

# Welcome

## Patient Information

Date \_\_\_\_\_  
Name \_\_\_\_\_  
Prefer to be called \_\_\_\_\_  
Address \_\_\_\_\_  
City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: (h) \_\_\_\_\_ (cell) \_\_\_\_\_  
e-mail \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
 Single  Married  Divorced  Separated  Widowed  
Spouse \_\_\_\_\_  
Do you have Children  Yes  No How Many? \_\_\_\_\_  
Referred to this office by \_\_\_\_\_

## Employment Information

Employer \_\_\_\_\_  
Address \_\_\_\_\_  
City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Occupation \_\_\_\_\_

## Insurance Information

Ins Company \_\_\_\_\_  
Type:  Health  Auto  Worker's Comp  Medicare  
\*Please bring your insurance card and ID to your first visit  
 I hereby authorize assignment of insurance benefits  
directly to provider for services rendered

## Emergency Contact

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone \_\_\_\_\_  
Who is your medical Doctor? \_\_\_\_\_  
Office location \_\_\_\_\_

## Account Information

Person Responsible for Account \_\_\_\_\_  
Relationship \_\_\_\_\_  
Billing address if different from patient address  
\_\_\_\_\_  
City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_

## Patient Condition

Reason for visit \_\_\_\_\_ When did your symptoms appear? \_\_\_\_\_  
Is this due to an accident?  Yes  No If Yes:  Auto  Work  Sports  Other \_\_\_\_\_  
Have you had this condition before?  No  Yes when \_\_\_\_\_  
Describe your complaint and its location \_\_\_\_\_  
Is it getting worse?  Yes  No  Constant  Comes and goes  Chronic  
Rate your pain: 0 = no pain 10 = unbearable 0 1 2 3 4 5 6 7 8 9 10  
Does it interfere with daily activities?  No  Yes explain \_\_\_\_\_  
Do you have  Numbness  Tingling Location \_\_\_\_\_  
What have you tried to relieve the problem(s)? \_\_\_\_\_  
Have you seen anyone else for this condition?  No  Yes Who? \_\_\_\_\_  
Have you ever been treated by a chiropractor?  No  Yes Dr's Name and location \_\_\_\_\_

Patient Health History

Are you currently taking any of the following? (Please list and give reason for taking)

Prescription medications \_\_\_\_\_

Over the counter medications \_\_\_\_\_

Vitamins/supplements \_\_\_\_\_

Do you currently have or have had any of the following diseases/medical condition? Check  Yes or No

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart attack            | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies          | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures/Epilepsy       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital heart defect | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble      | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis               |
| <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure     | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Fibromyalgia            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Low blood pressure      | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease   | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatoid arthritis    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Headaches               | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers/Colitis     | <input type="checkbox"/> Y <input type="checkbox"/> N Pneumonia               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart surgery           | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes           | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing trouble         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker               | <input type="checkbox"/> Y <input type="checkbox"/> N HIV/AIDS           | <input type="checkbox"/> Y <input type="checkbox"/> N Digestive problems      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness/Fainting      | <input type="checkbox"/> Y <input type="checkbox"/> N Miscarriage        | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Vision problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Pinched nerve           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid problems   | <input type="checkbox"/> Y <input type="checkbox"/> N Fractures               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Prostate trouble        | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis          | <input type="checkbox"/> Y <input type="checkbox"/> N Implants _____          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Appendicitis            | <input type="checkbox"/> Y <input type="checkbox"/> N Gout               | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer/tumors *         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Low back pain           | <input type="checkbox"/> Y <input type="checkbox"/> N Polio              | * Type _____  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Neck pain               | <input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox        | Date of diagnosis _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                  | <input type="checkbox"/> Y <input type="checkbox"/> N Scoliosis          | Treatment _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing    | <input type="checkbox"/> Y <input type="checkbox"/> N Mental illness     | Current status _____  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema               | <input type="checkbox"/> Y <input type="checkbox"/> N Multiple sclerosis |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                  | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis       |   |

Please list any other serious medical condition(s) you have ever had \_\_\_\_\_

List any surgeries/treatment/hospitalizations with dates \_\_\_\_\_

List any past serious accidents/injuries/broken bones/dislocations with dates \_\_\_\_\_

Family health history \_\_\_\_\_

Do you participate in any physical activity? \_\_\_\_\_

Do you smoke?  No  Yes How much \_\_\_\_\_ How long \_\_\_\_\_ Do you drink alcohol?  No  Yes \_\_\_\_\_/week

