Welcome

Patient Registration: Please print and fill out completely and bring to your first visit

Patient Information

Date _____

Name_____

Prefer to be called_____

Address_____

City/State_____Zip_____

Phone: (h)_____(cell)_____

e-mail_____

Birth Date_____ Age_____ ☐Male ☐Female

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse_____

Do you have Children ☐ Yes ☐ No How Many?_____

Referred to this office by _____

Employment Information

Employer _____

Address_____

City/State_____Zip_____

Phone_____Ext_____

Occupation_____

Insurance Information

Ins Company_____

Type: ☐Health ☐Auto ☐Worker's Comp ☐ Medicare

*Please bring your insurance card and ID to your first visit

☐ I hereby authorize assignment of insurance benefits directly to provider for services rendered

Emergency Contact

Name_____

Relationship_____

Phone_____

Who is your medical Doctor?_____

Office location_____

Account Information

Person Responsible for Account_____

Relationship_____

Billing address if different from patient address

_____

City/State_____Zip_____

Phone_____

Patient Condition

Reason for visit _____ When did your symptoms appear?_____

Is this due to an accident? ☐ Yes ☐ No If Yes: ☐ Auto ☐ Work ☐ Sports ☐ Other _____

Have you had this condition before? ☐No ☐ Yes when_____

Describe your complaint and its location_____

Is it getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes ☐ Chronic

Rate your pain: 0 = no pain 10 = unbearable 0 1 2 3 4 5 6 7 8 9 10

Does it interfere with daily activities? ☐ No ☐ Yes explain_____

Do you have ☐ Numbness ☐ Tingling Location_____

What have you tried to relieve the problem(s)?_____

Have you seen anyone else for this condition? ☐No ☐Yes Who?_____

Have you ever been treated by a chiropractor? ☐ No ☐ Yes Dr's Name and location_____

Patient Health History

Are you currently taking any of the following? (Please list and give reason for taking)
Prescription medications_____
Over the counter medications_____
Vitamins/supplements_____
Do you currently have or have had any of the following diseases/medical condition? Check ☐ Yes or No ☐

☐ Y ☐ N Heart attack
☐ Y ☐ N Congenital heart defect
☐ Y ☐ N High blood pressure
☐ Y ☐ N Low blood pressure
☐ Y ☐ N Headaches
☐ Y ☐ N Heart surgery
☐ Y ☐ N Pacemaker
☐ Y ☐ N Dizziness/Fainting
☐ Y ☐ N Anemia
☐ Y ☐ N Shingles
☐ Y ☐ N Prostate trouble
☐ Y ☐ N Appendicitis
☐ Y ☐ N Low back pain
☐ Y ☐ N Neck pain
☐ Y ☐ N Stroke
☐ Y ☐ N Difficulty Breathing
☐ Y ☐ N Emphysema
☐ Y ☐ N Asthma

☐ Y ☐ N Allergies
☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Kidney problems
☐ Y ☐ N Venereal disease
☐ Y ☐ N Ulcers/Colitis
☐ Y ☐ N Diabetes
☐ Y ☐ N HIV/AIDS
☐ Y ☐ N Miscarriage
☐ Y ☐ N Vision problems
☐ Y ☐ N Thyroid problems
☐ Y ☐ N Arthritis
☐ Y ☐ N Gout
☐ Y ☐ N Polio
☐ Y ☐ N Chicken Pox
☐ Y ☐ N Scoliosis
☐ Y ☐ N Mental illness
☐ Y ☐ N Multiple sclerosis
☐ Y ☐ N Tuberculosis

☐ Y ☐ N Seizures/Epilepsy
☐ Y ☐ N Hepatitis
☐ Y ☐ N Fibromyalgia
☐ Y ☐ N Rheumatoid arthritis
☐ Y ☐ N Pneumonia
☐ Y ☐ N Hearing trouble
☐ Y ☐ N Digestive problems
☐ Y ☐ N Artificial joints _____
☐ Y ☐ N Pinched nerve
☐ Y ☐ N Fractures
☐ Y ☐ N Implants _____

☐ Y ☐ N Cancer/tumors *
* Type _____
Date of diagnosis_____
Treatment _____
Current status_____

Please list any other serious medical condition(s) you have ever had_____
_____
List any surgeries/treatment/hospitalizations with dates_____
_____
List any past serious accidents/injuries/broken bones/dislocations with dates_____
_____
Family health history_____
Do you participate in any physical activity? _____
Do you smoke? ☐ No ☐ Yes How much_____ How long _____ Do you drink alcohol? ☐ No ☐ Yes _____/week
Do you drink coffee/caffeine drinks? ☐ No ☐ Yes Cups/day_____
Do you have high stress levels? ☐ No ☐ Yes reason_____
Do you wear ☐ Heel lifts ☐ arch supports/orthotics Do you have foot pain? ☐ No ☐ Yes
Does your job require ☐ Sitting _____hrs ☐ Standing _____hrs ☐ Lifting _____lbs
Hours of sleep per night _____ Quality ☐ Good ☐ Fair ☐ Poor

