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 a patient, 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, x-rays, 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. 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.

____ **10.** You have been shown and have read and agree to the **NOTICE OF PRIVACY PRACTICES ACT.**

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!

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 Idaho, Pennsylvania and South Carolina **ONLY**. I fully understand that Evan G. Kay DC is a licensed and practicing Chiropractor in the states of Idaho, Pennsylvania, Maryland, and South Carolina **ONLY**.

_____ 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 life-style 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 understand that Hyperbaric Treatment Center of MD is owned and operated by Kay Chiropractic & Natural Health Care Center, LLC

_____ 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, QEST4 Testing, HBOT, IonCleanse Detoxification, Beautiful Image Microcurrent Face Lift and Body Sculpting 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 Status:** **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 Problem
	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		EENT
	Sweats		Swollen Joints		Asthma
	Tremors				Colds
	Anxiety		GASTRO-INTESTINAL		Crossed Eyes
			Gas		Deafness
	MUSCLE & JOINT		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**		**GENITO-URINARY**
	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		**SKIN**		**Congested Breasts**
	Sore Throat		**Boils**		**Cramps**
	Tonsillitis		**Bruising**		**Excessive Flow**
			Dryness		**Hot Flashes**
	CARDIO-VASCULAR		**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**
	Diptheria		**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:_____

Work Phone:_____

Payment Method:_____**CASH**_____**CHECK**_____**CREDIT CARD**

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 any and all 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 un-opened/un-expired 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:** _____