EASTMAN-KINGREY CLINIC
WESTLAKE, LA

CONFIDENTIAL HEALTH HISTORY

Date_____ File_____

PERSONAL

Name_____ Sex_____ Age_____ Date of birth_____

Phone (home) _____ (cell)_____(work)_____

What do you prefer to be called?_____ SS#_____ Height_____ Weight _____

Marital status: Single__ Married__ Divorced__Widowed__ Number of children_____

Address _____ City _____ State____ Zip_____

Employer _____How long?_____ Employer address_____

Occupation _____ How long? _____

Spouse _____ Spouse's employer _____

Referred by_____ In case of emergency notify _____

CURRENT CONDITION

Please describe the principal health problems for which you came to this office. _____

_____

How and when did symptoms first occur? _____

List any other doctors seen for these problems _____

List any diagnosis (es) and type of treatment_____

Are you taking any medications for the current condition? Yes___ No__ Have they helped? A lot___ Some___ Not at all ___

Type of medications? Pain killers_ Muscle relaxers_ Anti-inflammatory _ Other _____

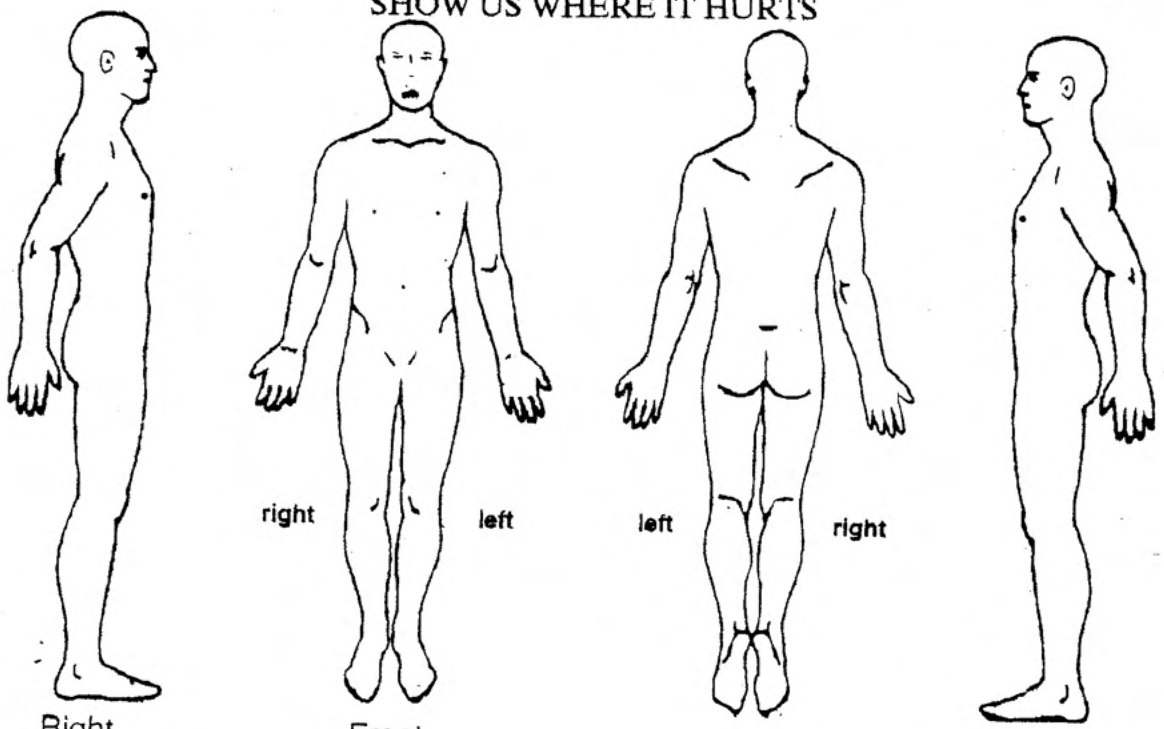
Have you lost any days of work? Yes__ No__ Dates_____

Have you had similar symptoms before? Yes__ No__ When?_____

Check if you currently have or recently had any of the following.

