Welcome to Kay Chiropractic

Registration and History

Name_____Social Security #_____
Address_____City_____State_____Zip_____
Date of Birth___/___/___Age_____Number of Children_____Marital Status_____
Home Telephone(___)_____Employer_____Work#(___)_____

Would you like us to contact your employer about our free Health Safety and Stress Talk? (Yes / No)
If Yes? Contact Person_____ Phone #(___)_____
Health insurance? (Yes /No) If yes, please list:_____ Policy #_____
Whom may we thank for referring you?_____
Email address_____

Health Information

Have you had previous chiropractic care? Yes_____No_____
Main Complaint_____
Other Complaints_____
How long have you had this condition?_____
Were these conditions cause by a Auto or Work accident? (Yes/ No)
Have you had similar conditions in the past? (Y/N)
What aggravates this condition?_____
Have you been treated by another medical doctor for this same condition?_____
Are you currently taking any medications? Yes__No___ If yes, please list_____
_____
What helps your symptoms?_____

Have you had any surgery, falls or accidents?
Yes___No___When?_____
Please
describe:_____
_____
_____
_____
Date of last physical
examination_____

Symptom Checklist

Abdominal Pain	Yes___ No___	Hip or Leg Pain	Yes___ No___
Anemia	Yes___ No___	Insomnia	Yes___ No___
Arm/Shoulder Pain	Yes___ No___	Kidney Problems	Yes___ No___
Bladder Problems	Yes___ No___	Lung or Bronchial Disorder	Yes___ No___
Circulatory Problems	Yes___ No___	Memory Problems	Yes___ No___
Depression	Yes___ No___	Neck Pain	Yes___ No___
Diabetes	Yes___ No___	Nervousness	Yes___ No___
Dizziness	Yes___ No___	Numbness	Yes___ No___
Fatigue	Yes___ No___	Palpitations	Yes___ No___
Headaches	Yes___ No___	Prostate Disorder	Yes___ No___
Heart Problems	Yes___ No___	Sinus Problems	Yes___ No___
High/Low Blood Pressure	Yes___ No___	Swollen Joints	Yes___ No___

I understand and agree that the health and accident insurance are an arrangement between an insurance carrier and me. Furthermore, I understand that the chiropractor will prepare any necessary reports and forms to assist me in obtaining payment from my insurance company and that any amount authorized will be paid directly to the chiropractor and credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if termination or suspension of treatment occurs, total payment for services rendered, which I am held accountable for will be due immediately.

Patient Signture_____Date_____

This notice describes how Chiropractic and Medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at Kay Chiropractic Clinic, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you to further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).

- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances.

- If we are providing health care services to you based on the orders of another health care provider. If we have provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information other than as outlined above will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and protected health information therein. We are also required to prove you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities or if you would like further information on our privacy policies submit your request in writing to:

Dr. Demerius Ware
30827 Hoover Rd, Warren MI 48093

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Printed Please)	Signature	Date

If you are a minor, or if you are being represented by another party.

_____	_____	_____
Representative (Printed Please)	Signature	Date

Description of the authority to act on behalf of the patient.

Kay Chiropractic
30827 Hoover Rd.
Warren, MI 48093

Patient authorization for appointment reminders and scheduling related matters.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointment, re-evaluations or other appointment related issues. The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information your decision will have no adverse effect on your care at Kay Chiropractic Clinic or on your relationship with our staff. Your signature indicates your authorization of this activity.

_____	_____	_____
Name (Printed)	Signature	Date

This authorization may be revoked at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Patient authorization for contact regarding chiropractic care, related health services and/or related health products.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops and products. The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care. If you choose not to authorize this information use, our decision will have no adverse effect on our care from Kay Chiropractic Clinic or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____	_____	_____
Name (Printed)	Signature	Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Kay Chiropractic _____

Consent for Treatment

I _____ do hereby the doctors of Kay Chiropractic Clinic, Dr. Demerius Ware to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with spine though the use of spinal adjustments and rehabilitative exercises for the solo purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personal the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the service provided, and agree to ensure full payment of all charges. I further understand that fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I 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 then known, and is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intent this consent form to cover the entire course of treatment for my present condition and for any future conditions (s) for which I seek treatment.

Signature _____ Date_____

(If under age 18) Parent's signature

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Signature_____ Date_____
(If under age 18) Parent's signature

Kay Chiropractic

30827 Hoover Rd., Warren, MI 48093
586-751-8984

Treatment of Minor Consent

I hereby authorize Dr. Demerius Ware and whomever he may designate as assistants to perform diagnostic tests and render chiropractic adjustments and other treatment to **MY MINOR CHILD: _____.**

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date: _____ Signature: _____

Witness: _____ Printed Name: _____

Relationship to Patient: _____