

# Kern Chiropractic Center

260 S. Parker St. Marine City, MI 48039  
810-765-9700 Kernchiro.Com kernchiropractic@yahoo.com

## PATIENT INFORMATION

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

Full Name: \_\_\_\_\_  
First MI Last (name you liked to be called)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Female: \_\_\_\_\_ Male: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Home: \_\_\_\_\_ Cell/Other: \_\_\_\_\_

I prefer to receive calls at: \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell

I am: \_\_\_\_\_ Under 18 \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ # Of Children: \_\_\_\_\_

Name of your Primary Care Physician: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone Number: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Work Comp. \_\_\_\_\_ Auto Ins. \_\_\_\_\_ Other

*\*If you have been involved in an Auto accident or a Work injury, please speak to one of the office staff before completing this form.*

## INSURANCE INFORMATION

Do You Have Health Insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Please give the receptionist your insurance card and driver's license so they can be copied.**

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Employer:	Employer:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Relationship to Patient:	Relationship to Patient:

Whom may we thank for referring you? \_\_\_\_\_

Where have you heard about us? \_\_\_\_\_

## HEALTH HISTORY

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List any surgeries and include when? \_\_\_\_\_

Have you had any long term hospitalizations?  No  Yes

If yes, please describe: \_\_\_\_\_

<u>Medications</u>	<u>Allergies</u>	<u>Vitamins/Herbs/Minerals</u>

## FAMILY HISTORY

S=Self

M=Mother

F=Father

\_\_\_\_ TB

\_\_\_\_ Cancer

\_\_\_\_ Mental Illness

\_\_\_\_ Diabetes

\_\_\_\_ Asthma

\_\_\_\_ Heart Disease

\_\_\_\_ Stroke

\_\_\_\_ Kidney Disease

\_\_\_\_ Lung Disease

\_\_\_\_ Blood Disorders

\_\_\_\_ Liver Disease

\_\_\_\_ HIV

\_\_\_\_ Scoliosis

\_\_\_\_ Osteoporosis

\_\_\_\_ Rheumatoid Arthritis

\_\_\_\_ Back Pain

### **PLEASE CHECK ALL CONDITIONS WHICH YOU HAVE OR HAVE HAD IN THE PAST.**

\_\_\_\_ Headaches

\_\_\_\_ Fainting / Dizziness

\_\_\_\_ Heart Attack

\_\_\_\_ Kidney trouble

\_\_\_\_ Shooting Head Pain

\_\_\_\_ Loss of Balance

\_\_\_\_ Heart palpitation

\_\_\_\_ Diabetes

\_\_\_\_ Sinus Trouble

\_\_\_\_ Ringling in Ears

\_\_\_\_ Chest pain

\_\_\_\_ Liver trouble

\_\_\_\_ Hay Fever

\_\_\_\_ Deafness

\_\_\_\_ High BP

\_\_\_\_ Disc Problem

\_\_\_\_ Asthma

\_\_\_\_ Poor Vision

\_\_\_\_ Low BP

\_\_\_\_ Spine curvature

\_\_\_\_ Neck pain/spasm

\_\_\_\_ Eye pain

\_\_\_\_ Abdominal Pain

\_\_\_\_ Tailbone/Pain

\_\_\_\_ Tightness of Throat

\_\_\_\_ Low back pain

\_\_\_\_ Constipation

\_\_\_\_ Painful Joints

\_\_\_\_ Sleeping Trouble

\_\_\_\_ Bursitis

\_\_\_\_ Ulcer

\_\_\_\_ Swollen Joints

\_\_\_\_ Thyroid Trouble

\_\_\_\_ Arthritis

\_\_\_\_ Nervous stomach

\_\_\_\_ Hip pain

\_\_\_\_ Twitching in Face

\_\_\_\_ Leg numbness

\_\_\_\_ Bladder

\_\_\_\_ Sciatica

\_\_\_\_ Fatigue

\_\_\_\_ Poor posture

\_\_\_\_ Gall Bladder

\_\_\_\_ Knee Pain

\_\_\_\_ Depression

\_\_\_\_ Cold hands/feet

\_\_\_\_ Indigestion

\_\_\_\_ Pain legs

\_\_\_\_ Pins & needles/arms

\_\_\_\_ Swollen ankles

\_\_\_\_ Prostate

\_\_\_\_ Groin Pain

\_\_\_\_ Mid Back Pain

\_\_\_\_ Nervousness

\_\_\_\_ Menstrual

\_\_\_\_ Pain in feet

\_\_\_\_ Tightness in Shoulders

\_\_\_\_ Hernia

\_\_\_\_ Anemia

\_\_\_\_ Pinched nerve

## HABITS

\_\_\_\_\_ Smoking

\_\_\_\_\_ Packs/Day

\_\_\_\_\_ None

\_\_\_\_\_ Sitting

\_\_\_\_\_ Alcohol

\_\_\_\_\_ Drinks/Week

\_\_\_\_\_ Moderate

\_\_\_\_\_ Standing

\_\_\_\_\_ Coffee/Caffeine

\_\_\_\_\_ Cups/Day

\_\_\_\_\_ Daily

\_\_\_\_\_ Light Labor

\_\_\_\_\_ High Stress Level. Why? \_\_\_\_\_

\_\_\_\_\_ Heavy

\_\_\_\_\_ Heavy Labor

## EXERCISE

## WORK ACTIVITY

**FOR WOMEN:** Are you pregnant?  No  Yes  Not Sure

If yes, how far along? \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

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.

