EASTMAN-KINGREY CLINIC
WESTLAKE, LA

CONFIDENTIAL HEALTH HISTORY

Date:_____ File:_____

PERSONAL

Name: _____ Sex: M/F 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: _____
Preferred Language: _____E-mail: _____

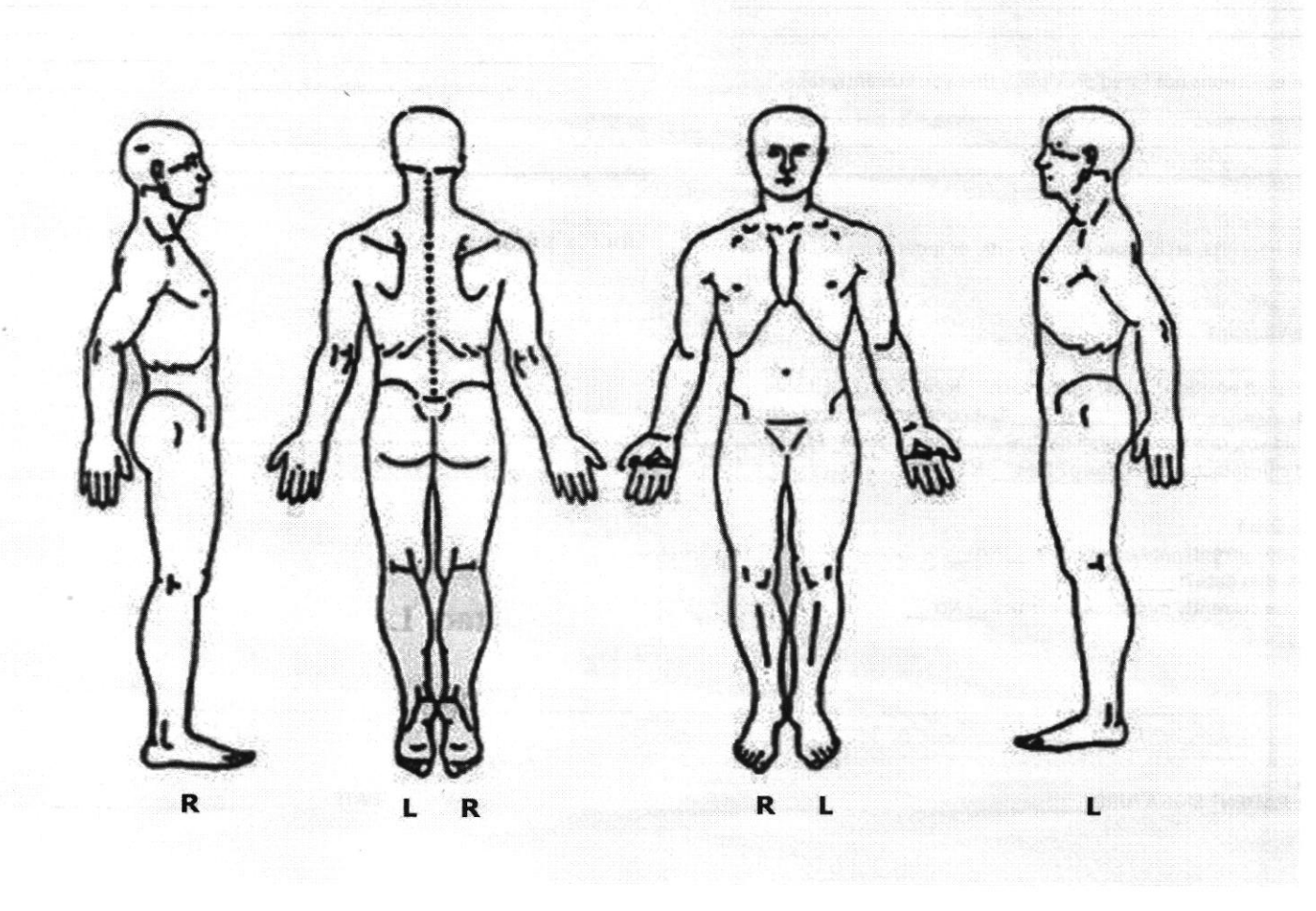
CURRENT CONDITION

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 loss____ Loss of bladder control____ None____

SHOW US WHERE IT HURTS. CIRCLE AREAS ON THE BODY THAT BROUGHT YOU IN TODAY!



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
__ TMI 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

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 take:

_____
_____
_____

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:** _____

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 Charles T. Kingrey, Jr. D.C. and/or Jana Kingrey D.C.

I understand and am informed that, as 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 an 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, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions 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-Kingrey 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 denies or paid at a lower percentage rate due to such policy limitations as yearly maximum payment amounts, yearly number of visit 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

NO CALL-NO SHOW/CANCELATION POLICY

I have been informed of the cancelation policy by the staff/doctors at Eastman Kingrey Clinic. I understand that I am required to cancel and/or reschedule my appointments 24 hours prior to scheduled appointments. Failure to do so will result in a charge of $25.00 to my account. I also understand that a $25.00 charge will be added to my account for failure to appear for any scheduled appointment without communication to our office (no call-no show). For an existing patient with a new condition or new patient appointment requiring an exam and x-rays, a no call-no show charge of $50.00 will added to accounts if failure to appear without communication with our office. By signing this form, I understand the terms of the Cancelation Policy and the charges that would be applies to my account without compliance.

_____

Patient 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

CONSENT TO TREAT MINOR CHILD

I hereby authorize Dr. Charles T. Kingrey, Jr. and/or Dr. Jana Kingrey 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

EXPLANATION OF CHIROPRACTIC MEDICARE BENEFITS

***MEDICARE COVERS 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 limited to 12 (twelve) per calendar year.
Your condition may require, in our judgement, 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 will decide in your case.

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

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**

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 descries 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% Asssistance

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

0	1	2	3	4
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain; 25% Of The Day	Intermittent Pain; 50% Of The Day	Frequent Pain; 75% Of The Day	Constant Pain; 100% Of The Day

8. Lifting

0	1	2	3	4
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With Any Weight

9. Walking

0	1	2	3	4
No Pain; Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain With All Walking

10. Standing

0	1	2	3	4
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain With Any Standing

Patient Signature _____ **Date** _____

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 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 each week. 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 patient and the insurance company.** Insurance companies often send a payment directly to the clinic for services rendered to the patient and the funds are applied to your account balance for the specific days of service. On occasion, the insurance company will send payment to the patient. If this occurs, you can choose to: 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 our 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 initial 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. 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, exams 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 and they will not reimburse if there is no medical necessity or for maintenance.

_____ **Medicaid:** I am eligible for Medicaid, and I understand I am responsible for services not covered by Medicaid. I understand that I will be approved for so many visits and any visit unapproved will be my responsibility to pay at time of service.

_____ **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 Printed	**Patient/Guardian Signature**	**Date**

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 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 your 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 to give 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 (Print) **Personal Representative Signature**

_____

Description of Personal Representative's authority to act for the patient