~ K & S Chiropractic ~

(HIPPA PRIVACY RECORDS)

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

In the course of your care as a patient at K & S Chiropractic, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, with your permission may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services.)
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences. You have the right to inspect and / or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have

the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules. If you have a complain regarding our privacy notice, practices, or any aspect of our privacy activities, or if you would like further information about our privacy policies and practices please contact Dr. Brown or Dr. Samson.

This notice is effective as of April 15, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (printed)	Signature	Date
Personal Representative (printed)	Signature	Date

K&S Chiropractic

PLEASE READ AND SIGN THE FOLLOWING:

OFFICE POLICY

Since every insurance plan has its own special requirements, it is impossible for us to be familiar with each and every plan. Therefore, we must look to you, the patient, to assume the responsibility of knowing what your insurance coverage is. In the last analysis, the patient is always responsible for payment for any services rendered. We will, of course, be happy to complete all of the necessary forms and to submit to your insurance company, claims for you and whatever documentation they require. However, this is done strictly as a service for you.

We provide the best services that we are capable of providing and expect that payment for those services be made as promptly as possible. It is important, therefore, for you to become an informed consumer relative to your insurance coverage.

If your insurance company requires pre-certification or pre-authorization for any services, it is your responsibility to obtain the authorization and to notify both the front desk and the doctor. We will do our best to try and keep you up to date with any certifications or authorizations. However, ultimately it is your responsibility.

Patient acknowledges that he/she is responsible for payment of all charges due for all services rendered by K & S Chiropractic. In the event that patientôs account is referred to an attorney for collection, the patient shall be responsible for all costs associated with such collection efforts, including reasonable attorney fees and court costs. Additionally, the patient shall be responsible for pre-judgment interest in the amount of 10% per annum on any balances that have not been paid within thirty (30) days of billing.

Please contact us if you have any questions about pre-certification or about your statement in general, and please always feel free to discuss your concerns directly with your doctor. We are here for you, and it is our pleasure to be of service to you.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I am informed and understand that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

_____

Signature of Patient - SEALED Date

_____

Signature of Witness Date

ABOUT YOU

Today's Date:_____ **Name:**_____
What you prefer to be called:_____ O **Male** O **Female** **Age:**_____
Birthdate:_____ **SS#**_____
Home Address:_____**City**_____**State**____**Zip**_____
Home Phone #:_____**Cell #**_____
Employer &
Address:_____
Occupation:_____ **Work #**_____
Marital status: O **single** O **married** O **divorced** O **widowed** **Spouse's Name:**_____
E-Mail _____ **Referred by:**_____

REASON FOR VISIT

Describe cause of pain:

_____
_____

When did condition begin?_____/_____/_____
Where is the discomfort?

Head:
☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck:
☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back:
☐ Right midback ☐ Left midback ☐ Central midback
☐ Right low back ☐ Left low back ☐ Central low back

Trunk:
☐ Abdomen ☐ Chest ☐ Back of ribs ☐ Front of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper extremity:

☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shouder	☐ Rear of left shoulder
☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand

Lower extremity:

☐ Front of right lower leg	☐ Rear of right lower leg	☐ Front of left lower leg	☐ Rear of left lower leg
☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
☐ Front of right knee	☐ Rear or right knee	☐ Front of left knee	☐ Rear or left knee
☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear or left ankle
☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot

Does the discomfort radiate/travel? O yes O no If yes, where?: _____

Describe the quality of the discomfort. Choose all that apply.
☐ Aching ☐ Sharp ☐ Annoying ☐ Shock-like ☐ Burning ☐ Shooting ☐ Deep ☐ Stabbing
☐ Diffuse ☐ Stiffness ☐ Dull ☐ Throbbing ☐ Heavy ☐ Tightness ☐ Intolerable ☐ Tingling
☐ Pulling ☐ Other _____

Describe the onset of the discomfort. Choose only one.

☐ Gradual ☐ Insidious ☐ Recent ☐ Spontaneous ☐ Sudden ☐ Traumatic ☐ Unknown

Describe the intensity of the discomfort. Choose only one.

☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderate to severe ☐ Severe

How often do you feel this discomfort?

☐ Constant ☐ Frequent ☐ Intermittent ☐ On and off ☐ Random ☐ Recurring

How has this complaint changed since the onset?

☐ Improved ☐ Stayed the same ☐ Worsened

What aggravates this condition? Choose all that apply.

☐ Almost any movement	☐ Love life	☐ Athletic activity and/or exercise	☐ Lying down	☐ Bathing
☐ Pulling	☐ Bending	☐ Pushing	☐ Caring for family	☐ Reaching
☐ Carrying	☐ Reading	☐ Changing positions	☐ Repetitive motions	☐ Resting
☐ Climbing stairs	☐ Running	☐ Computer use	☐ Concentrating	☐ Cooking
☐ Grocery shopping	☐ Sitting	☐ Daily child or pet care	☐ Squatting	☐ Driving
☐ Standing	☐ Eating	☐ Falling or staying asleep	☐ Stretching	☐ Stress
☐ Talking on telephone	☐ Twisting	☐ Getting in or out of car	☐ Getting out of bed	☐ Turning
☐ Getting up from sitting	☐ Unknown	☐ Getting up from lying down	☐ Household chores	☐ Walking
☐ Working	☐ Lifting	☐ Looking over shoulder	☐ Yard work	☐ Other

What improves this condition? Choose all that apply.

☐ Nothing	☐ Cold packs	☐ Chiropractic adjustment	☐ Prescription medication	
☐ Exercise	☐ Rest	☐ Heat packs	☐ Stretching	
☐ Massage	☐ Work	☐ Over-the-counter medications	☐ Physical therapy	☐ Other

What treatment have you received for this condition up to now?

☐ None	☐ Acupuncture	☐ Chiropractic care	☐ Over-the-counter medications
☐ Homeopathic medicine	☐ Physical therapy	☐ Prescribed medications	☐ Medical care
☐ Surgery	☐ Nutritional supplements		☐ Other

Were any diagnostic tests performed to assess this condition (ex: X-rays, MRIs, etc.)?

O yes **O** no **O** unsure

Have you ever had any previous episodes of this condition?

O yes **O** no

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over	☐ Looking over shoulder	☐ Caring for family	☐ Love life
☐ Climbing stairs	☐ Lying down	☐ Concentrating	☐ Reaching overhead
☐ Dressing myself	☐ Rising out of chair or bed	☐ Driving a car	☐ Showering or bathing
☐ Exercising	☐ Sitting	☐ Getting in/out of car	☐ Standing
☐ Getting to sleep	☐ Staying asleep	☐ Grocery shopping	☐ Using a computer
☐ Household chores	☐ Walking	☐ Lifting objects	☐ Yard work

Any additional systems complaints? Describe.

☐ Musculoskeletal: _____

☐ Neurological: _____

☐ Head, eyes, ears, nose, and throat: _____

☐ Cardiovascular: _____

☐ Respiratory: _____

☐ Gastrointestinal: _____

☐ Genitourinary: _____

☐ Endocrine: _____

PAST, FAMILY, AND SOCIAL HISTORY

List your past surgical history. Indicate the year in which the surgeries were performed. If no surgical history, please write N/A.

_____
_____
_____

Describe any past illnesses or conditions the doctor should be aware of and the age at which the illnesses reportedly occurred. If personal history is good, please write N/A.

_____
_____
_____

Number of children: _____ Number of pregnancies: _____ Number of deliveries: _____
Are you pregnant or have you had any signs of pregnancy? O yes O no
Are you presently taking any medication (including vitamins or supplements)? If yes, please list.

_____
_____

List your family health history. Choose all that apply to you and blood relatives only.