For women:
Are you pregnant? ☐ No ☐ Yes _____weeks Due date _____ Nursing ☐ No ☐ Yes
Are you on birth control? ☐ No ☐ Yes _____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

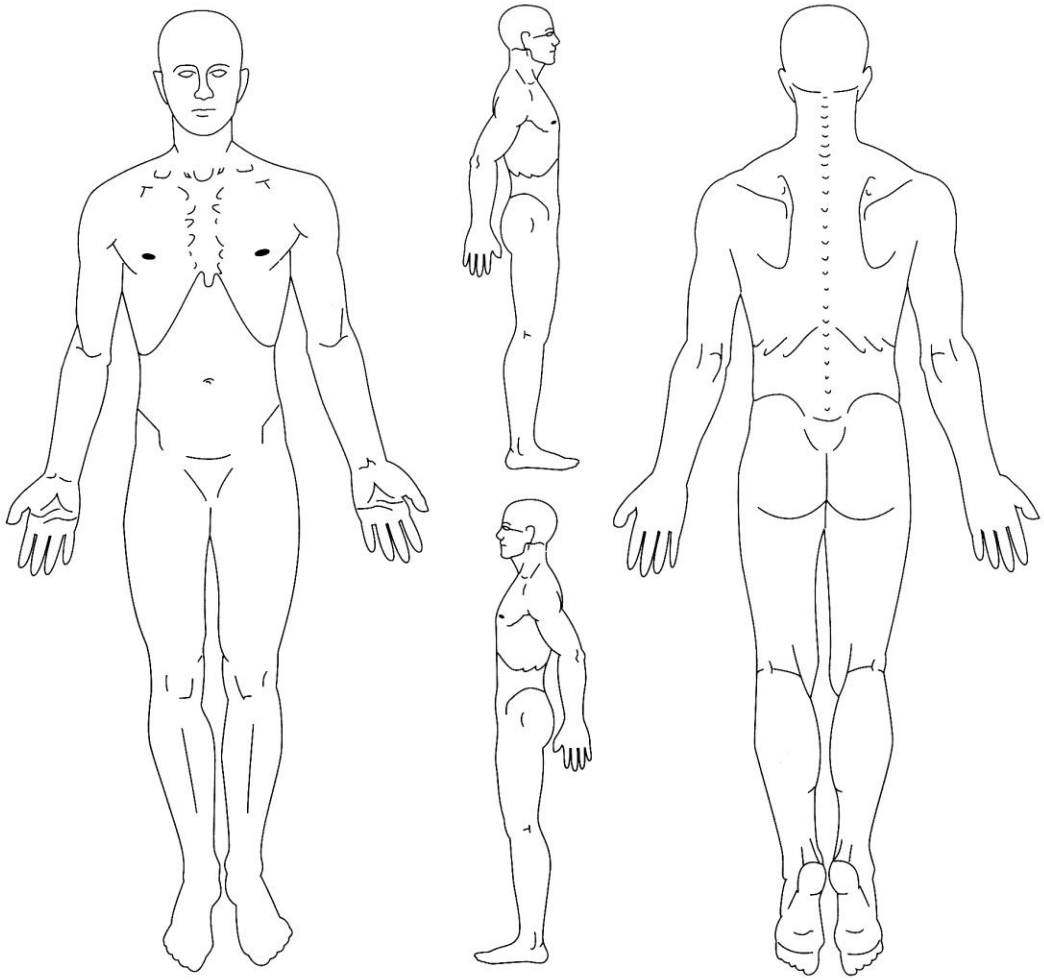
Patient / Guardian signature _____ Date _____

Patient Name(Print)_____ Date_____

Patient ID #_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain

Informed Consent to Chiropractic Treatment

Terry L. Henderson, D.C.
Douglas P. Krift, D.C.

The nature of chiropractic treatment: The doctor will use his 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, massage therapy, mechanical traction or low level laser therapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscle strain, ligamentous sprain, dislocation 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 minority 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 occurring: 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 at one in one million to one in twenty million, and can even be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

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

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *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.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks 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 adhesions, 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.

Print name:_____

Signature:_____ Date:_____

Witness: _____ Date:_____

Receipt of Notice of Privacy Practices

ALTERNATE COMMUNICATION REQUEST FORM

Patient Name _____ Date of Birth ____/____/_____
(Print full name)

I wish to be contacted in the following manner (check all that apply):
By home, cell or work phone listed in my registration as below.

