _____

What is your: Height _____ **Weight**_____ **Age** _____

Have you ever been to a chiropractor? ☐ No ☐ Yes, How long ago? _____

Do you have a family physician? ☐ No ☐ Yes Physician's Name: _____

Have you been hospitalized in the past? ☐ No ☐ Yes, Date & Reason: _____

Have you ever had surgery? ☐ No ☐ Yes Date, reason, results of surgery: _____

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Abnormal Weight Gain/Loss
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Abdominal Pain
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Rheumatiod Arthriti
☐	☐ Hip Pain	☐	☐ Epilepsy	☐	☐ Systemic Lupus
☐	☐ Knee Pain	☐	☐ General Fatigue	☐	☐ Dizziness
☐	☐ Low Back Pain	☐	☐ Visual Disturbances	☐	☐ Asthma
☐	☐ Shoulder Pain	☐	☐ Angina	☐	☐ Depression
☐	☐ Other: _____				
			Females Only	☐	☐ Pregnancy

Guardian Signature:_____ Date: _____
Patient Signature:_____ Date:_____

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DATE: _____ PATIENT NAME: _____ ACCNT:_____

DISCLOSURE AND CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Jeff Gray, D.C., and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for Dr. Gray. I have had the opportunity to discuss with Dr. Gray, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended for the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

Patient Name (please print full name): _____

Patient Signature (please sign full name): _____

Date Signed: _____

If necessary, Patient Guardian and/or Representative Name: _____

Patient Guardian and/or Representative Signature: _____

To be completed by doctor or staff:

Summit View Health Center Witness Name (please print):_____

Summit View Health Center Witness Signature: _____

Date Signed: _____

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DATE: _____ PATIENT NAME: _____ ACCNT:_____

PRIVACY NOTICE

We are committed to protecting the privacy of your personal information. The purpose of this notice is to inform you of the types of personal information we obtain and how we protect that information.

What is personal information?

We treat any information that is identifiable to you as your personal information, whether or not it may be otherwise available to the public. We collect personal information related to your:

- Health condition, including health care treatment and payment; and
- Identity, such as your name, age, or address.

Why do we collect your personal information?

We collect personal information from you to help us:

- Properly diagnose and treat your healthcare needs;
- Submit claims to your insurance company for payment of services provided to you;
- Determine the appropriate products to offer you;
- Provide case management services; and
- Provide quality improvement services.

How do we collect your personal information?

We collect your personal information through you and your insurance. For example, we receive personal information from you on the personal information form you fill out at your initial visit and from your insurance company through transactions, such as verifying insurance coverage or the submission of a claim for reimbursement of covered benefits.

To whom do we disclose your personal information?

We will not disclose your personal information to any company for that company's marketing purposes. We will not disclose your personal information unless we are allowed or required by law to make the disclosure, or if you give us permission. Following are examples of disclosures we may make as allowed or required by law or with your permission:

- To your health insurance company in connection with an insurance transaction, such as verifying that you have coverage, or in connection with claims,
- To respond to legal request such as a subpoena;
- If required, to assist in health oversight investigations and audits
- Subject to certain restrictions, we may disclose information required by law enforcement officials.
- To a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Following are some examples:
  - In connection with scheduling or reminding you of appointments;
  - Allowing a person to pick up medical supplies, x-rays, or other similar forms of health information;
  - In the event of an emergency.

How do we protect your personal information?

We protect your personal information by:

- Treating all of your personal information that we collect as confidential;
- Stating confidentiality policies and practices, as well as disciplinary measures for privacy violations, in our employee handbooks;
- Restricting access to your personal information to only those employees who need to know your personal information in order to provide our services to you, such as paying a claim for a covered benefit;
- Disclosing only your personal information that is necessary for a service company to perform its function on our behalf and only when the company agrees to protect and maintain the confidentiality of your personal information; and
- Maintaining physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your personal information.

How can you reach us?

We are located at 1227 West 9000 South, Suite G in West Jordan. Our telephone number is (801) 748-0140. We are always happy to assist you or answer any questions you may have.

Revisions

We may amend this notice at any time and will inform you of changes as required by law.

Patient Name_____
Patient Signature_____
Date_____

Witness Name_____
Witness Signature_____
Date_____

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OFFICE POLICY

DATE: _____ PATIENT NAME: _____ ACCNT:_____

The following is an explanation of our office policy. We believe a clear definition of our office policy will allow us both to concentrate on the most important issue, **regarding and maintaining your health**. We will be happy to answer any questions you may have regarding our office policy, your account or insurance coverage.

PATIENT PAYMENT POLICY

We feel that the patient's health needs are paramount. Therefore the following payment policy is an attempt to allow you, the patient, to receive the care you need and keep your account current with the least amount of difficulty.

1. Our office accepts cash, personal checks, money orders and the following credit cards: Visa, MasterCard, American Express and Discover.
2. Payment of x-rays (if needed) is expected at the time of service.
3. Payment of co-pay, deductible, massage therapy, or non-covered service is expected at the time of service.
4. All records, including x-rays, are the property of **Summit View Health Center, LLC**. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. Copies of records will be provided, at the patient's expense, when a Release of Information Form is signed by the patient or responsible party.

Most insurance companies provide Chiropractic coverage, however the benefits and limitations vary widely. We will contact your insurance company to confirm your coverage and submit your insurance claims for you. **However, it will be your responsibility to obtain chiropractic benefits with respect to the amount of the deductible, co-pay, or non-covered services from your insurance company.**

AUTOMOBILE (NO FAULT) INSURANCE

Under Utah State Law, if you are injured in an automobile accident, you are covered under the terms of your automobile no-fault insurance for Chiropractic treatment. This also applies if you are a passenger or pedestrian involved in an accident. If you have been injured in an automobile related accident, please notify us immediately so that we can file the proper forms.

WORKERS COMPENSATION INSURANCE

If you are injured on the job, you are eligible for workers compensation insurance to pay for any needed Chiropractic treatment. If you have been injured on the job, please notify us immediately so that we can file the proper forms.

MASSAGE THERAPY

As a courtesy to our patients, massage therapy is a service available at our office. The charge for non-therapeutic massage therapy is $60.00 per hour of massage. Massage charges must be paid in full at the time of service. A $25 fee will be charged for all no-show's or cancellations within 24 hours of your scheduled massage therapy appointment.

PLEASE READ CAREFULLY

I also agree to pay a minimum finance charge of 1.5% per month or a minimum of $2.00 whichever is more on any amount not paid after 30 days. This is an annual percentage of 18%. If collection is made by suit or otherwise, patient and/or responsible party agrees to pay interest until paid, collection costs, all attorney fees and court costs.

I understand and accept to the above policies.

Patient's/Responsible Party Signature: _____ Date: _____

SVHC Witness Signature: _____ Date: _____