### **Uses and Disclosures**

Here are some examples of how we might have to use or disclose your health care information:

1. Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer to them for diagnosis, assessment, or treatment of your health condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4. Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

### **Permitted uses and disclosures without your consent or authorization**

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

1. We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
2. We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
3. We are permitted to use your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
4. We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
5. We are permitted to use or disclose your health information in response to a court order, or in response to a subpoena, discovery request, or other lawful purpose.
6. We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries, or to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.
7. We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
8. We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.

# NOTICE OF PRIVACY PRACTICES CONT.

9. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
10. We are permitted to use or disclose your health information if we provide care to you that is related to a work place injury to the extent necessary to comply with Michigan's worker's compensation laws.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

## **Your right to revoke your authorization**

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization.
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

## **Your right to limit uses or disclosures**

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

## **Your right to receive confidential communication regarding your health information**

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

## **Your right to inspect and copy your health information**

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time frame reasonably proximate to your request. There may be a cost associated with your request if we must copy information for you.

## **Your right to amend your health information**

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

## **Your right to receive an accounting of the disclosures we have made of your results**

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

1. Those disclosures required for your treatment, to obtain payment for your services, or run our practice.
2. Those disclosures made to you.
3. Those disclosures we are permitted to make without your consent or authorization as described above.
4. Those disclosures made based on an authorization signed.
5. Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.
6. Those disclosures for national security or intelligence purposes.
7. Those disclosures made to correctional officers or law enforcement officers.

# NOTICE OF PRIVACY PRACTICES CONT.

8. Those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12-months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

## **Your right to obtain a paper copy of this notice**

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

## **Our duties**

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

## **Re-disclosure**

Information that we use or disclose 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

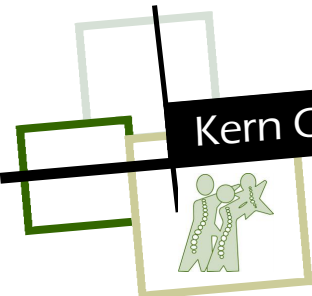
## **Your right to complain**

You may complain to us or the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

## **To contact us**

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

**Kern Chiropractic Center**  
**260 S. Parker St.**  
**Marine City, MI 48039**  
**(810) 765-9700**  
**[Kernchiro.com](http://Kernchiro.com)**



**Kern Chiropractic Center**

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## TERMS OF ACCEPTANCE

**When a client seeks chiropractic health care and we accept a client for such care, it is essential for both to be working towards the same objective.**

Chiropractic has only one goal. It is important that each client understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

