OFFICE POLICY AND PROCEDURE

_____ **1.** All new patients must complete the ***Patient Health History*** form and sign the ***Notice of Privacy Practices*** as well as and the ***Patient Agreement*** form.

_____ **2.** You will have a consultation with the doctor to discuss your health issues.

_____ **3.** Preliminary screening tests will be performed to help determine if you are a candidate for our treatment. If you are not accepted as apatient, we will assist you in locating the type of physician or specialist we feel your condition requires.

_____ **4.** Additional diagnostic examinations, such as laboratory tests, neurological and orthopedic tests, kinesiological exams, xrays, blood and urinalysis may also be required.

_____ **5.** If you should require immediate medical attention, emergency first aid will be administered and 911 will be called.

_____ **6.** The doctor will review with you all of the findings, explain their significance and make recommendations for treatment. We welcome family members to attend the **Report Of Findings** at your request. Patients that respond the best are those who learn to help themselves. Our job is to help you do so.

_____ **7.** Treatments begin and continue as scheduled until your condition is fully corrected, or until the maximum possible improvement is obtained. If you do not respond to treatment, or are dissatisfied with your progress, you may stop taking treatment at any time without further financial obligation, (except for services previously rendered). In addition, upon request, your case records will be made available for review, by the physician of your choice.

_____ **8.** Payment is required at the time the above service is performed. We accept cash, checks and most major credit cards. In Pennsylvania, South Carolina and Virginia we will supply you with a super bill for you to submit to your insurance for possible reimbursement. Not all insurances cover our treatments; you are responsible for all charges. We are NOT participating providers of any insurance programs including Medicare and Medicaid. We do not accept Personal Injury or Workman's Compensation cases.

_____ **9.** We reserve time especially for you. If you are unable to keep your appointment, please let the office know at least 24 hours in advance so other patients who are waiting for appointments may utilize this time. A charge of $50.00 will be made unless the office receives the required notice.

A good relationship can only be maintained through open lines of communications. Please feel free to ask any questions and discuss any topics. We are here for YOU!

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATOIN IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credential activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any tie. Your revocation will not affect any use or disclosures permitted by our authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for

any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant tot the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, xrays, or other similar forms of health information.

Marketing HealthRelated Services: We will not use your health information for marketing communications without your written authorization. Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at and get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable costbased fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page. $10.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in

this format. If you prefer, we will prepare a summary or an explanation of your health information for a

fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. If you request this accounting more than once in a 12month period, we may charge you a reasonable, costbased fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website, or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, have questions or concerns, please contact us.If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon your request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

By signing below I acknowledge that I have received and reviewed all the information pertaining to the Notice of Privacy Practices. The Doctor is authorized to treat me and will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis.

Date:_____ Name: _____

PATIENT AGREEMENT

_____ I fully understand that Robert J. Kay DC, ND, CNC, Evan G. Kay DC, are not medical doctors, psychologists, acupuncturists or massage therapists. I also understand that they do not diagnose or treat for any specific disease or condition. If I have any disease, health problems or health conditions, I am now being advised to seek qualified medical advice from a licensed physician.

_____ I fully understand that Robert J. Kay DC, ND, CNC is a licensed and practicing Chiropractor in the states of Virginia, Pennsylvania and South Carolina **ONLY**. I fully understand that Evan G. Kay DC is a licensed and practicing Chiropractor in the states of Pennsylvania, Maryland, and South Carolina **ONLY**. I am aware that Dr Robert J. Kay practices as a Naturopath and Nutritional Consultant in the state of Maryland and does not practice Chiropractic or render manipulation. If Chiropractic treatment is needed in the state of Maryland, he will refer you to a licensed Chiropractor in your area.

_____ I am here solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or for any investigative purpose.

_____ I understand Robert J. Kay DC, ND, CNC, Evan G. Kay DC, teach their patients how to build their own health through training in the effective use of lifestyle modification, pollution avoidance, clean air, pure water, proper foods, diet, rest, exercise, goal orientation, positive mental attitude and stress reduction techniques.

_____ I understand Robert J. Kay DC, ND, CNC, Evan G. Kay DC, use Body Energetics Technique (a muscle testing energy technique) to test and treat their patients.

_____ Recommendations, suggestions and references for meals, menus and related purchases as well as taking nutritional supplements is up to the discretion of the patient and is for building the body, increased stamina and energy and general health maintenance and **DOES NOT** involve diagnosing, prognosticating or prescribing for the treatment of any disease or health condition.

_____ I understand that Robert J. Kay DC, ND, CNC, Evan G. Kay DC, are dedicated to educating their patients to help themselves achieve better health with emphasis on education and self care.

_____ I have read and understand what is written above. My signature below signifies that I agree to retain Robert J. Kay DC, ND, CNC, Evan G. Kay DC, to educate me through lecture, Body Energetics Technique, Asyra Testing, HBOT, IonCleanse Detoxification and any other methods they deem useful to help me reach my goal.

