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.*

______________________________ ____________________
Patient Name Printed Date

____
Patient Signature

______________________________ ____________________
Witness Name Printed Date

____
Witness Signature

Our purpose at The Khoury Centre is to help as many people as possible achieve maximum health through chiropractic care, guidance, and education. Insurance regulations prohibit us from discounting or negotiating co-pays, co-insurances, deductibles, and other fees and charges. All fees for services are payable at the time they are rendered. We accept cash, checks, Visa, MasterCard, etc... Verification of your benefits prior to your visit is your responsibility and is not a guarantee of payment, the patient is responsible for all bills incurred at this office.

We will bill your insurance company for their portion of the bill if we are in their provider network. All patients are expected to supply this office with any and all information necessary to file and bill your claims. If claims are denied due to lack of insurance coverage for any reason, payment of any balance is the responsibility of the patient. Please note that insurance companies will only provide reimbursement for services which they deem medically necessary and will not provide coverage for treatment that is considered wellness care, maintenance care, or for chronic conditions. Any checks sent to you from your insurance company for services rendered in this office must be brought into our office within 3 days.

I hereby authorize the Doctor to examine and diagnose my condition as he or she deems appropriate.

______________________________ ____________________
Patient Signature Date

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Confidential Patient Health Record
PERSONAL HISTORY

Name: ______________________________ Date of Birth: ____________ Age: ____ Sex: □ M □ F

Address: ______________________________ City: ______________ State: ________ Zip: ___________

Home Phone: ______________________________ Cell Phone: ______________________________

Height: ______________ Weight: ______________ Race: ______________ Ethnicity: ______________

Employer: ______________________________ (Circle one)

Type of Work: ______________________________ Single Married Widowed Divorced Separated

Email: ______________________________ Name of Emergency Contact: ____________________

Referred to this office by: ____________________ Phone number of emergency contact: ______________

CURRENT HEALTH CONDITION

Reason for visit: ____

Is this condition: □ Job related □ Auto accident □ N/A

When did this condition begin? ______________________________ Has the condition occurred before? □ Yes □ No

Other doctors seen for this condition: □ Yes □ No If yes, who? ______________________________

Type of treatment: ______________________________ Results: ______________________________

Previous chiropractic care: □ None □ Doctor's name & date of last visit: ______________________________

Name of Primary Care Physician (PCP): ____
PCP address: ____

Do we have permission to contact your PCP regarding your care and provide information about your case? □ Yes □ No

______________________________ ____________________
Patient Signature Date

Please list any diagnoses you have received as well as your current medications, dosage, date started, and prescribing doctor.

____

____

Please list any tests (X-rays, labs, MRI, etc.) and/or surgeries that you have had. Please include date and result of tests or surgery.

____

____

Immediate Family History – Please list family member & condition:

Relationship	Disease(s) or condition(s)	Deceased?	Cause of death
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	

Do you smoke? □ Yes □ No If yes, how often: ________ Do you drink coffee? □ Yes □ No If yes, how often: ___________

Do you drink alcohol? □ Yes □ No If yes, how often: ___________ Do you wear a shoe lift/orthotics? □ Yes □ No

Do you use drugs? □ None □ Recreationally □ Addicted Do you exercise? □ Yes □ No If yes, how often:_________

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Confidential Patient Health Record

Historical Information

- Have you ever been diagnosed or told you have any of the following?
  1. High Blood Pressure (hypertension) □ Yes □ No
  2. Hardening of the arteries (arteriosclerosis) □ Yes □ No
  3. Diabetes □ Yes □ No
  4. Heart or blood vessel diseases □ Yes □ No
  5. Bone spurs on the neck bones (cervical spondylosis) □ Yes □ No
  6. Whiplash injury (flexion-extension injury) (cervical spine) □ Yes □ No
  7. Have any of your relatives suffered a stroke? □ Yes □ No
  8. Were you ever a smoker? If yes, from __________ to ________________ □ Yes □ No
  9. Do you take any medications on a regular basis? □ Yes □ No
     - You will be asked to list these on page 3
  10. (Women Only) Have you ever taken oral Contraceptives? □ Yes □ No
      - If yes, from ______________________ to _______________________