Trauma___ Fever___ Infection___ Weight 1oss ___ Loss of bladder control ___ None ___

SHOW US WHERE IT HURTS



HEALTH HISTORY

Check the following conditions/procedures you have/had

_Anemia
_Cancer
_Diabetes
_Epilepsy
_Fibromyalgia
_Gout
_Hepatitis
_HIV/AIDS
_Lupus
_Multiple Sclerosis

_Osteoporosis
_Rheumatoid Arthritis
_Thyroid Condition
_Urinary Tract Infections
_Venereal Disease

_Asthma
_Emphysema
_Tuberculosis

_Artificial Joints
_Bone Fracture
_Bone Fusion
_Disc Herniation
_Dislocations
_Hernia
_Sciatica
_Scoliosis
_Tendon/Ligament Rupture
_TMJ Condition
_Whiplash

_Arteriosclerosis
_Cardiovascular Disease
_Heart Attack/Stroke
_Heart defect
_Heart Murmur
_High Blood Pressure
_Low Blood Pressure
_Pacemaker

_Colitis
_Gallbladder Condition
_Gastric Reflux
_Hemorrhoids
_Kidney Condition
_Liver Condition
_Rectal Polyps
_Ulcers

_Endometriosis
_Hormone Replacement
_Ovarian/Uterine Cyst

_Prostate Condition
_Testicle Condition

Please Circle the appropriate letter for any of the following symptoms.

O-OCCASIONAL
F-FREQUENT
C-CONSTANT

HEAD AND NECK
O F C Severe/frequent Headaches
O F C Jaw Pain
O F C Eye Problems
O F C Sinus Problems
O F C Ear Problems
O F C Nose Bleeding
O F C Nose Discharge
O F C Sore Throat
O F C Dental Problems
O F C Swollen Lymph Nodes

GENITOURINARY
O F C Bladder Trouble
O F C Excessive Urine
O F C Painful Urination
O F C Discolored Urine
O F C Urinary Infection

RESPIRATORY
O F C Difficulty Breathing
O F C Coughing Blood
O F C Coughing Phlegm
O F C Chest Pain

CARDIOVASCULAR
O F C Pain over Heart
O F C Rapid Heartbeat

GASTROINTESTINAL
O F C Weight Trouble
O F C Excessive Thirst
O F C Excessive Hunger
O F C Poor Appetite
O F C Heartburn
O F C Abdominal Pain
O F C Nausea/Vomiting
O F C Diarrhea
O F C Constipation
O F C Black Stool
O F C Bloody Stool

MUSCULOSKELETAL
O F C Back Pain
O F C Neck Pain
O F C Pain between Shoulders
Pain or Numbness in:
O F C Shoulders
O F C Arms
O F C Elbows
O F C Hands
O F C Hips
O F C Legs
O F C Knees
O F C Feet
O F C Swollen/Stiff Joints
O F C Loss of Strength
O F C Walking Problems

NERVOUS
O F C Seizures
O F C Fainting
O F C Dizziness
O F C Paralysis
O F C Loss of Feeling

FEMALES ONLY
O F C Vaginal Discharge
O F C Irregular Vaginal Bleeding
O F C Vaginal Pain
O F C Breast Pain
O F C Breast Lumps
O F C Hot Flashes

Please Answer

List any health conditions within the last year

_____
_____
_____

List any medications not listed previously that you currently use.

_____
_____
_____

List approximate date of any other operations, diseases, serious illnesses or accidents you have had.

