Khoury Chiropractic, Inc.

640 Washington Street
Dedham, MA 02026
(781) 329-3344

Wassim G. Khoury, D.C
Dawn-Marie Khoury, D.C., D.I.C.C.P.

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Khoury Chiropractic Inc.'s *Notice of Privacy Practices for Protected Health Information.*

Parent/Guardian Name Printed _____ Date _____

Patient/Guardian Signature _____

Witness Name Printed _____ Date _____

Witness Signature _____

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Name of Child: _____
Address: _____
City: _____ State:_____ Zip: _____
Home Phone Number: _____
Child's Date of Birth: _____ Age: ____ Sex: □M □F
Name of Emergency Contact: _____
# of weeks of Pregnancy with child: _____

Name of Parent: _____
Parent's Address (if different from child):
_____
City:_____ State:_____ Zip: _____
Cell Phone Number: _____
Email: _____
Phone Number of Emergency Contact: _____
Referred to This Office By: _____

Name of Primary Care Physician (Pediatrician): _____ PCP Phone: _____
Race: _____ Ethnicity: _____

Do we have permission to contact your PCP with information regarding your child's care? □ Yes □ No

_____ _____
Patient Signature Date

List any concerns you have about your child's health:_____

YES	NO	**REGARDING PREGNANCY:**
□	□	Did your diet include sugar, white flour, or trans fats?
□	□	Did you have any back pain during pregnancy?
□	□	Did you consume any alcoholic beverages during pregnancy?
□	□	Did you smoke cigarettes, drink caffeine, or take medications?
□	□	Did you receive any vaccinations or shots?
□	□	Were you physically ill at any time?

List medications taken during pregnancy: _____
_____

YES	NO	**REGARDING LABOR/DELIVERY:**
□	□	Did you experience back pain during labor?
□	□	Did you experience a difficult or prolonged labor?
□	□	Was your delivery extremely rapid?
□	□	Was your baby's presentation head down?
□	□	Was your baby posterior or breech?
□	□	Was another individual supporting you during labor and delivery?

Did the delivery involve any of the following?

□	□	Forceps
□	□	Vacuum suction
□	□	C-section
□	□	Pulling or twisting of your baby
□	□	Pitocin (chemically induced labor)
□	□	Epidural

Where was your child delivered? □ Home □ Birthing Center □ Hospital

YES	NO	**NUTRITION:**
□	□	Did you breast feed your child? If yes, for how long? _____
□	□	Did your child have difficulty latching on?
□	□	Was your baby formula-fed? If yes, what type/brand of formula? _____
□	□	Were solid foods introduced before 6 months?

Did your baby's diet include the following **before 1 year old**?

□	□	Cow's milk
□	□	Soy
□	□	Sugar
□	□	Trans-Fats
□	□	Wheat/Grains
□	□	White Flour
□	□	Nuts
□	□	Corn

Does your child's diet include any of the following **currently?**

□	□	Cow's milk
□	□	Sugar
□	□	Artificial Sweeteners (Splenda, Nutrasweet)
□	□	Soda
□	□	White Flour
□	□	Grains or Wheat
□	□	Trans Fats (margarine, packaged foods, etc.)
□	□	Soy
□	□	Does you child have any allergies?

List any allergies (food or environmental): _____

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

EMOTIONAL HEALTH:

YES NO
- ☐ ☐ Does your child fail to follow directions?
- ☐ ☐ Is your child hyperactive?
- ☐ ☐ Does your child have difficulty socializing with others?
- ☐ ☐ Does your child often have “temper tantrums?”
- ☐ ☐ Does your child get frustrated easily?

Other behavioral problems: _____

MEDICAL HISTORY:

YES NO
- ☐ ☐ Has your child ever taken an antibiotic?

Number of antibiotic prescriptions: _____
Reason for antibiotics: _____

- ☐ ☐ Did your child receive any vaccinations?
- ☐ ☐ If yes, did your child present behavioral or physical changes after vaccination?
- ☐ ☐ Has your child ever been hospitalized?

Reason and date of hospitalization:

_____

- ☐ ☐ Has your child had any surgeries?

List surgeries: _____

- ☐ ☐ Exposure to ultrasound? How many and what was the medical reason?

_____

FAMILY HISTORY:

YES NO
- ☐ ☐ Do any other family members have health problems?

List siblings:
Brother(s): Age(s) _____
Sister(s): Age(s) _____

GROWTH AND DEVELOPMENT:

At what age did your child sit up? _____ months
At what age did your child crawl? _____ months
At what age did your child walk? _____ months
At what age did your child talk? _____ months

Child’s Height and Weight **at Birth**:
Height: _____ Weight: _____
APGAR scores at birth: _____

Child’s Height and Weight **at Last Physical**:
Height: _____ Weight: _____

List any concerns about your child’s growth and development: _____

_____

List your child’s current medications and/or Supplementation/vitamins: _____

_____

PHYSICAL TRAUMA:

YES NO
- ☐ ☐ Did your child ever fall when learning to sit-up, stand, walk, run, ride a bike, play sports?
- ☐ ☐ Has your child ever fallen, tripped, or hit his/her head?
- ☐ ☐ Has your child ever fallen from a height greater than 2ft?
- ☐ ☐ Has your child ever broken a bone, dislocated or sprained a joint?
- ☐ ☐ Has your child ever been in a motor vehicle accident? Date of accident: _____
- ☐ ☐ Does your child carry a backpack greater than 15% of his/her body weight?
- ☐ ☐ Does your child spend more than 1 hr per day in front of the TV, video games, or computer?
- ☐ ☐ Did his/her mother ever fall when pregnant with this child?