- Have you ever had any of the following, even short, temporary attacks, in the last year?
  1. Blurred Vision □ Yes □ No
  2. Double Vision □ Yes □ No
  3. Diminished or partial loss of vision in one or both eyes? □ Yes □ No
  4. Complete loss of vision in one or both eyes? □ Yes □ No
  5. Ringing, buzzing or any noise in the ear(s)? □ Yes □ No
  6. Hearing loss in one or both ears? □ Yes □ No
  7. Slurred speech or other speech problems? □ Yes □ No
  8. Difficulty swallowing? □ Yes □ No
  9. Dizziness? □ Yes □ No
  10. Temporary lack of understanding? □ Yes □ No
  11. Loss on consciousness, even momentary blackouts? □ Yes □ No
  12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? □ Yes □ No
  13. Any other abnormal sensations in any part of your body? □ Yes □ No
  14. Weakness, clumsiness, or loss of strength in the face, finger, hands, arms, or legs? □ Yes □ No
  15. Sudden collapse without loss of consciousness? □ Yes □ No

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
CENTRE FOR HEALTH AND WELLNESS

Below is a list of diseases which may seem unrelated to the purpose of your appointment; however, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD and write in approximately when:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Smallpox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

Have you been tested HIV Positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

NERVOUS SYSTEM CODE
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Headaches

GASTRO-INTESTINAL CODE
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

GENITO-URINARY CODE
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

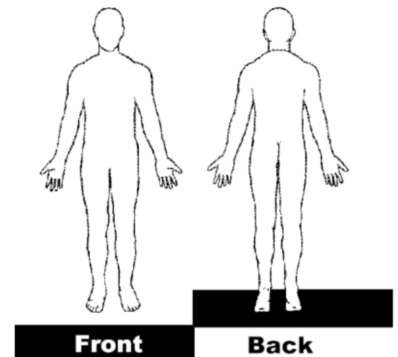
MALE/FEMALE CODES
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

____
____

FEMALES ONLY
When was your last period?
____

Are you Pregnant?
☐ Yes ☐ No

GENERAL CODE
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever



Please outline on the diagram the area of your discomfort

The above health history and information is complete and accurate. If a new symptom or condition arises during my treatment, I will notify the doctor as soon as possible.

______________________________ ______________________
Patient Signature Date

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

KHOURY CHIROPRACTIC INC.
INFORMED CONSENT

State law requires us to obtain your informed consent prior to examination and treatment. What you are being asked to sign is simply a confirmation that we have discussed the following:

The primary purpose of treatment by Doctor of Chiropractic is to correct subluxations, which will restore normal nervous system function and allow the body to heal naturally.

Treatment

The results of treatment cannot be guaranteed, but most of our patients improve when their treatment plan is followed as directed. You are solely responsible for your health and recovery.

Doctors: We are fortunate to have two highly skilled doctors in this practice; Dr. Wassim Khoury, and Dr. Dawn-Marie Khoury. Regardless of which doctor you see initially we encourage you to see both doctors during the early stages of your care. Although you may prefer one doctor's treatment over another's you won't know this unless you have seen each of them at least once. It is also important so that all the doctors in the practice are familiar with your case and in the event of doctor illness or vacation your care will have the continuity needed to reach the best possible outcome.

The Chiropractic Adjustment: We do not offer to diagnose or treat any condition other than the subluxation and neuromusculoskeletal disorders. We will inform you of any other abnormalities found during examination and will refer you to another practitioner for diagnosis and treatment of these abnormalities. We will use our hands to analyze the spine in order to locate vertebral subluxations. If subluxations are found, we will adjust these regions by using gentle forces with the hands to provide mobility to the area in order to facilitate correction of the subluxations. You may hear an audible "pop" or "click," this is air being released from the joint space.

Adjunctive Treatment: For some cases, this office finds it necessary to use adjunctive therapy in order to facilitate correction of vertebral and/or extremity subluxations. These therapies may include electric modalities, ice, heat, exercise rehabilitation, nutritional or lifestyle modifications.

The Material Risks

As with any health care procedure, there are certain complications that may arise due to a chiropractic adjustment. This office has never experienced any of these complications due to our gentle and precise adjusting techniques. These material risks are as follows: soft tissue injury, muscle or ligament sprain/strain, fracture, and stroke.