_____
_____
_____
_____
_____
_____
_____

DO YOU:

Wear heel lifts, arch supports, sole lifts, or inner soles? Y / N
Smoke? Y / N
Exercise? Y / N
Take Vitamins? Y / N

Allergies_____
Usual sleeping position? Back____ Stomach___ Right Side___ Left Side ___
Mattress: Age___ Type_____ Is it comfortable Yes___ No___
How would you rate your overall health? Excellent___ Good___ Fair___ Poor___
Received chiropractic care before? Yes___ No___

FEMALES ONLY:
Are you currently pregnant? Yes___ No___
If yes, due date? _____
Are you currently menstruating? Yes___No___

Doctor's Notes:

PATIENT SIGNATURE_____ DATE_____

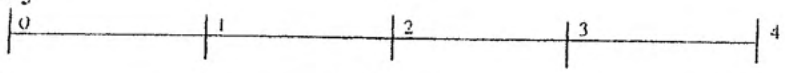
NAME: _____ DATE: _____ FILE# _____

Functional Rating Index

For use with Neck and/or Back Problems only.

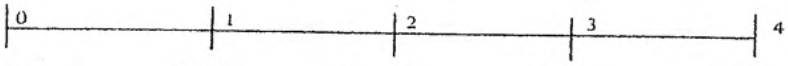
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



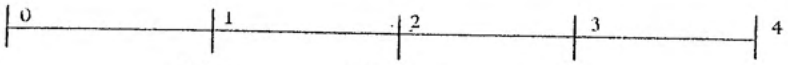
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



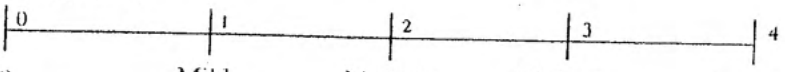
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



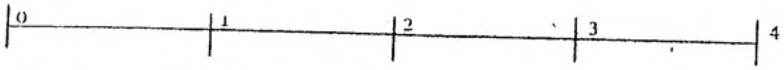
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

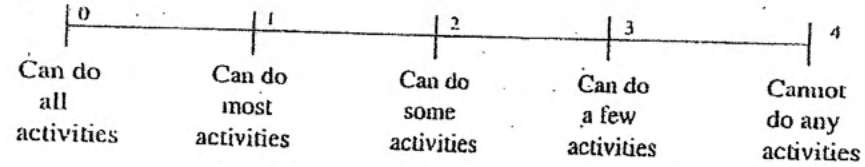
5. Work



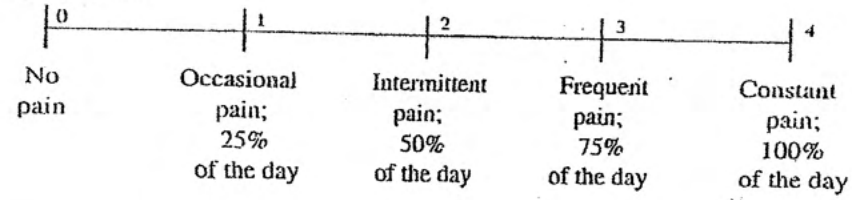
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

