CONSENT TO TREAT

I do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

The practice of chiropractic includes many standard examination procedures. These include physical therapy examination, orthopedic and neurological testing, palpation, specialized instrumentations, laboratory tests, radiological examinations, physical therapy and rehabilitative procedures. Additionally there is a procedure unique to the chiropractic profession- the chiropractic spinal adjustment. Adjustments may be preformed on joints of the spine and extremities.

Although spinal adjustments are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: Soreness, dizziness, fractures/joint injury, stroke.

Along with the doctor's examination, I have completed a case history and have discussed my past history to minimize the risk of any complication from treatment and I freely assume these risks.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm.

I am aware of reasonable alternatives to these procedures such as rest, home applications of therapy, prescription or over-the-counter medications, exercises, possible surgery, or non treatment.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to me signing this consent form. I have made my decision voluntarily and freely. Having this knowledge, I knowingly authorize Kay Chiropractic to proceed with chiropractic care and treatment.

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

Kay Chiropractic
Michael A. Kay, D.C
6945 Hwy 72 W. Suite D. Huntsville, AL 35806
Phone: (256) 890-0266 Fax: (256) 890-0268

Please Fill Out Completely
Write N/A in any space that does not apply.

Name_____ Age_____ Date of Birth___/___/___ Married____ Single____
(First) (Middle) (Last)

Address_____ City_____ State_____ Zip_____

Home Phone (____)_____ Cell Phone (___)_____ Work Phone (___)_____

SSN_____-_____-_____ Employer_____ E-Mail Address_____

Insurance Company_____ Who referred you to us?_____

Emergency Contact: Name: _____ Relationship:_____ Phone Number:_____

Female Patient: Are you Pregnant? _____ Yes _____ No

Name of Insured_____ Date of Birth____/____/____ SSN _____-_____-_____
(First) (Middle) (Last)

Insured's Employer _____ Insured's Phone Number _(_____)_____

Spouse's Name_____ Age_____ Date of Birth_____/_____/_____
(First) (Middle) (Last)

SSN_____-_____-_____ Employer_____ Employer's Phone (_____)_____

Spouse's Insurance Company _____

Authorization and Assignment of Benefits

? You, Kay Chiropractic and Dr. Michael A. Kay, are authorized by me to release any information you deem appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred at Kay Chiropractic by me. I also request a payment of government benefits either to myself or to the party who accepts the assignment on the HYFCA-1500 form used to file my insurance.

? I authorize payment of medical benefits to the physician or supplier listed on the HFCA-1500 form used by Dr. Kay and Kay Chiropractic for services described to the said HFCA-1500 form.

? I authorize and assign the direct payment to Kay Chiropractic of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

? I give assignment and lien against any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.

? In the event that any insurance company obligated by contractual agreement to make payment to me or to you, for the charges made for you services refuses to make such payment upon demanded by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see it fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit.

? If the insurance payment is not received within 60 days from the time the insurance is filed, I understand that I will be billed for the remaining balance.

? I understand that interest in the amount of 1.5% per month will accrue for any balance over 30 days and that any balance over 90 days will be turned over to collections and I will be responsible for any and all collection and attorney fees. I waive the Statue of Limitations regarding my doctor's right to recover.

Signed_____ Date____/____/_____

Kay Chiropractic

Chiropractic Case History

Name_____ Date_____

Have you ever received Chiropractic care? Yes No If yes, when? _____

1. Reasons for seeking chiropractic care:

Is your problem related to an accident? Yes No

If yes, please explain:_____

Type of Accident:_____ Date of Accident:_____

2. Identifying Complaints:

Primary Complaint: _____

Secondary Complaint: _____

Complaint began when and how? _____

Please circle the type of complaint: dull aching sharp burning throbbing deep nagging other: _____

Does this pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade intensity/severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible complaint imaginable)