Do you drink coffee/caffeine drinks?  No  Yes Cups/day \_\_\_\_\_

Do you have high stress levels?  No  Yes reason \_\_\_\_\_

Do you wear  Heel lifts  arch supports/orthotics Do you have foot pain?  No  Yes

Does your job require  Sitting \_\_\_\_\_hrs  Standing \_\_\_\_\_hrs  Lifting \_\_\_\_\_lbs

Hours of sleep per night \_\_\_\_\_ Quality  Good  Fair  Poor

For women:

Are you pregnant?  No  Yes \_\_\_\_\_weeks Due date \_\_\_\_\_ Nursing  No  Yes

Are you on birth control?  No  Yes \_\_\_\_\_

**I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.**

Patient / Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

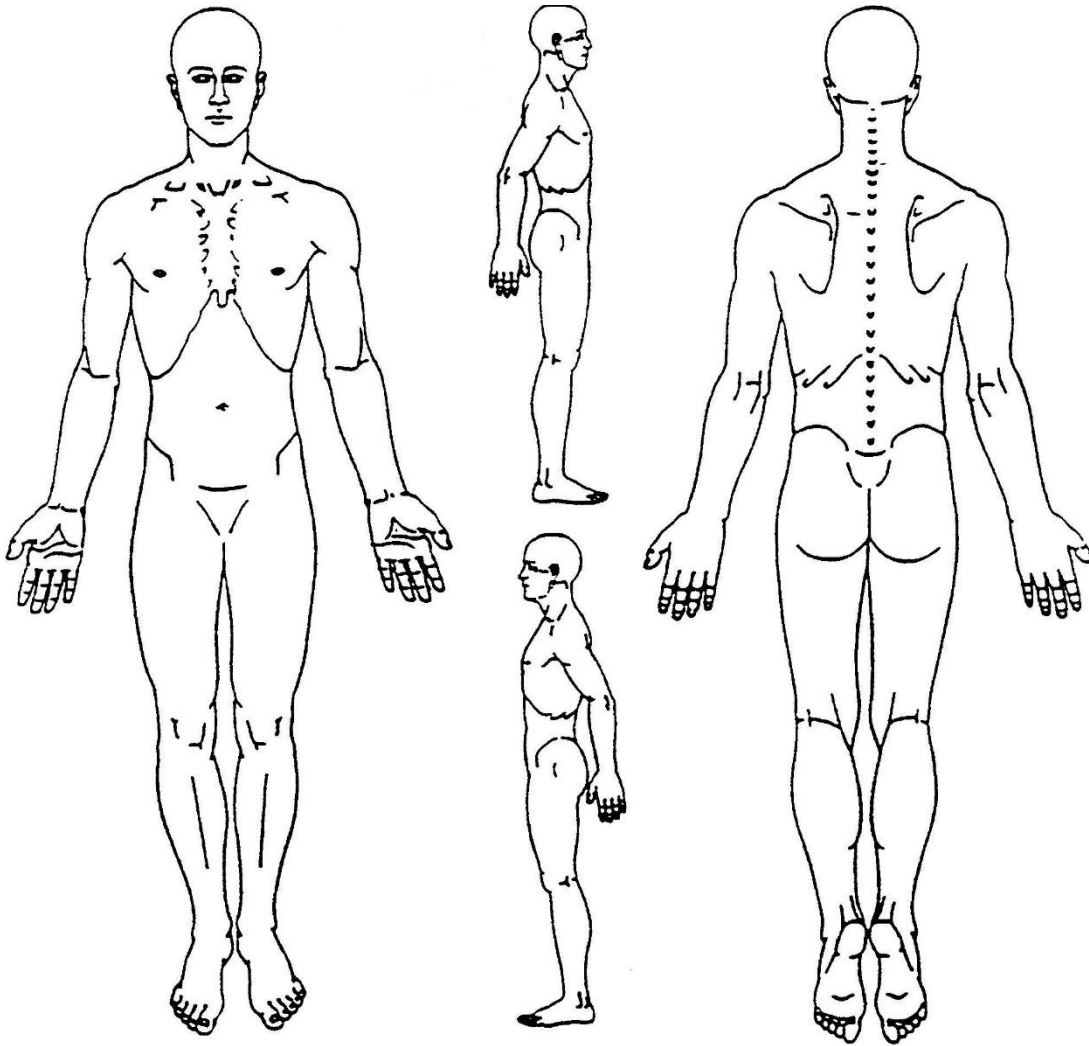
Reviewed by; initials \_\_\_\_\_

Patient Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Patient ID # \_\_\_\_\_