Please Turn Over

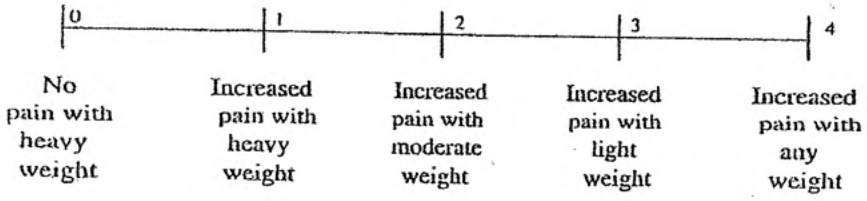
6. Recreation



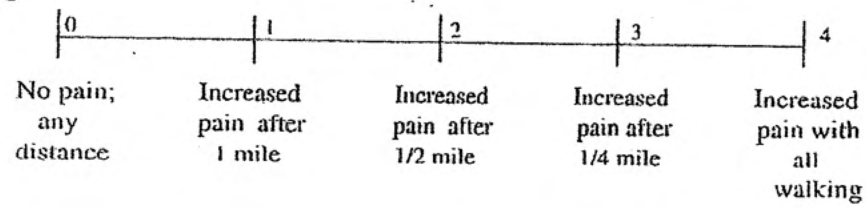
7. Frequency of pain



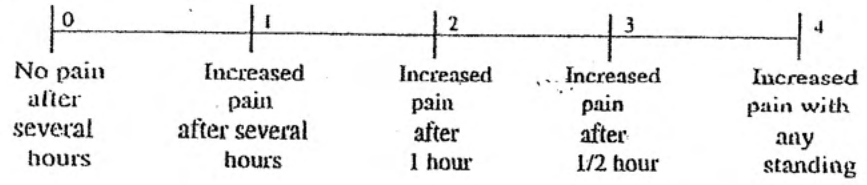
8. Lifting



9. Walking



10. Standing



Patient's Signature **Date**

EASTMAN-KINGREY CLINIC
CONSENT/RELEASE

PATIENT _____ DATE _____ FILE#_____

PATIENT INFORMED CONSENT

I hereby request and/or consent to the performance of chiropractic examinations and/or procedures on (or on the patient names above for who I am legally responsible) by Dr. Kenneth R. Eastman, Dr. Lorraine L. Eastman and/or Dr. Charles T. Kingrey, Jr. D.C.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic care, including but not limited to strokes, sprains and strains, fractures, dislocations and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or other office personnel the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor will perform and examination in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts as then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask question about its content, and by signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

_____ _____
Patient/Guardian Signature Doctor's Signature

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of any medical information necessary to process any claims. I authorize payment of any medical benefits to be paid directly to Eastman Chiropractic Clinic for any medical services rendered to me. This authorization shall remain in effect until cancelled by me.

_____
Patient Signature

INSURANCE/PATIENT RESPONSIBILITY

I have been informed and am aware that my health insurance coverage may have some limitations pertaining to chiropractic care. I am also aware that this could cause benefits to be denied or paid at a lower percentage rate due to such policy limitations as yearly maximum payment amounts, yearly number of visits limits, referral needed from primary care physicians, etc.

I am aware that my visits may not be covered by my insurance and that I will be fully responsible for payment of services rendered at such time that a denial is received from my insurance carrier.

_____
Patient Signature

CONSENT TO TREAT MINOR CHILD

I hereby authorize:
Dr. Kenneth R. Eastman, Dr. Lorraine L. Eastman and/or Dr. Charles T. Kingrey, Jr and whoever he or she may designate as assistants to administer chiropractic care as deemed necessary to my _____
(indicate relationship to child).
Name of child _____.

_____
Parent/Guardian Signature

VERIFICATION OF NON-PREGNANCY

By my signature on this form, I hereby state that, to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this particular time.

_____
Patient Signature

EXPLANTION OF CHIROPRACTIC MEDICARE BENEFITS

MEDICARE DOES NOT COVER CHIROPRACTIC CARE BUT WITH LIMITATIONS.

The only service covered by Medicare is manual manipulation of the spine. These manipulations under some circumstances and with certain carriers are limits to 12 (twelve) per calendar year.

Your condition may require, in our judgment, more treatments than allowed by Medicare. We can apply for additional treatments by submitting a "medical necessity statement" on your behalf. Your case will be sent for review. We cannot guarantee or predict what the review board will decide in your case.

ANY VISITS OVER 12 (TWELVE) IN THIS CALENDAR YEAR, NOT APPROVED BY MEDICARE, WILL BE YOUR FINANCIAL RESPOSIBILITY.

Medicare does not cover the cost of x-rays, examinations, therapy, supports, supplements or any other services offered in this office.

Any services other than spinal manipulation will be your financial responsibility.