Client Signature:_____Date: _____

PATIENT HISTORY

Name: Date:

Address: City:

State: Zip: Home Phone:

Cell Phone: Work Phone:

Email: Date of Birth: Age:

Gender: Marital Referral:

Chief Complaint:

When Did The Condition Begin:

Condition Getting: (circle) Better Worse Constant Comes and Goes

Condition Interfering With: (circle) Work Sleep Daily Routine

Do You Smoke: NO YES What: How Much How Long:

Check off what applies:

	GENERAL		**Low Back Pain**		**Difficult Digestion**
	Allergy		**Neck Pain**		**Abdomen Distension**
	Chills		**Stiffness**		**Excessive Hunger**
	Convulsions		**Pain Between Shoulders**		**Gall Bladder**
	Dizziness		**Pain in Shoulders**		**Hemorrhoids**
	Fainting		**Pain in Arms**		**Intestinal Worms**
	Fatigue		**Pain in Elbows**		**Jaundice**
	Fever		**Pain in Hands**		**Liver Trouble**
	Headache		**Pain in Hips**		**Nausea**
	Loss of Sleep		**Pain in Knees**		**Stomach Pain**
	Loss of Weight		**Pain in Feet**		**Poor Appetite**
	Nervousness		**Pain in Tail Bone**		**Vomiting**
	Depression		**Poor Posture**		**Vomiting Blood**
	Neuralgia		**Sciatica**		
	Numbness		**Spinal Curvature**		**EEN**
	Sweats		**Swollen Joints**		**Asthma**
	Tremors				**Colds**
	Anxiety		**GASTROINTESTINAL**		**Crossed Eyes**
			Gas		**Deafness**

	MUSCLE &		**Belching**		**Dental Decay**
	Arthritis		**Colitis**		**Earache**
	Bursitis		**Colon Troubles**		**Ear Discharge**
	Foot Trouble		**Constipation**		**Ringing in Ears**

	Hernia		Diarrhea		Swollen Glands
	EENT Cont		Poor Circulation		Loss of Pigment
	Enlarged Thyroid		Rapid Heart Beat		
	Eye Pain		Slow Heart Beat		GENITOURINARY
	Failing Vision		Ankle Swelling		Bed Wetting
	Cataracts				Blood in Urine
	Far Sighted		RESPIRATORY		Frequent Urination
	Near Sighted		Chest Pain		Loss of Bladder Control
	Color Blind		Chronic Cough		Kidney Infection
	Gum Troubles		Difficulty Breathing		Kidney Stones
	Hay Fever		Spitting Up Blood		Prostate Trouble
	Hoarseness		Phlegm		Pus in Urine
	Nasal Obstruction		Wheezing		
	Nosebleeds				WOMEN ONLY
	Sinus Infection		SKI		Congested Breasts
	Sore Throat		Boils		Cramps
	Tonsillitis		Bruising		Excessive Flow
			Dryness		Hot Flashes
	CARDIOVASCULAR		Hives		Irregular Cycle
	Arteriosclerosis		Allergy		Menopause
	High B/P		Itching		Painful Menstruation
	Low B/P		Rash		Vaginal Discharge
	Pain Over Heart		Varicose Veins		Pregnant

Check The Following Conditions You Have Had:

	Alcoholism		Epilepsy		Pleurisy
	Anemia		Migraine Headaches		Pneumonia
	Appendicitis		Goiter		Polio
	Arteriosclerosis		Gout		Rheumatic Fever
	Arthritis		Heart Disease		Scarlet Fever
	Cancer		Influenza		Stroke
	Neck/Back Surgery		Lumbago		Tuberculosis
	Cold Sores		Malaria		Typhoid Fever
	Diabetes		Measles		Ulcers
	Dintheria		Miscarriage		STD's
	Eczema		Multiple Sclerosis		Whooping Cough
	Emphysema		Mumps		Immunizations

Please list any other medical conditions you have had (include accidents/illnesses):

_____

_____

_____

Family Health History:

_____
_____
_____

List All Medications:

_____
_____
_____

List All Nutritional Supplements:

_____
_____
_____

Person Responsible For Account:
Name:_____Relationship:_____
Billing Address:_____
Ss#:_____Dl#:_____State:_____
Work Phone:_____
Payment Method:_____CASH_____CHECK_____CREDIT CARD
Credit Card #:_____
Exp Date:_____CVV:_____Billing Zip Code:_____

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the Doctor. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for <u>any and all</u> legal fees, collection agency fees, and any other expenses incurred in collecting this debt. A $25.00 bounced check fee will be assessed for any returned checks. Any unopened/unexpired nutrients can be returned for a credit toward your next visit or another nutrient.

I 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.

Patient Signature:_____Date: _____