How frequently is the complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

_____

4. Past Health History:

A. Previous illness you've had in your life: _____

_____

B. Previous injury or trauma: _____

_____

Have you ever broken any bones? Which? _____

C. Allergies: _____

_____

D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/ Date of Delivery	Outcome

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at Death

6. Social and Occupational History:

A. Level of Education:

O high school O some college O college graduate O post graduate studies

B. Job Description: _____

C. Work Schedule: _____

D. Recreational Activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statuses.

Parent or Guardian Signature _____ Date _____

Kay Chiropractic

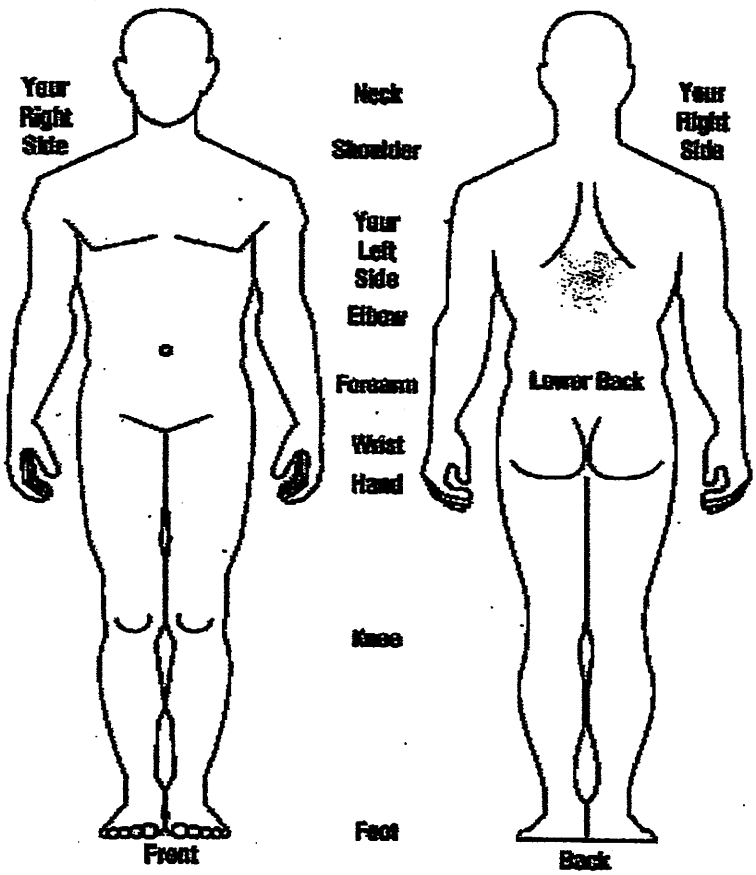
SYMPTOM DIAGRAM

NAME:_____ **DATE:**_____

Please be sure to fill this form out with as much detail as possible. Mark an (X) on each area of pain or symptom. Describe how it feels on the side. Mark any areas of radiating symptoms into head, arms, shoulders, legs, etc.

Symptom Examples:

Sharp
Stabbing
Dull
Stiff/Sore
Throbbing
Burning
Tingling
Pins/Needles
Numbness



VISUAL ANALOGUE PAIN SCALE

NOTE: If you have more than one complaint, please circle that pain scale number and list each symptom above.

1. **What is your pain RIGHT NOW?**

0 1 2 3 4 5 6 7 8 9 10

2. **What is your TYPICAL OR AVERAGE PAIN?**

0 1 2 3 4 5 6 7 8 9 10

HIPPA Notice of Privacy Practices

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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures or Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, you protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose you protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health Issues as Required by Law, Communicable diseases: health oversight: abuse or neglect: Food and Drug Administration Requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance within the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action on reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with the respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in , a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requests and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit, use, and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternate means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any such changes. You then have the right to withdraw as provided in the notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you by filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

I authorize Kay Chiropractic and it's agents to leave information regarding my treatment at Kay Chiropractic to family members, work associates, or others over the telephone. I also authorized Kay Chiropractic and it's agents to leave information regarding my treatment on my home, cellular, and office voicemail and other messaging systems that may be appropriate. This information may include, but not limited to, appointment reminders and incoming calls concerning your treatment and appointment times.

We are required by the law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date: _____