I have read and understand the above statement.

_____ _____

Patient Signature Date

NECK DISABILITY INDEX QUESTIONNAIRE

NAME_____ **AGE**_____ **DATE**_____ **SCORE**_____

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

SECTION 1 - Pain Intensity A. I have no pain at the moment. B. The pain is very mild at the moment. C. The pain is moderate at the moment. D. The pain is fairly severe at the moment. E. The pain is very severe at the moment. F. The pain is the worst imaginable at the moment.	*SECTION 6 - Concentration/* A. I can concentrate fully when I want to with no difficulty. B. I can concentrate fully when I want to with slight difficulty. C. I have a fair degree of difficulty in concentrating when I want to. D. I have a lot of difficulty in concentrating when I want to. E. I have a great deal of difficulty in concentrating when I want to. F. I cannot concentrate at all.
SECTION 2 -Personal Care (Washing, Dressing, etc.) A. I can look after myself normally without causing extra pain. B. I can look after myself normally, but it causes extra pain. C. It is painful to look after myself and I am slow and careful. D. I need some help, but manage most of my personal care. E. I need help every day in most aspects of self care. F. I do not get dressed, I wash with difficulty and stay in bed.	*SECTION 7 - Work* A. I can do as much work as I want to. B. I can only do my usual work, but no more. C. I can do most of my usual work, but no more. D. I cannot do my usual work. E. I can hardly do any work at all. F. I cannot do any work at all.
SECTION 3 - Lifting A. I can lift heavy weights without extra pain. B. I can lift heavy weights, but it gives extra pain. C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E. I can lift very light weights. F. I cannot lift or carry anything at all.	*SECTION 8 – Driving* A. I can drive my car without any neck pain. B. I can drive my car as long as I want with slight pain in my neck. C. I can drive my car as long as I want with moderate pain in my neck. D. I cannot drive my car as long as I want because of moderate pain in my neck. E. I can hardly drive at all because of severe pain in my neck. F. I cannot drive my car at all.
SECTION 4 - Reading A. I can read as much as I want to with no pain in my neck. B. I can read as much as I want to with slight pain in my neck. C. I can read as much as I want to with moderate pain in my neck. D. I cannot read as much as I want because of moderate pain in my neck. E. I cannot read as much as I want because of severe pain in my neck. F. I cannot read at all.	*SECTION 9 – Sleeping* A. I have no trouble sleeping. B. My sleep is slightly disturbed (less than 1 hour sleepless). C .My sleep is mildly disturbed (1-2 hours sleepless). D. My sleep is moderately disturbed (2-3 hours sleepless). E. My sleep is greatly disturbed (3-5 hours sleepless). F. My sleep is completely disturbed (5-7 hours)
SECTION 5 – Headaches A. I have no headaches at all. B. I have slight headaches which come infrequently. C. I have moderate headaches which come infrequently. D. I have moderate headaches which come frequently. E. I have severe headaches which come frequently. F. I have headaches almost all the time.	*SECTION 10 – Recreation* A. I am able to engage in all of my recreational activities with no neck pain at all. B. I am able to engage in all of my recreational activities with some pain in my neck. C. I am able to engage in most, but not all of my recreational activities because of pain in my neck. D. I am able to engage in a few of my recreational activities because of pain in my neck. E. I can hardly do any recreational activities because of pain in my neck. F. I cannot do any recreational activities at all.

COMMENTS: _____

_____

_____

Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name:_____ **File #** _____ **Date:** _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem right now.

