

The Khoury Centre For Health And Wellness

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Khoury Chiropractic Inc.'s (d.b.a. The Khoury Centre For Health And Wellness) *Notice of Privacy Practices for Protected Health Information*.

Patient Name Printed

Date

Patient Signature

Witness Name Printed

Date

Witness Signature

Confidential Patient Health Record

PERSONAL HISTORY

Name: _____ Business Employer: _____
Address: _____ Type of Work: _____
City: _____ Work Phone: _____
State: _____ Zip/Postal Code: _____
Home Phone Number: _____ Circle One: Single Married Widowed Divorced Separated
Date of Birth: _____ Age: ___ Sex: M F
Social Security Number: _____ Name Of Spouse (If applicable): _____
Drivers License Number: _____ Name of Emergency Contact: _____
Referred To This Office By: _____ Phone Number of Emergency Contact: _____

Who is Responsible For Your Bill, You and Spouse Workers' Comp Auto Insurance Medicare
 Personal Health Insurance Co.: _____ Health Card Number: _____
Insured Person's Name: _____ Insured Person's Date of Birth: _____

CURRENT HEALTH CONDITION

Reason for Visit: _____
Other Doctors Seen For This Condition: Yes No If Yes Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____ Has the Condition Occurred Before? Yes No
Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
Date of Accident: _____ Time of Accident: _____
Have You Made A Report Of Your Accident To Your Employer: Yes No
Drugs You Take Now: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine Insulin Other

Do You Wear a Shoe Lift? Yes No
Do You Suffer From Any Other Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones
 Other _____
Major Accidents Or Falls: _____
Hospitalization (Other Than Above): _____
Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please circle the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?
 1. High Blood Pressure (hypertension) Yes No
 2. Hardening of the arteries (arteriosclerosis) Yes No
 3. Diabetes Yes No
 4. Heart or blood vessel diseases Yes No
 5. Bone spurs on the neck bones (cervical spondylosis) Yes No
 6. Whiplash injury (flexion-extension injury) (cervical spine) Yes No
 7. Have any of your relatives suffered a stroke? Yes No
 8. Were you ever a smoker? If yes, from _____ to _____ Yes No
 9. Do you take any medications on a regular basis? Yes No
 - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)

 - 10. (Women Only) Have you ever taken oral Contraceptives? Yes No
 - If yes, from _____ to _____

 - Have you ever had any of the following, even short, temporary attacks, in the last year?
 1. Blurred Vision Yes No
 2. Double Vision Yes No
 3. Diminished or partial loss of vision in one or both eyes? Yes No
 4. Complete loss of vision in one or both eyes? Yes No
 5. Ringing, buzzing or any noise in the ear(s)? Yes No
 6. Hearing loss in one or both ears? Yes No
 7. Slurred speech or other speech problems? Yes No
 8. Difficulty swallowing? Yes No
 9. Dizziness? Yes No
 10. Temporary lack of understanding? Yes No
 11. Loss on consciousness, even momentary blackouts? Yes No
 12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? Yes No
 13. Any other abnormal sensations in any part of your body? Yes No
 14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? Yes No
 15. Sudden collapse without loss of consciousness? Yes No
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Our purpose at The Khoury Centre For Health And Wellness is to help as many people as possible achieve maximum health through chiropractic care, guidance, and education.

All services are payable at the time they are rendered. We accept cash, checks, Visa and MasterCard. We do not send bills to our patients for personal balances. If you have a treatment schedule for multiple appointments in one week and do not wish to pay each time, you may pre-pay at the beginning of the week. This will save you time at each appointment.

As a courtesy to you we will bill your insurance company for their portion of the bill. Any checks sent to you by mistake must be brought into our office within 3 days. Failure of a patient to make payment will result in unnecessary upset.

Worker's compensation and auto accident patients will be expected to supply this office, in a timely manner, with any and all information necessary to file your claims.

I hereby authorize the Doctor to treat my condition, as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____ **Date** _____