HAS YOUR CHILD SUFFERED FROM ANY OF THE FOLLOWING HEALTH PROBLEMS?

YES NO
- ☐ ☐ Torticollis/Wry neck
- ☐ ☐ Reflux/vomiting
- ☐ ☐ Failure to thrive/difficulty gaining weight
- ☐ ☐ Difficulty turning head to one side
- ☐ ☐ Hyperactivity/ADD
- ☐ ☐ Ear Infections
- ☐ ☐ Difficulty Sleeping
- ☐ ☐ Bed Wetting
- ☐ ☐ Irritability
- ☐ ☐ Colic
- ☐ ☐ Frequent Colds
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Gas Pains
- ☐ ☐ Rashes/Eczema
- ☐ ☐ Milk/Lactose Intolerance
- ☐ ☐ Food sensitivities
- ☐ ☐ Allergies
- ☐ ☐ Asthma
- ☐ ☐ Headaches
- ☐ ☐ Learning Disorder
- ☐ ☐ Poor Posture
- ☐ ☐ Chicken Pox
- ☐ ☐ Pneumonia
- ☐ ☐ Whooping Cough (Pertussis)
- ☐ ☐ Measles
- ☐ ☐ Flu
- ☐ ☐ Diabetes
- ☐ ☐ Cancer, Leukemia
- ☐ ☐ Back pain
- ☐ ☐ Neck pain
- ☐ ☐ Autism/Autistic spectrum disorder
- ☐ ☐ Weight trouble/overweight

☐ Other

KHOURY CHIROPRACTIC, INC. POLICIES:

Our purpose at The Khoury Centre is to help as many people as possible achieve maximum health through chiropractic care, guidance, and education.

It is our policy that payments for all services are due at the time they are rendered and are not billed periodically to patients. Billing for patients' personal balances increases offices expenses resulting in higher costs of services. We accept cash, personal checks, and most credit cards.

As a courtesy to you we will bill your insurance company for their portion of the bill. All patients are expected to supply this office, in a timely manner, with any and all information necessary to file and bill your claims. Any checks sent to you from your insurance company for services rendered in this office must be brought into our office within 3 days.

It is understood and agreed that the amount paid to the Doctor for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Although unlikely, some patients may experience mild discomfort due to examination procedures. I hereby authorize the Doctor to examine and diagnose my child's condition, as he or she deems appropriate.

Parent/Guardian signature: _____ Date _____

CONSENT TO TREATMENT OF MINOR
(CHILD UNDER 18)

I hereby request and authorize the doctor(s) of The Khoury Centre to perform diagnostic tests and render chiropractic adjustments and other treatments as necessary to my child, the said patient.

This authorization also extends to all other doctors and trained office staff and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____
Parent/Guardian Name Printed Relationship to Patient

_____ _____
Patient/Guardian Signature Date

_____
Witness Signature

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Please read the following updated policies initial next to each notice and sign the bottom, in signing you acknowledge you have received and understand this notice. A copy can be provided upon request.

Note: Insurance may not always pay for everything, even some care that you or your health care provider have good reason to think you need. You may choose not to receive services that may cost additional charges due to non-coverage. In these cases of non-coverage where you have received specific treatments, you the patient are responsible for the balance.

INITIAL_____

PATIENT RESPONSIBILITIES

Insurance: As a patient, it is your responsibility to notify the Front Desk Office if and when there are changes to your insurance (ie. Change of insurance carriers). Failure to do so causes the office to bill the wrong insurance company resulting in non-payment. In the event this happens you, the patient, are responsible for any outstanding/non-covered costs. *We may try to rebill the new insurance but there are certain time limits put in place where this may not be possible if the date of service is outside of the allottable period.*

INITIAL_____

Appointment Policy: Please give the office 24 hours notice if you need to cancel or reschedule your appointment. **Any appointment not cancelled within 24 hours will be assessed a missed appointment fee of $65.**

INITIAL_____

_____ _____

Patient Signature Date

640 Washington Street
Dedham, MA 02026
(781) 329-3344

Wassim G. Khoury, D.C.
Dawn-Marie Khoury, D.C., D.I.C.C.P.

Khoury Chiropractic, Inc. D.B.A. The Khoury Centre For Health & Wellness

640 Washington Street
Dedham, MA 02026
(781) 329-3344

Wassim G. Khoury, D.C.
Dawn-Marie Khoury, D.C., D.I.C.C.P.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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 you 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 to 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 run our practice efficiently and effectively.
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 your treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine. We may also send appointment reminder postcards to your home address.

   You have the right to refuse to give us 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.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

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 if we are providing health care services to you based on the orders of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5. We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five 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.164.508 (b)(5)(i)
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. If you wish to revoke your authorization, please write us at

Khoury Chiropractic, Inc.
640 Washington Street
Dedham, MA 02026

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.

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

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.

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 disclosure we have made of your records

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

- those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- those disclosures made to you
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- those disclosures for national security or intelligence purposes.
- those disclosures made to correctional officers or law enforcement officers.
- those disclosures that were made prior to the effective date of the HIPPA 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 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 to the Secretary for 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 addressed to:

Khoury Chiropractic, Inc.
640 Washington Street
Dedham, MA 02026

To contact us

If you would like further information about our privacy policies and practices or a copy of this document in a larger font, please contact:

Khoury Chiropractic Inc.
640 Washington Street
Dedham, MA 02026
(781) 329-3344

This notice is effective as of January 1, 2020. This notice will expire seven years after the date upon which the record was created.