**Health:** A state of optimal physical, mental and social well-being, no merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interface to the transmission of mental impulse, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, \_\_\_\_\_ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.  
I therefore accept chiropractic care on this basis.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

### PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am **NOT** pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

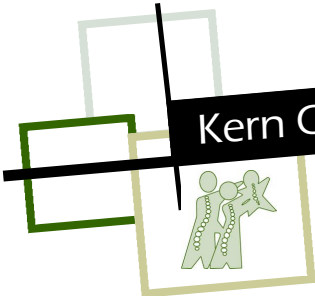
Date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

### CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_  
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_



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## NOTICE OF PRIVACY PRACTICES

It is our desire for our staff to use your name, address, e-mail and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products. In addition this information may be used to remind you about scheduled appointments, re-evaluations or other appointment related issues.

There are several other circumstances in which we may have to use or disclose your health care information:

- To another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- Within our practice for quality control or other operational purposes.

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.

It is the desire of this office to utilize any picture or written testimonial offered for the promotion of chiropractic and our office. We use these in the office in testimonial books as well as on open display boards for other clients and visitors to view. From time to time we utilize these in our office advertising as well.

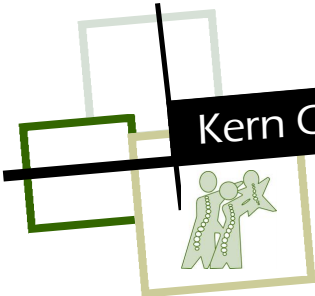
If you choose not to authorize this use your decision will have no adverse effect on your care from this office or on your relationship with our staff.

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or have had the opportunity to read it if I so chose) and understood the Notice.**

**Client Name (please print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Client/Parent or Guardian**

*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.*



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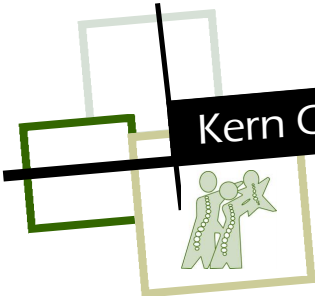
# AUTHORIZATION & ASSIGNMENT OFFICE & POLICY ON COLLECTION OF FEES

In consideration of your undertaking to treat me, I agree to the following:

- You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
- I authorize the direct payment to you of any sum I now or hereafter owe to you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
- In the event my insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) below and authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies processes, whether it is all or part of what is due, I personally owe you.
- We expect you to honor the financial arrangements you make with our office. If you find that you cannot fulfill the agreement you have made with us, advise our office immediately so new arrangements may be made. Any checks sent to your home by the insurance company for payment of your care at our office must be brought or sent to our office within three days of receiving it. When sending any insurance payments to our office, be sure to include any documentation or checks stubs that arrive with the payment. Failure to comply with the above policies or failure to make payment of any overdue account, or to otherwise communicate with our office, will result in collection proceedings and you will be responsible for any legal collection fees.
- Any balances over 30 days old, without a payment made each month, will be charged 4.2% of the outstanding balance.
- If your account is put into collection there will be a fee of \$50.00 for any amount over \$300.00 and \$30.00 fee for any amount under \$300.00. There will be a charge of \$20.00 for returned checks.
- All information regarding no-fault insurance and/or worker's compensation is provided for illustration only, and the accuracy for such information is not warranted by Kern Chiropractic Center or its officers or agents. No information provided herein constitutes legal advice. Clients are advised to consult an attorney with regards to any information regarding their legal rights and legal entitlements.

**Please sign your name below indicating that you have read the above and understand it.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_



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## JOINT TREATMENT AREA AGREEMENT

I acknowledge that Dr. Kern of Kern Chiropractic Center may/will be adjusting me and discussing my condition and treatment regimen in a joint adjusting area.

If I have any questions, wish to be adjusted, or to discuss my health care in private I have the option to schedule a time with the doctor in a private consultation/adjusting room.

I do not wish to be adjusted in the joint adjusting area; I request to be treated in a private room.

**Client Name (please print)** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Client/parent or guardian**