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

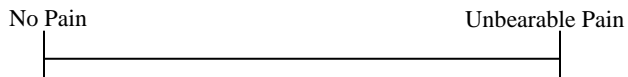
- D** = Dull
- S** = Stabbing/Cutting
- B** = Burning
- T** = Tingling (Pins & Needles)
- N** = Numb
- C** = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

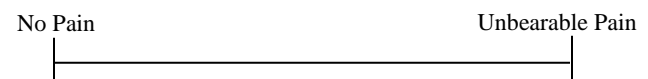
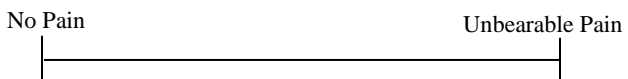
Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain the past week:

Rate your **worst** pain in the past week:



# Informed Consent to Chiropractic Treatment

Terry L. Henderson D.C.  
Douglas P. Krift D.C.  
Philip A. Ryan IV D.C.

**The nature of chiropractic treatment:** The doctor will use his hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, massage therapy, mechanical traction or low-level laser therapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscle strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** the risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can even be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

**Unusual risks:** I have had the following unusual risks of my case explained to me.

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.**

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Terry Henderson D.C., Douglas P. Krift D.C.,  
Philip A. Ryan IV D.C.  
1467 South Fort Thomas Avenue  
(859) 781-8700

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## Financial Policy

All medical charges are the responsibility of the patient or guardian. We offer, as a courtesy to our patients, filing of claims to their health insurance companies. We are network providers with some insurance companies, but not all. If you have questions regarding our network status with your insurance, we recommend that you contact your carrier by calling the customer service number on the back of your card.

**Office Copay:** All deductibles, copays, and co-insurances are the responsibility of the patient and are due at time of service. There will be a \$5.00 fee for billing charges not paid at the time of service. Some insurance companies have office copays that only pay for office visits and **NOT** x-rays, supplements, supplies, etc. For coverage questions, contact the customer service number on the back of your insurance card.

**Authorization:** If your insurance company requires a referral before being seen in our office, it is your responsibility to contact your primary care physician to obtain authorization. Always check with your insurance company to make sure the authorization has been approved.

**Worker's Compensation:** Patients are required to supply us with the following information: Your claim number, date of injury, employer, contact phone number, and billing address. If your claim is inactive, **you** must contact the insurance company to have your claim reactivated before your appointment. If you are changing physicians, have a *change of physician* form turned into your insurance company before your appointment.

**Billing: Know your policy!** You are responsible for any rejected claims, non-covered expenses, deductibles, coinsurance/copays, and medical claims that are over 90 days past due and no response from your insurance company. Each month we send out billing statements to our patients that owe a balance on their accounts. A late fee of \$10.00 will be assessed every billing cycle for all past due balances. Cash, checks, Visa, Discover, or Mastercard can be used to pay accounts with a balance due. When no payment or response has been forthcoming from the patient, the account will be turned over to a collection agency after 120 days. No further medical care will be scheduled until the account is paid in full.

**Self Pay Pricing:** (NO INSURANCE) Patients who do not have, or choose to not use their insurance, because of deductibles, high copays, etc. The first time (new patient) visit will be \$65.00 (not including x-rays). Each subsequent visit will be \$40.00, due at the time of service, \$45.00 if you choose to be billed. **All treatment received after regular business hours will be subjected to an addition \$10.00 fee.**

**NET and CRA:** The services are \$40.00 per 15 minutes and are **NOT COVERED** by **ANY** insurance.

**Massage: Due to limited scheduling time allotted for massage, there is a 50% fee for missed appointments not cancelled 24 hours in advance.**

**Cancellations and No Shows: There will be a \$40.00 charge for missed physician appointments not cancelled at least 3 hours in advance. You MUST call the office to cancel ALL appointments; if we are not in, please leave a message. We DO NOT accept emails or texts for cancellations!**

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Receipt of Notice of Privacy Practices**

**ALTERNATE COMMUNICATION REQUEST FORM**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Print full name)

I wish to be contacted in the following manner (check all that apply):  
By home, cell, or work phone listed in my registration as below.