SECTION 1 - PAIN INTENSITY
- ☐ The pain comes and goes and is very mild
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE
- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - LIFTING
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - WALKING
- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - SITTING
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half hour
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

SECTION 6 - STANDING
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

SECTION 7 - SLEEPING
- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than ½.
- ☐ Because of pain my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - TRAVELLING
- ☐ I get no pain whilst travelling.
- ☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain whilst travelling but it does not compel me to seek alternative form of travel.
- ☐ I get extra pain whilst travelling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Pain Severity Scale:

Rate your usual level of pain today by checking one box on the following scale

0	1	2	3	4	5	6	7	8	9	10

No pain **Excruciating pain**

Date:_____
CA:_____

PATIENT DATA SHEET

General Information

First Name_____
Middle Initial_____
Last Name_____

For Office Use Only

Account Number_____
Patient Height_____
Patient Weight_____
Patient BMI_____
Patient Blood Pressure_____

Race (circle only 1) American Indian, Alaska Native, Asian, White, Black or African American, Native Hawaiian, Other Pacific Islander, Declined to state

Ethnicity (circle only 1) Declined to state, Hispanic or Latino, Not Hispanic or Latino

Preferred Language _____

Email Address _____

Smoking Status (circle only 1) Current Every Day Smoker, Current Some Day Smoker, Former Smoker, Never Smoker

Smoking Start Date:_____ End Date:_____

In an effort to quit smoking, I am currently taking:_____

Do you have any allergies to medication? Yes No
If yes, please indicate the following:

Allergy:_____
Reaction:_____
Start Date:_____
End Date: _____

Allergy:_____
Reaction:_____
Start Date:_____
End Date: _____

Allergy:_____
Reaction:_____
Start Date:_____
End Date: _____

Allergy:_____
Reaction:_____
Start Date:_____
End Date: _____

Are you currently taking any medications? Yes No
If yes, please indicate the following:

Medication:_____
Route: Oral, Intravenous, Other:_____
Frequency:_____
Began Use:_____
Discontinued Use:_____

Medication:_____
Route: Oral, Intravenous, Other:_____
Frequency:_____
Began Use:_____
Discontinued Use:_____

Medication:_____
Route: Oral, Intravenous, Other:_____
Frequency:_____
Began Use:_____
Discontinued Use:_____

Medication:_____
Route: Oral, Intravenous, Other:_____
Frequency:_____
Began Use:_____
Discontinued Use:_____

CHIROPRACTIC ASSOCIATION OF LOUISIANA AUTHORIZATION

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Chiropractic Association of Louisiana (CAL). This disclosure will be made if we need the CAL's assistance to receive reimbursement for your services or, we need the CAL's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the CAL this information. You are also giving the CAL authorization to re-disclose your information to the party responsible for the payment of your services, the CAL's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to whom your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we may send to the CAL at any time. (§164.524).

This notice is effective as of _____. This authorization will expire six years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient name printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal representative printed Personal representative signature

_____

Description of personal representative's authority to act for the patient.

Clinic Name

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with a family member. If we are unable to reach you at home, we will leave a message at your worksite on an answering machine or with a co-worker.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of the date below. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____	_____
Patient name printed	Date
_____	_____
Patient signature	Authorized provider representative
_____	_____
Personal representative (printer)	Personal representative signature

_____

Description of personal representative's authority to act for the patient

EASTMAN-KINGREY CLINIC
902 Sampson Street
Westlake, La 70669

(337) 436-3145

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Eastman-Kingrey Clinic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

Eastman-Kingrey Clinic

Financial Policy

Eastman-Kingrey Clinic is happy to work with our patients to provide to provide the best quality of services. This letter is to acquaint you with our office billing procedures. Please read the following carefully and initial the appropriate method of payment. Your health insurance policy may have a deductible as well as a percentage (co-insurance or co-pay fee) for which you, the patient, are responsible for. Therefore, it is our policy to have all initial visit fees paid for, by the patient, at the time of his/her appointment.

