

**KINETIC CHIROPRACTIC**  
**CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health car information.

- We may have to disclose your health information to another health car provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance companies have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Lisa L. Koenig  
Doctor of Chiropractic  
Board Certified  
Applied Kinesiologist

**IN AN EFFORT TO MAKE THIS OFFICE  
MORE EFFICIENT AND PLEASANT,  
IT WOULD BE GREATLY APPRECIATED IF...**

YOU REMEMBER THAT **YOUR PAYMENT AND THE COST OF ALL SUPPLEMENTS AND SUPPLIES YOU RECEIVE ARE DUE ON THE DAY OF YOUR APPOINTMENT.** AS A COURTESY, WE WILL SUPPLY YOU WITH A SUPERBILL FOR YOUR INSURANCE COMPANY.

YOU UNDERSTAND THAT THERE IS A **48-HOUR CANCELLATION POLICY** IN THIS OFFICE. IF YOU DO NOT GIVE US AT LEAST 48 HOURS NOTICE THAT YOU CANNOT MAKE YOUR APPOINTMENT, YOU WILL BE CHARGED THE **\$100.00 CANCELLATION FEE.** THIS FEE APPLIES TO BOTH MASSAGE AND CHIROPRACTIC APPOINTMENTS.

YOU HAVE HAD ANY NEW ACCIDENTS OR INJURIES SINCE YOUR LAST VISIT; PLEASE INFORM THE RECEPTIONIST PRIOR TO SEEING THE DOCTOR AT THE BEGINNING OF YOUR TREATMENT. IF YOU HAVE MOVED SINCE YOUR LAST VISIT, PLEASE INFORM THE RECEPTIONIST OF YOUR NEW ADDRESS AND TELEPHONE NUMBER.

YOU REMEMBER ON THE DAY OF YOUR APPOINTMENT **NOT TO WEAR COLOGNES OR PERFUMES.** THERE ARE MANY OF US, BOTH STAFF AND OTHER PATIENTS, WHO ARE ALLERGIC TO THESE SUBSTANCES AND MAY SUFFER CONSIDERABLY.

YOU REMEMBER THAT WE, UNFORTUNATELY, **DO NOT HAVE ANY PATIENT PARKING AVAILABLE.**

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**Signature**

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**Date**

Lisa L. Koenig  
Doctor of Chiropractic  
Board Certified  
Applied Kinesiologist

## TERMS OF ACCEPTANCE

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

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

*Adjustment:* The 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:* The state of optimal physical, mental and social well-being, not 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 interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxation or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination if we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. Our only practice is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

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

Oakland, CA 94611 \* 510.909.4190

# CASE HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_ Case Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex:  M  F Marital Status:  S  M  D  W # of Children: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Telephone (Work): \_\_\_\_\_ Ext. \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Spouse's Telephone (Work): \_\_\_\_\_  
 Past Chiropractic Care:  Yes  No When? \_\_\_\_\_ Doctor's Name: \_\_\_\_\_  
 Results: \_\_\_\_\_ Referred by: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_ State: \_\_\_\_\_  
 Spouse's Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Spouse's Social Security Number: \_\_\_\_\_ Spouse's Driver's License Number: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Contact Number \_\_\_\_\_

Are your present problems due to an injury?  No  Yes  On the Job  Auto Accident  Personal Injury  Other: \_\_\_\_\_  
 Has the accident been reported?  No  Yes  To Employer  Auto Carrier  Other: \_\_\_\_\_  
 Are you now or have you ever been disabled? (Service or Work)?  No  Yes When? \_\_\_\_\_ Why? \_\_\_\_\_  
 Have you retained an attorney?  No  Yes Name & Address: \_\_\_\_\_

Pain Symptoms: 1. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 (in order of 2. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 severity) 3. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_

**Please mark the intensity of your pain today.**

0 - NO PAIN

10 - INTENSE PAIN

Example Neck

0	1	2	3	4	5	6	7	8	9	10
1. _____										
2. _____										
3. _____										

**Please mark area & type of pain on the drawings using the codes listed below.**

N-Numbness  
T-Tingling  
S-Soreness

P-Pain  
A-Ache  
ST-Stiffness

**DOCTORS USE ONLY**

HABITS	EXERCISE	FAMILY HISTORY				
<input type="checkbox"/> Smoking Packs/Day: _____ <input type="checkbox"/> Drinking Alcohol: _____ <input type="checkbox"/> Caffeine Cups/Day: _____	<input type="checkbox"/> None <input type="checkbox"/> Light Activity <input type="checkbox"/> Moderate Activity <input type="checkbox"/> Active <input type="checkbox"/> Very Active <input type="checkbox"/> Elite Athlete	Diabetes <input type="checkbox"/> Heart <input type="checkbox"/> Kidney <input type="checkbox"/> Cancer <input type="checkbox"/> Other <input type="checkbox"/>	Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother, # of: _____ Sister, # of: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?**

<input type="checkbox"/> 541 Appendicitis	<input type="checkbox"/> 280 Anemia	<input type="checkbox"/> 429.9 Heart Disease	<input type="checkbox"/> 716 Arthritis
<input type="checkbox"/> 480 Pneumonia	<input type="checkbox"/> 055 Measles	<input type="checkbox"/> 240 Goiter	<input type="checkbox"/> 345 Epilepsy
<input type="checkbox"/> 390 Rheumatic Fever	<input type="checkbox"/> 072 Mumps	<input type="checkbox"/> 487 Influenza	<input type="checkbox"/> 319 Mental Disorder
<input type="checkbox"/> 045 Polio	<input type="checkbox"/> 052 Chicken Pox	<input type="checkbox"/> 511 Pleurisy	<input type="checkbox"/> 724.2 Lumbago
<input type="checkbox"/> 011 Tuberculosis	<input type="checkbox"/> 250 Diabetes	<input type="checkbox"/> 303.9 Alcoholism	<input type="checkbox"/> 690 Eczema
<input type="checkbox"/> 033 Whooping Cough	<input type="checkbox"/> 239 Cancer	<input type="checkbox"/> 099 Venereal Disease	<input type="checkbox"/> 042 HIV Positive
<input type="checkbox"/> 493.9 Asthma	<input type="checkbox"/> 346.9 Migraine Headaches	<input type="checkbox"/> 054.9 Herpes	<input type="checkbox"/> 340 Multiple Sclerosis

(OVER)