Home	Cell	Work		Other _____
___	___	___	O.K. to leave message on voicemail	_____
___	___	___	O.K. to leave message with individual	_____
___	___	___	Leave message with call back number only	_____
___	___	___	Do not leave a message	_____

Written Communication

\_\_\_ O.K. to mail to my home address    \_\_\_ O.K. to fax to this number \_\_\_\_\_  
\_\_\_ O.K. to email the email listed on my registration

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I, \_\_\_\_\_, give permission to the following individuals to obtain the indicated  
(Patient name or Responsible Party)  
information:

\_\_\_\_\_ whose relationship is to me \_\_\_\_\_ Phone(\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
(name of person)

\_\_\_\_\_ whose relationship is to me \_\_\_\_\_ Phone(\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
(name of person)

\_\_\_\_\_ whose relationship is to me \_\_\_\_\_ Phone(\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
(name of person)

\_\_\_ Set up or cancel appointments on my behalf.  
\_\_\_ Test results on my behalf.  
\_\_\_ Speak to the doctor/staff in person or by telephone on my behalf.  
\_\_\_ Refill supplements on my behalf.

Effective Date \_\_\_\_\_ Expires \_\_\_\_\_ Revoked \_\_\_\_\_

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It is the responsibility of the patient to notify the physician's office if there is a change in this information.

By signing this waiver, I release the physician and staff therein, from liability for release of information pertaining to my medical care as designated above. I further acknowledge that I have received a copy of the physician's Notice of Privacy Practices.  
Effective date of the notice: 01/01/2010

Terry Henderson D.C.

Douglas P. Krift D.C.

Philip A. Ryan IV D.C.

1467 S. Ft. Thomas Ave., Ft. Thomas, KY 41075

**Terry L. Henderson D.C. Douglas P. Krift D.C.  
Philip A. Ryan IV D.C.**

**NOTICE OF PRIVACY PRACTICES FOR  
PROTECTED HEALTH INFORMATION**

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

**I. Uses and Disclosures**

- B. We may use or disclose your protected health information without your written consent, written authorization, or oral agreement for the following purposes:
- **Treatment.** *Example:* We may use your health information with our office to provide health care services to you or we may use your health information to another provider if it is necessary to refer you to them for service.
  - **Payment.** *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.
  - **Health Care Operations.** *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities
- C. We may use or disclose your protected health information without your written consent, written authorization, or oral agreement under the following circumstances:
- If we provide services to you while you are an inmate.
  - If we provide services to you in an emergency treatment situation.
  - If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
  - If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.
  - If we need to notify, or assist in the notification of, a family member, personal representative, or another person responsible for your care of your location, general condition, or death.
  - If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury, or disability.
  - If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.
  - If we are required to disclose your health information to the Food and Drug Administration.
  - If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.
  - If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect, or domestic violence.
  - If we are required to disclose your health information to a health oversight agency for oversight activities required by law.
  - If we are required to disclose your health information in response to a court order or a subpoena.
  - If we are required to disclose your health information to a law enforcement official.
  - If we are required to disclose your health information to a coroner, medical examiner, or funeral director.
  - For research purposes.
  - If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.
  - If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

**WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.**

## **II. Your Rights**

- **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.
- **Right to Receive Confidential Communications.** You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.
- **Right to Inspect and/or Copy.** You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.
- **Right to Amend.** You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official, and you must provide a reason to support the requested amendment.
- **Right to Receive an Accounting.** You have the right to receive an accounting of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not including the following disclosures:
  - Disclosures made to carry out treatment, payment, and health care operations;
  - Disclosures made to you;
  - Disclosures made in our facility directory;
  - Disclosures made to individuals involved with your care;
  - Disclosures made for national security or intelligence purposes;
  - Disclosures made to correctional institutions or law enforcement officials;
  - Disclosures made prior to compliance date of the HIPAA Privacy Rule.
- **Right to Receive Notice.** You have the right to receive a paper copy of this Notice, upon request.

## **III. Our Duties**

- We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.
- We must abide by the terms of Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

## **IV. Complaints**

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

## **V. How to Contact Us**

If you would like further information about our privacy practices, please contact:

**Terry L. Henderson D.C.**  
**Douglas P. Krift, D.C.**  
**Philip A. Ryan IV D.C.**  
**1467 S. Fort Thomas Ave**  
**Fort Thomas, KY 41075**  
**(859)781-0087**

**EFFECTIVE DATE NOTICE: 01/01/2010**