NEW PATIENT ENTRANCE FORM

Welcome to Khouri Chiropractic & Health Solutions, LLC

Welcome! How did you hear about our office? _____

Patient First Name: _____ MI_____ Last Name_____

Social Security # _____ Date of Birth_____

Street Address _____ Apt. #_____

City _____ State_____ Zip Code _____

Phone: (Cell)_____(Home):_____(Work):_____

Email: _____

Marital Status: Single _____ Married_____ Divorced_____ Widowed_____

Occupation: _____ Employer: _____

Health Insurance Company: _____ Policy #: _____

Insured's Name: _____ Insureds Date of Birth: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

What do you enjoy doing most in life?_____

What Brings you into our office?

Main Complaint: _____

Have you been to another doctor for this problem? (Circle One) Yes No Who?_____

On what date did your symptom first appear?_____

Did the symptom appear: (Circle One) Gradually Suddenly Progressively Over Time

What makes the symptom better?:_____

What makes the symptom worse?_____

How would you describe the symptom?: (Circle One) Dull Sharp Ache Numb Cramp Throb Other

Describe other: _____

How much of the day do you feel the symptoms?: (Circle One) 100% 75% 50% 25% 10%

Are symptoms worst during any certain time of the day?_____

On a scale of 1-10, with 10 being the worst, what would you rate your symptoms? _____

Patient Signature _____ Date _____

Khouri Chiropractic & HealthSolutions, LLC

PATIENT HEALTH HISTORYFORM

{Circle yes or no and fill in "type" if applicable)

Family Health History *(Mother, father, sister, grandparents)*

Cancer	Yes	No	Type_____
Heart Disease	Yes	No	Type_____
Diabetes	Yes	No	Type_____
Liver Disease	Yes	No	Type_____
Stroke	Yes	No	Type_____
Arthritis	Yes	No	Type_____
Osteoporosis	Yes	No	Type_____
Other	Yes	No	

Personal Health History

Cancer	Yes	No	
Heart Disease	Yes	No	
Kidney Disease	Yes	No	
Liver Disease	Yes	No	
Diabetes	Yes	No	Type_____
Stroke	Yes	No	
Arthritis	Yes	No	Type_____
Osteoporosis	Yes	No	
Other	Yes	No	
Headaches	Yes	No	How often:_____
Fainting	Yes	No	How often:_____
Dizziness/Vertigo	Yes	No	How often:_____
Loss of Sleep	Yes	No	How often:_____
Rapid Weight Gain	Yes	No	
Rapid Weight Loss	Yes	No	

Musculoskeletal System

Muscle Weakness	Yes	No	
Muscle Twitching	Yes	No	
Swollen/Painful Joints	Yes	No	
Muscle Aches/Spasms	Yes	No	
Neck Pain	Yes	No	
Upper Back Pain	Yes	No	
Middle Back Pain	Yes	No	
Lower Back Pain	Yes	No	
Arm/Hand Pain	Yes	No	
Leg/Foot Pain	Yes	No	
Fractures/Dislocations	Yes	No	

Lifestyle

Do you exercise?	Yes	No	How often:_____
Do you hydrate with water?	Yes	No	How often:_____
Do you smoke?	Yes	No	How often:_____
Do you drink alcohol?	Yes	No	How often:_____
Do you drink caffeine?	Yes	No	How often:_____

Neurological System

Radiating pain in arm	Yes	No
Radiating Leg pain	Yes	No
Numbness in Arms/Hands	Yes	No
Numbess in Legs/Feet	Yes	No
Paralysis	Yes	No
Seizures	Yes	No
Other	Yes	No

Cardiovascular System

High Blood Pressure	Yes	No
Poor Circulation	Yes	No
Chest Pain	Yes	No
Other	Yes	No

Respiratory System

Chronic Cough	Yes	No
Coughing Blood	Yes	No
Difficulty Breathing	Yes	No
Asthma	Yes	No
Wheezing	Yes	No
Emphysema	Yes	No
Other	Yes	No

Psychological History

Anxiety	Yes	No
Depression	Yes	No
ADD/ADHD	Yes	No
Insomnia	Yes	No
Other	Yes	No

Doctor Visits/ Meds/ Supplements

Hopitalizations:_____

_____

Surgeries:_____

_____

Mother Vehicle Accidents:_____

_____

Over-the-Counter Drugs:_____

_____

Medications:_____

_____

Vitamins/Supplements:_____

_____

Last Doctor of Medicine (MD) seen?_____

_____

Last Doctor of Chiropractic (DC) seen?_____

_____

Is there anything else you'd like the doctor to be aware of prior to your visit today?

