**Kinsley Chiropractic Center**

***Kris Kinsley, DC***

551 Broad Street \* Waverly, NY 14892 \* (607) 565-9212



Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/St/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact/relationship/phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_ft \_\_\_\_in. Weight: \_\_\_\_\_ lbs. Blood Pressure: \_\_\_\_\_/\_\_\_\_\_ Who referred you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke currently? Yes or No If yes, how much?: \_\_\_\_\_/day Have you ever smoke before? Yes or No

Do you have or have you ever had any of the following? *Circle all that apply* *Please explain for any circled responses below*

|  |  |  |  |
| --- | --- | --- | --- |
| Y | N | Heart Problems (*high BP, MI, Pacemaker, etc*) |   |
| Y | N | Ears, Nose, Throat Problems |  |
| Y | N | Lung or Breathing Problems (*Asthma, COPD, Emphysema, etc*) |  |
| Y | N | Stomach or Intestinal Problems (*Colitis, Crohns, Diverticulitis, etc)* |  |
| Y | N | Bone Problems *(Osteoporosis, Rheumatoid, etc)* |  |
| Y | N | Skin Problems (*Psoriasis, Eczema, etc*) |  |
| Y | N | Neurological Problems *(Stroke, MS, Parkinson’s, Epilepsy, ALS, etc)* |  |
| Y | N | Fever, Night Sweats, Chills, Fatigue, Loss of Appetite |  |
| Y | N | Diabetes (*Type I or Type II*) ,Thyroid (*Hyper or Hypo*) |  |
| Y | N | Anemia |  |
| Y | N | Cancer |  |
| Y | N | Surgeries |  |
| Y | N | Drug Allergies |  |

List of Current Medications including dosages (*PLEASE PRINT*) :

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Name of Medication | Dosage |  | Name of medication | Dosage |
| 1 |  |  | 5 |  |  |
| 2 |  |  | 6 |  |  |
| 3 |  |  | 7 |  |  |
| 4 |  |  | 8 |  |  |

We invite with you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with the business manager. If your account is not paid in 90 days of the date of service and no arrangements have been made, you will be responsible for any expenses incurred in collecting your account (including any late charges). It is your responsibility to supply us with the correct insurance information. If this information is not correct and your insurance does not pay due to incorrect information supplied by you, you will be responsible for any charges incurred. You will be responsible for any charges billed to your insurance company that are not covered by your insurance company such as spinal exams, cold laser therapy, PEMF therapy, warm pack therapy, and or spinal decompression, even if your insurance company states you are not responsible for these services. A $30 returned check fee will be applied to insufficient funds from your bank.

MVP, Cigna, Medicare & Medicare replacement patients will be charged an initial $50 exam fee that is not covered by your insurance company. This will not be billed & must be paid up front. If your insurance company does not cover an exam fee, regardless of insurance company you will be responsible for that fee, even if they state you are not responsible.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the provider to release any information necessary to process insurance claims or to obtain medical records including radiology reports on my behalf. I have read and 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, address change or insurance. I accept chiropractic care from Kinsley Chiropractic Center on this basis

**\*Who do you authorize access to your records, Name & phone #s?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print Name) (Signature of patient or guardian)

I authorize Dr. Kris Kinsley or staff to administer such procedures and treatment as they deem necessary, to my son or daughter or ward of custody.

Relationship to minor child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witnessed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (mother, father, grandparent, legal guardian)

**Kinsley Chiropractic Center**

**Notice of Privacy Practices (Effective 10/08/2012)**

**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.**

**Our Pledge to You**

The Health Care providers at Kinsley Chiropractic Center in partnership with physicians, other health care providers and agencies. These privacy practices will be followed by: any health care provider who treats you at any location by all employees and staff, any business associate or partner who agrees to maintain your privacy.

**Some Ways Your Medial Record May Be Used or Shared**

We may use or share medical information about you:

 For treatment such as referral to a specialist or other health care agency

 For payment, such as your insurance company, Medicare, Blue Cross, Etc

 For health care functions, such as to improve our services

 For regulatory agencies, such as during an audit or survey of our facilities

 With those whom you designate to be involved in your care

 In an emergency or disaster, so that family or friends can be told where you are or how you are

 When required for public health reports, abuse or neglect reports, funeral arrangements, or organ donation

 When required by law, such as a request from law enforcement or legal order

 When required by military authorities, if you are a member of the military or are a veteran

**Uses and Disclosures That Require Your Authorization**

In any other situation, not covered by this notice, we will get your written authorization before using or shsaring your health information. You make revoke any authorization in writing.

**Your Rights Regarding Medical Information About You**

In most cases, you may review and obtain a copy of your medical records. There may be a fee for the cost to copy and mail it. Your request must specify how or where you wish to receive your medical records. We will honor all reasonable requests.

**Changes To Kinsley Chiropractic Center Privacy Notice**

We may change our privacy policies at any time. Changes will apply to new medical information. Before we make major changes in our policies, we will post the change in our office. You can get a copy of the current privacy notice at any time. The effective date is listed just below the title.

**Complaints & Appeals**

You may contact the Kinsley Chiropractic Privacy Officer if you think that your privacy rights have been violated or you disagree with our decision about access to your records.

We will not punish you in any way for filing a complaint. You may also send a written complaint to the US Department of Health and Human Services of Civil Rights.

 Privacy Officer Officer of Civil Right

 Kinsley Chiropractic Center US Dept of Health & Human Services

 551 Broad St. 1961 Stout St. #1428

 Waverly, NY 14892 Denver, CO 80294

**I have read and understand the Notice of Privacy Practices**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Signature) (Date)**