☐No family history of diabetes, cancer, hypertension, and progressive neurological disorders

☐Unknown	☐Extremity issues	☐Fracture	☐Heart disease	☐AIDS/HIV
☐Hepatitis	☐Alcoholism	☐Hereditary disorder	☐Alzheimerôs	☐Hernia
☐Anemia	☐Herniated disc	☐Anorexia	☐High blood pressure	☐Arthritis
☐High cholesterol	☐Asthma	☐Hospitalization	☐Bleeding disorders	☐Kidney disease
☐Breast lump	☐Liver disease	☐Bronchitis	☐Migraine headaches	☐Bulimia
☐Miscarriage	☐Cancer	☐Multiple sclerosis	☐Chemical dependency	☐Natural labor
☐Congenital anomaly	☐Neuromuscular issues	☐Depression	☐Osteoarthritis	☐Diabetes
☐Trauma/injury	☐Emphysema	☐ Epilepsy	☐OTHER _____	

How would you describe your personal social habits? Choose all that apply.

☐No change in social habits since injury		☐Does not smoke, drink alcohol or take recreational drugs		
☐A social drinker	☐A light drinker	☐A moderate drinker	☐A heavy drinker	☐A recovering alcoholic
☐Current everyday smoker		☐Never smoked tobacco	☐ Ex-smoker	
☐Does not use recreational drugs		☐ Is drug addicted	☐ Is a recovering drug addict	

How would you describe your present exercise habits? Choose all that apply.

☐No changes in exercise habits since condition began

☐Daily	☐None	☐Every other day		
☐Few times a week	☐Once a week	☐Almost nothing		
☐Racquetball	☐ Running	☐Aerobic	☐Snowboarding	☐Stretching
☐Soccer	☐Strength	☐Baseball	☐Tennis	☐Basketball
☐Volleyball	☐Walking	☐Cycling	☐Weight training with a personal trainer	
☐Football	☐Pilates	☐Golf	☐Spinning	☐Handball
☐Hiking	☐Yoga	☐Zumba	☐Ice skating	☐Other

How would you describe your diet and nutritional status? Choose all that apply.

☐No changes in diet or nutrition since condition began

☐Controlled	☐Out of control	☐Restricted	☐Unrestricted

Family/Primary Physician: _____ Date of last exam: _____
Have you had previous chiropractic care? O yes O no

SIGNATURE: _____ DATE: _____

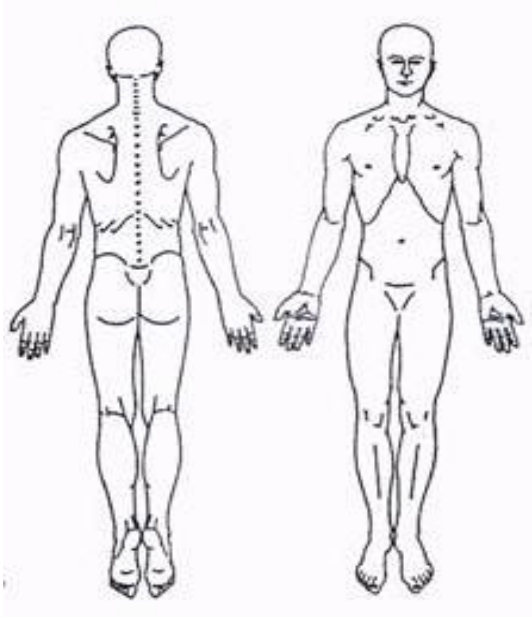
ELECTRONIC HEALTH RECORD (EHR) INFORMATION

Preferred language: _____
Ethnicity: _____
Race: _____
Smoking status: O smoker O non-smoker
Type of tobacco: O cigarettes O chewing tobacco O cigar O pipe O other
Have you tried to quit? O yes O no How much tobacco do you use? _____
Current medications and dosage:

_____
_____
_____
Medication allergies: _____
_____

PAIN CHART

Name:_____ Date: _____



Use the letters to indicate the type of pain you are having AT THIS TIME

A= Ache	B= Burning
N= Numbness	P=Pins and needles
S= Stabbing	O= Other

- We invite you to discuss with us any questions regarding our services.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims as well as to other health care providers.
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.**

K & S CHIROPRACTIC, LLC Signature_____ Date_____