Home- Cell- Work

___ ___ ___ O.K. to leave message on voicemail
___ ___ ___ O.K. to leave message with individual
___ ___ ___ Leave message with call-back number only
___ ___ ___ Do not leave a message

Other_____
_____
_____
_____
_____

Written Communication
___ O.K. to mail to my home address ____ O.K to fax to this number_____
___ O.K. to email the email address listed on my registration

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I, _____ give permission to the following individuals to obtain the
(Patient name or Responsible party)
indicated information:

_____whose relationship to me is _____ Phone (___) ___-_____.
(name of person)

_____whose relationship to me is _____ Phone (___) ___-_____.
(name of person)

_____whose relationship to me is _____ Phone (___) ___-_____.
(name of person)

_____ Set up or cancel appointments on my behalf.
____ Test results on my behalf.
____Speak to the doctor/staff in person or by telephone on my behalf.
____ Refill supplements on my behalf.

Effective Date _____ Expires _____ Revoked _____

It is the responsibility of the patient to notify the physician's office if there is a change in this information.

By signing this waiver, I release the physician and staff therein, from liability for release of information pertaining to my medical care as designated above. I further acknowledge that I have received a copy of the physician's Notice of Privacy Practices.
Effective date of the notice: 01/01/2010.

Terry L. Henderson D.C.

Douglas P. Krift D.C.
1467 S Ft. Thomas Ave.
Fort Thomas, KY 41075

Philip A. Ryan IV D.C.

Terry L. Henderson, D.C. Douglas P. Krift, D.C.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

I. Uses and Disclosures

B. We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes.

- Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.
- Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.
- Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

C. We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

- If we provide services to you while you are an inmate.
- If we provide services to you in an emergency treatment situation.
- If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.
- If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition or death.
- If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.
- If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.
- If we are required to disclose your health information to the Food and Drug Administration.
- If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.
- If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.
- If we are required to disclose your health information to a health oversight agency for oversight activities required by law.
- If we are required to disclose your health information in response to a court order or a subpoena.
- If we are required to disclose your health information to a law enforcement official.
- If we are required to disclose your health information to a coroner, medical examiner or funeral director.
- For research purposes.
- If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.
- If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

II. Your Rights

- Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.
- Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.
- Right to Inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.
- Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.
- Right to Receive an Accounting. You have the right to receive an accounting of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not include the following disclosures:

  Disclosures made to carry out treatment, payment and health care operations;
  Disclosures made to you;
  Disclosures made in our facility directory;
  Disclosures made to individuals involved with your care;
  Disclosures made for national security or intelligence purposes;
  Disclosures made to correctional institutions or law enforcement officials; and
  Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

- Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request.

III. Our Duties

- We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected 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 this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

IV. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

V. How to Contact Us

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

Terry L. Henderson, D.C.
Douglas P. Krift, D.C.
1467 S Fort Thomas Ave
Fort Thomas, KY 41075 (859) 781-8700

EFFECTIVE DATE OF NOTICE: 01/01/2010

Terry L. Henderson D.C., Douglas P. Krift D.C. &
Philip A. Ryan IV D.C.
1467 South Fort Thomas Avenue
(859) 781-8700

Financial Policy

All medical charges are the responsibility of the patient or guardian. We offer, as a courtesy to our patients, filing of claims to their health insurance companies. We are network providers with some insurance companies, but not all. If you have questions regarding our network status with your insurance, we recommend that you contact your carrier by calling the customer service number on the back of your card.

Office Copay: ***Know your policy!*** You are responsible for any rejected claims, non-covered expenses, deductibles, coinsurance/copays, and medical claims that are over 90 days past due and no response from your insurance company. All deductibles, copays, and co-insurances are the responsibility of the patient and are due at time of service.

Worker's Compensation: Patients are required to supply us with the following information: Your claim number, date of injury, employer, contact phone number and billing address.

Billing: Each month, we send out billing statements to our patients that owe a balance on their accounts. **A late fee of $10.00 will be assessed EVERY billing cycle for all past due balances.** When no payment or response has been forthcoming from the patient, the account will be turned over to a collection agency after 120 days. No further medical care will be scheduled until the account is paid in full.

AS OF JULY 1, 2022

Self-Pay Pricing: Those patients who choose not to use their insurance.

- The first visit will be $70.00 (not including x- rays). IF spinal x-rays need to be taken; it will be an additional $55.
- Each subsequent visit will be $45.00.
- **NET and CRA:** These services are $45.00 per 15 minutes
- **ALL treatment received outside of regular business hours will be subjected to an additional $10.00 fee.**
- **There will be a $5.00 fee for all charges not paid at the time of service.**

Cancellations and No Shows

Massage:

- **Due to limited scheduling, we require a 24-hour notice to cancel a massage.**
- **We will charge the FULL fee for the allotted time missed if not cancelled in advance.**

Physicians:

- **We require a 3-hour notice to cancel, there will be a $45.00 charge for appointments not cancelled in advance.**
- **You MUST call the office to cancel ALL appointments; if we are not in, leave a message.**
- **We DO NOT accept emails or text for cancellations.**

Signature_____ Date_____