None of the previously mentioned risk factors have ever occurred in this office. It is estimated that the probability of stroke occurring is 1 in 5.85 million; about the same as getting struck by lightening (Haldeman et al., Canadian Medical Association Journal, Oct 2001.) Fractures may occur if a patient has some underlying weakness of the bones, which we check for during your history, examination, and x-ray analysis. Due to the rarity of occurrence of the previously mentioned risk factors, **statistics of their probability are equal to or less than 1 in a million.**

The risks associated with adjunctive therapy such as ice, heat, or electric modalities may include a skin reaction, such as burns or redness. However, we always take great precaution to protect your skin and test your sensitivity before applying modalities. **Patient burns have never occurred in this office.**

It is common after an adjustment, as well as after traction, massage therapy, exercise, in fact almost any healthcare treatment, to experience soreness in the region being adjusted. These symptoms are called recovery symptoms and usually subside after the first few adjustments. If this occurs, you should apply ice to the region for 15-20 minutes each hour with a damp towel between the ice and the skin.

Associates and Assistants

In this office we use trained staff personnel to assist the doctor with portions of your examination and treatment. Occasionally when the doctor is out of town or unavailable, another doctor will treat you.

Treatment Options

Medication: Prescription and non-prescription medication, such as non-steroidal anti-inflammatories, painkillers, or muscle relaxers may be used to relieve symptoms, such as pain, muscle spasm and swelling. However, medication can only mask the symptoms related to subluxation complexes and cannot correct the cause of this problem. Professional literature describes highly undesirable effects from long-term use of prescription and non-prescription pain medications. Some of these effects include: kidney failure, ulcers, gastrointestinal toxicity, stomach bleeding, congestive heart failure, diverticular disease, and even death in 16,500 people per year (Wolfe, New England Journal of Medicine, 1999). Doctors of Chiropractic do not prescribe medication.

Surgery: Surgery is always a possibility, but the expense, danger, and ineffectiveness of such treatment is more a probability than a possibility. Adverse reactions to anesthesia, doctor caused mishaps, or infection may result.

Physical Therapy: Physical therapy is effective to stretch and strengthen muscles in the area of involvement. However, if a joint is out of alignment and muscles are strengthened to support the misaligned position; your condition may be complicated further and may in fact worsen. Physical therapy has been shown to be more effective for stabilization and prevention of subluxation complexes when engaged in *after* a phase of chiropractic treatment. When used as a second phase of care, physical therapy will strengthen muscles to stabilize the spine or joint in its correctly aligned position.

Non-Treatment

Remaining untreated can result in adhesion/calcium formation in joints, increased pain, increased muscle spasm and tightness, and reduction in associated joint mobility. These processes in turn can facilitate such conditions such as arthritis and disc degeneration and may in fact make treatment more difficult and less effective the longer it is postponed. The probability is very high that prolonged non-treatment will complicate a later exacerbation and reduce the chances of future correction and rehabilitation.

THE DOCTOR HAS EXPLAINED TO THE RISKS THAT CAN BE ASSOCIATED WITH THE CHIROPRATIC EXAMINATION AND TREATMENT. I UNDERSTAND THESE RISKS AND HAVE DISCUSSED ANY QUESTIONS OR CONCERNS WITH THE DOCTOR.

I HEREBY STATE THAT I HAVE READ THIS CONSENT FORM, AND IT MAY BE USED THROUGHOUT MY TREATMENT IN THIS OFFICE. HAVING BEEN INFORMED OF THE RISKS, I HEREBY GIVE MY CONSENT TO TREATMENT.

______________________________ ____________________
Patient Name Printed Date

____
Patient Signature

______________________________ ____________________
Witness 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
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
CENTRE FOR HEALTH AND WELLNESS

CONSENT TO TREATMENT OF MINOR
(CHILD UNDER 18)

Child/Dependent Name: ________________________________

I hereby request and authorize any of the doctors of The Khoury Centre for Health and Wellness to perform diagnostic tests and render chiropractic adjustments and other treatments as necessary to my child/dependent. This authorization also extends to all other 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 Date

____
Parent/Guardian Signature

______________________________ ______________________
Witness Name Printed Date

____
Witness Signature

CONSENT TO DISCLOSE MEDICAL INFORMATION (OPTIONAL)

In compliance with HIPAA, the Khoury Centre is not authorized to provide information to other individuals without your explicit consent. If you wish to authorize KHOURY CHIROPRACTIC, INC to share your medical information with individuals other than yourself, please complete this form with specifications of your wishes.
I authorize KHOURY CHIROPRACTIC, INC and its staff to discuss my medical information including financial purposes, appointments, diagnosis and treatment information with the following exceptions:

____

____

____

Below, please list the names and relationship of authorized individuals:

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

I understand that as part of KHOURY CHIROPRACTIC, INC treatment, payment, or healthcare operations, it may be necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

______________________________ ____________________
Patient Name Printed Date

____
Patient Signature

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

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