_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her 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, therapeutic ultrasound or dry needling may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of the bone, muscular strain, ligamentous sprain, dislocations 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 majority 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: 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 between one in one million to one million to one in twenty million, and can be further reduced by screening procedures. The probability of an adverse reaction due to ancillary procedures is also considered “rare."

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

1. Over-the-counter analgesics. The risks of these medications include irritation to the stomach, liver, kidneys, and other side effects in a significant number of cases.
2. 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.
3. Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
4. Surgery in conjunction wit h medical care adds the risk 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 adhesion 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 herby give my full consent to treatment.

Printed Name	Signature	Date

Khouri Chiropractic & Health Solutions, LLC

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective, April 14, 2003, the Federal law known as Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and wi ll collect in the future .

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the Information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your Information in connection with your treatment. For example, we may make a referral to or consult with another chiropractor or other health care professional and make disclosures of your Information in connection with providing or coordinating your treatment.

PATIENT ACKNOWLEDGMENT

Please sign this form below under the heading " Patient Acknowledgement" to acknowledge that you have today received a copy of our Privacy Practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature Patient Name (Please Print)

_____

Date

PATIENT CONSENT

Please sign this form below under the heading "Patient Consent" to acknowledge that you have received a copy of our Privacy Practices.

I consent to your disclosures of my information that you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____

Patient Signature Patient Name (Please Print)

_____

Date

Khouri Chiropractic & Health Solutions LLC

Doctor's Lien

I (Print Name:)_____, hereby understand that I am directly and fully responsible to Khouri Chiropractic & Health Solutions, LLC for all professional bills submitted for services rendered me and this agreement is made solely for Khouri Chiropractic Health Solutions LLC' s additional protection and in consideration of pending payment.

I understand that payment is expected at the time services are rendered. (Initial Here:)_____

If coverage for services are denied by insurance carrier, I understand I am financially responsible to Khouri Chiropractic & Health Solutions, LLC for the balance in full. (Initial Here:) _____

If I am on an extended payment plan approved by the Khouri Chiropractic Staff, I will make timely payments not to exceed 30 days between payments and no less than 25% of my total balance including that day's services.

Patient Signature _____ Date_____

Cancelled/ Rescheduled Appointments

At Khouri Chiropractic, we strive to accommodate as many patients as possible in a safe and efficient manor, in order to best serve you and others. We ask that you call or email us if you need to reschedule or cancel your upcoming appointment.

For massage therapy appointments, there is a penalty for not notifying us of any changes prior to 24 hours or more of your scheduled appointment. If we are notified within 24 hours of a cancellation or rescheduling of your massage therapy appointment, **we will charge you 100% for the massage therapy treatment**. Please understand that this not only allows for as many clients to be served through massage therapy, but it also enables massage therapists to be compensated for their time.

Please sign below acknowledging that you understand the consequences of late cancellation.

Patient Signature _____ Date_____

Khouri Chiropractic & Health Solutions, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH I INFORMATION ABOUT YOU MAY BE USED AND DISCOISED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HELATH INFORMATION IS IMPORTANT TO US.

In the course of your care as a patient at Khouri Chiropractic & Health Solutions 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 for further diagnosis, assessment, or treatment.
- Your health records as well as your billing records may be disclosed to another party, such as an insurance carrier, a HMO, a PPO, or your employer (if they are 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 for other health related information that may be of interest to you.

If you are not available to receive an appointment reminder, a message may be left on your answering machine or voicemail. Further, you have the right to Inspect or obtain a copy of the information we use for these purposes. You also have t he right to refuse to provide 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 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 judgement, 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 described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the ti me 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 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 the record was created or for as log as the information remains in our files. In addition, you have the right to request an amendment to your health information. Request 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 to protect the health information therein. We are also required to provide 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 passible following the changes. Any change in our privacy notice will apply for all your health information in our files.

Information that we use to disclose based on this privacy notice may be subject to re-disclosure by the person or persons 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 activities or any aspect of our privacy activities, you should direct your complaint to:

Dr. Stephen Khouri, D.C.

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

Dr. Stephen Khouri, D.C.

This notice is effective as of November 2010. This notice, and any alterations or amendments made hereto, will expire seven years after the date to which the record was created. My signature on the Patient Acknowledgement and Consent Form acknowledges that I have received a copy and understand this notice.