Claims are sent out to insurance companies every Monday morning. Upon receipt of payment for services rendered, you will also receive statements from your insurance company, referred to as explanation of benefits (EOB's), which will inform you of any payments made. Since there are no guarantees of payment from the insurance company, you the patient are held liable for unpaid balances. **Health insurance is an agreement between the patient and the insurance company.** Insurance companies often send a payment directly to the clinic for services rendered to the patient and these funds are applied to your account balance for a specific day's service, on occasion the insurance company will send payment directly to the patient. If this occurs you can do 2 things, 1) endorse the payment and bring it to the clinic and the funds can be applied to the balance or 2) you keep the payment and are responsible for paying off the balance.

We encourage you to ask any questions you may have regarding out financial policy, so that you may have a clear understanding. Our goal is to concentrate on returning you to optimal health and establish overall well being, we have prepared the following checklist in order to help our patients determine their responsibility toward payment for chiropractic services please check the statement that applies to you:

_____ Private insurance: I understand that as a service to me, Eastman-Kingrey Clinic will bill my insurance company for services rendered, however; I fully understand that it is my financial responsibility to be liable for all healthcare expenses regardless of insurance coverage. I agree to assume all financial responsibility.

_____Medicare: I am eligible for Medicare and I understand it reimburses only **for manipulation of the spine, it does not reimburse for therapy or x-rays.** I, the patient, am responsible for payment of spinal manipulation, therapy, and x-rays at the time of service. I understand that Medicare will only reimburse up to the 12th visit, they will not reimburse if there is no medical necessity or for maintenance care.

_____ Private Pay (Cash): As I have no insurance or third parties liable for my healthcare expenses, I agree to assume all payment responsibility and keep my account current. (Please be sure to talk with our office about pre-payment incentives and payment options.)

My signature gives this office permission to give out any pertinent information to any insurance company, attorney, or adjustor who needs this information to facilitate the payment of a claim. A photocopy of this shall be deemed valid.

_____	_____	_____
Patient name	Patient/Guardian Signature	Date

NOTICE TO MEDICARE – PART B BENEFICIARIES
ADVANCE NOTICE OF NON-COVERED SERVICES

1. Medicare limits chiropractic reimbursement to **manual spinal manipulation**. Reimbursement is based on "active" care only, maintenance care is not covered.

2. Medicare ***DOES NOT*** reimburse for charges of **exams, x-rays, therapy, extremity manipulation, supplements or supports** from a chiropractor.

3. **X-rays and/or an exam** may be required to update your condition should a new course of treatment be initiated. Typically x-rays and/or examination are good courses of treatment for patients with your condition. Medicare *DOES NOT* pay for either and the **law forbids the doctor from providing you any of these services on a complimentary basis.**

4. Medicare patients will be responsible for deductible amounts, co-pays, non-covered charges and any denied visits which exceed Medicare guidelines.

5. Medicare secondary policies may be affected by Medicare denials.

6. Medicare supplemental policies only pay for what Medicare approves and does not pay ***(the manipulation is the only service Medicare approves for Chiropractic)***

_____ Our office **agrees to Accept Assignment**
You will be responsible for 20% co-payment on the allowable charge for manual manipulation in addition to those charges for all services not covered which are listed above.

__X__ Our office **DOES NOT ACCEPT ASSIGNMENT**
You will be responsible for all charges incurred. Charges for manual spinal manipulation will be assessed at Medicare's Limiting Charge. Our office will file your claims for you and reimbursement from Medicare will be based on 80% of the allowable charge for manipulation only.

7. I have been provided with a list of typical charges for the services that I will be rendered and agree to these charges.

It is understood that I may receive the following treatments which will not be covered by Medicare and the charges for which I will be responsible.

___Manipulations to Extremities	$_____
___X-rays	$_____
___Physical Examination	$_____
___Massage Therapy	$_____
___Ultrasound	$_____
___Ice/heat	$_____
___	$_____
___	$_____

I have read and understand the limitations of my Medicare coverage and the affects it may have on any supplement or secondary policies. I am aware that I will be responsible for any charges that Medicare denies or does not cover.

_____ _____
Signature of Patient Date