

Office Policy and Procedures

Step 1: All new patients are requested to fill out each side of the personal health history and sign the *Notice of Privacy Practices* and the *Client Agreement*.

Step 2: You will have a consultation with the doctor to discuss your health problems.

Step 3: Preliminary screening tests will be performed to help determine if you are a Chiropractic or Naturopathic case. 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.

Step 4: If the preliminary screening tests indicate that we can help you to achieve your goals, additional diagnostic examinations, such as laboratory tests, neurological/orthopedic tests, kinesiological exams, x-rays, blood and urinalysis may also be required.

Step 5: If you require immediate medical attention, emergency first aid will be administered and 911 will be called.

Step 6: The doctor will review with you all of his findings, explain their significance and make recommendations for treatment. Family members are welcome and may attend the Report of Findings at your request. Patients who respond the best are those who learn to help themselves. Our job is to help you do so.

Step 7: Treatments will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been 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.

Step 8: Payment is required at the time above service is performed. We accept cash, personal checks, money orders, travelers' checks and most major credit cards. In Pennsylvania and Virginia we will supply you with a super bill for you to submit to your insurance. 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 cases or Workman's Compensation.

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 \$40.00 will be made unless the office receives the required notice.

A good relationship can only be maintained if we keep communications open between us. Please feel free to ask any questions that you may have.

Notice of Privacy Practices

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.

Law requires us to keep your medical information private, have you sign this notice describing our legal duties, privacy practices, and your rights regarding your medical information and follow the terms of the notice that is now in effect.

We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. Before we make any important change we will change this notice and make the new notice available upon request.

The use and disclosure of your medical information permitted by law may be released for any of the following reasons:

FOR TREATMENT: We may disclose medical information about you to doctors, nurses, technicians, or other people who are assisting in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

COURT ORDERS and JUDICIAL and ADMINISTRATIVE PROCEEDINGS: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or any other lawful process. Under limited circumstances we may share your information with law enforcement officials.

You have the right to look at or get copies of your medical information at any time. If you request copies you will be charged \$1.00 for each page, and postage if you want the copies mailed to you. You may also request additional restrictions on your medical records. Any request must be in written form.

By signing below I acknowledge that I have received and reviewed all of the information pertaining to the Notice of Privacy Practices. The Doctor is authorized to treat me and will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Date: _____

Patient Name: _____

If you have any questions about this notice or if you think we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services.

CLIENT AGREEMENT

1. I fully understand that Robert J. Kay, N.D, D.C., is not a medical doctor and is not a psychologist. I also understand that he does not diagnose or treat for any specific condition or disease. If I have any disease, health problems, or health condition I am now being advised to seek qualified medical advice from a licensed physician.
2. I am here as a client, on this or any subsequent visit, 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 purposes.
3. I understand that Robert J. Kay, N.D. teaches clients how to build their own health through training in the effective use of life-style modification, pollution avoidance, clean air, pure water, proper foods, rest, exercise, goal orientation, positive mental attitudes, and stress reduction techniques.
4. I realize that any evaluation test is not medical in nature and such tests are not procedures used for diagnosis or treatment of any health condition or disease. I know that such evaluation testing is not approved by any branch of the medical profession and is not approved by the Food and Drug Administration.
5. Recommendations, suggestions, and references to meals, menus, or nutritional supplements are for body building, increased stamina and energy, and general health maintenance and do NOT involve any diagnosing prognosticating, or prescribing for the treatment of any disease or health condition.
6. I understand that Robert J. Kay, N.D. is dedicated to educating clients to help themselves to better health with emphasis on education and self-care.
7. I have read and understand what is written above. My signature below signifies that I agree to retain Robert J. Kay, N.D. to educate me through lecture, testing evaluation, and demonstrations, in methods available for me to help myself to improvement of my over-all general health.

Client Signature: _____ Date _____

Address _____

Phone _____

Date of Birth _____

8. I have read and understand what is written above. I am the parent/guardian of the minor child named above and I agree to retain Robert J. Kay, N.D., D.C. to educate us through lecture, testing evaluation, and demonstrations, in methods available for us to help ourselves to improvement of our over-all general health.

Maryland Patients Only: This is a Naturopathic Practice only. If Chiropractic is needed we will be happy to refer you to a local Chiropractor. We do not practice Chiropractic in this office.

Parent/Guardian Signature _____ Date _____

About You		
Today's Date: _____/_____/_____ File #: _____		
Name: _____		
What You Prefer To Be Called: _____		Gender: Male Female
Birth date: _____/_____/_____ Age: _____ SSN#: _____		
Mailing Address: _____		
City	State	Zip
Home Phone #: _____		
Other Phone #'s: _____		
Referred By: _____		
Employer: _____		How Long: _____
Employer's Address: _____		
City	State	Zip
Occupation: _____		Work Phone #: _____
Marital Status (Please Circle): Single Married Divorced Separated Widowed		
Spouse's Name: _____		

Reason For Visit

Have you ever been to a Holistic Health Practitioner? Yes No

If so, whom? _____ Phone #: _____

The reason for this visit is a result of (*Please Circle*): Work Sports Auto Trauma Chronic

(*Explain what happened*) : _____

Please describe the pain & its location: _____

When did the condition begin? _____/_____/_____

Is this condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your (*Please Circle*): work sleep daily routine

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

In Event of Emergency

Emergency Contact Name: _____

Emergency Contact Phone #: _____

Health History

Are you taking any of the following medications (Please Circle)?

Nerve Pills Pain killers (including aspirin) Muscle relaxers Stimulants

Blood Thinners Tranquilizers Insulin Others: _____

Have you ever had any of the following diseases/medical conditions?

Heart Attack / Stroke Heart Surg./Pacemaker Heart Murmur

Congenital Heart Defect Mitral valve prolapse Artificial Valves

Alcohol / Drug Abuse Venereal Disease Hepatitis

HIV+ / Aids Shingles Cancer

Frequent Neck Pain Emphysema / Glaucoma Anemia

High/Low Blood Pressure Psychiatric Problems Rheumatism Fever

Severe/Frequent Headaches Kidney Problems Ulcers / Colitis

Fainting/Seizures/Epilepsy Sinus Problems Asthma

Diabetes / Tuberculosis Difficulty Breathing Chemotherapy

Lower Back Problems Artificial Bones / Joints Arthritis

Please list any other serious medical condition(s), you have or ever had:

Please list anything that you may be allergic to: _____

List any past serious accidents with dates: _____

Family Health History: _____

Do you smoke? No Yes / How much? _____ How long? _____

Are you wearing (Please Circle): Heel Lifts Sole Lifts Inner soles Arch supports

What is the age of your mattress? _____ Is it comfortable? Yes No

For Women: Are you taking Birth Control? Yes No

Are you Pregnant? No Yes / How long? _____ Nursing? Yes No

Account Info		
Person ultimately responsible for account:		
Name: _____		
Relation: _____		
Billing Address: _____		
City	State	Zip
SSN: _____		
D.L. #: _____		
Work Phone #: _____		
Payment method:	Cash	Check
Credit Card – Enter card # above (if accepted)		

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

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.

Signature: _____ Date _____