KAIZO HEALTH
CHIROPRACTIC + REHABILITATION

Patient Information

Patient Name: _____
Last **First** **Middle**

Street Address: _____
Street **City** **State** **Zip**

Phone: (H) _____ (W) _____ (C) _____
☐ I authorize Kaizo Health to leave messages on answering services & to send SMS messages for reminders, surveys, specials, announcements etc.

Birth date:____/____/____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Other

Email: _____ Gender: ○Male ○Female ○Other ○Prefer not to say
☐ I authorize Kaizo Health to send me emails for reminders, e-statements/bills, and informational newsletters.

Occupation _____ Employer's Name _____

Employer's Address _____
Street **City** **State** **Zip**

Emergency Contact Information

Emergency
Contact:_____
Name **Relationship** **Phone #**
☐ I authorize Kaizo Health to leave or give information to spouse, emergency contact or any member of household listed above.

Referral Source and Primary Care Doctor Information

How did you hear about us? _____ ***Primary Care Physician*** _____

Health Insurance Information
Is your injury related to an auto accident, worker's comp accident, or other accident resulting in legal proceedings? ○ YES ○ NO

Primary Health Insurance Name: _____ ***Phone #***_____

Policyholder's Name (if not self}: _____ Relationship _____ D.O.B. ____/_____/____

Secondary Health Insurance Name: _____ ***Phone #***_____

Policyholder's Name (if not self}: _____ Relationship _____ D.O.B. ____/____/____

If you would like to put a credit card on file check the box and fill in your Credit Card Information

☐ I prefer to be charged automatically on my credit card for any out of pocket cost or balances relating to my care and treatment that are not covered By my insurance. With the signature at the bottom of the page I authorize Kaizo Health to charge any of these charges on the credit card listed below. I will present the card at the first visit. To protect my safety the complete credit card number cannot and will not be kept on file:

☐ VISA ☐ MC ☐ AMEX ☐ DISCOVER LAST 4 DIGITS OF CC#:_____ EXP DATE: _____

By signing the bottom of this page I authorize that the information provided above is true to the best of my knowledge. I understand that I may be billed administrative and filing fees for withholding information as it relates to my medical history and insurance coverage.

Print Name_____ **Signature**_____ **Date** _____
(Parent/Guardian if patient is a minor)

INSURANCE AUTHORIZATION OF TREATMENT, INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Kaizo Health / First Choice Physicians LLC t/a Sport & Spine Rehab, Greenstein and Associates DC t/a Metro Sport & Spine, Sport & Spine Rehab of McLean, Sport & Spine Rehab of Ft. Washington, and/or Sport and Spine Rehab of Fairfax all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

FINANCIAL POLICY

1. I am ultimately responsible for full payment for any and all services rendered.
2. I am considered as a SELFPAY patient until I have provided completed insurance forms, and that your office has qualified and accepted my coverage, otherwise I pay at the time of service.
3. I am responsible for any costs not covered by my insurance and therefore must pay deductibles, copays, coinsurances and one-time initial $5 medical supply/administrative/processing fee at the time of service.
4. Insurance Benefits quoted by my insurance company are NOT a guarantee of payment or coverage.
5. Sport and Spine Rehab/Kaizo Health makes every attempt to receive authorization of treatment from insurance companies for treatment received at one of our facilities. However, there may be times when the insurance company does not provide this authorization in a timely manner. SSR/KH will submit claims as a courtesy to me. If my insurance carrier has not paid a claim within the terms of the contract within 60 days of submission, SSR/KH will submit an appeal one time. If the claim is not paid within 30 days of the appeal, I will be responsible for taking an active part in the recovery of my claim. After 90 days, I will be responsible for the balance and I authorize the use my credit card, if supplied, to be charged for full payment. If I do not have a card on file I must remit payment in full upon receipt of the bill.
6. In the event I discontinue my plan of care prior to the doctor's consent, I am responsible for any outstanding balance and the courtesy of insurance assignment is immediately discontinued.
7. Sport and Spine Rehab/Kaizo Health will attempt to bill me for 90 days via email, mail and phone for any outstanding balances. If I have not made a payment after 90 days my account may be sent to a collection agency for further action including potential credit reporting. I agree to reimburse Sport and Spine Rehab/KaizoHealth for the fees of any collection agency, which may be based on a percentage not to exceed 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, incurred by Sport and Spine Rehab/Kaizo Health in such collection efforts.
8. I agree that in order for Sport and Spine Rehab to service my account or to collect any amounts I may owe, Sport and Spine Rehab may contact me by telephone at any telephone number associated with my account. This includes wireless telephone numbers, which could result in charges to me. Sport and Spine Rehab may also contact me by sending text messages or e-mails, using any e-mail address I have provided to them. Methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that Sport and Spine Rehab Holdings, LLC or any agency working on behalf of SSR Holdings, LLC may contact me/us as described above.
9. I understand that I can be charged a $25.00 NO SHOW/LATE CANCEL fee for any appointment not rescheduled or canceled at least 24 hours in advance.

Note: Information collected in these forms or in the treatment process may be used in its raw data form (no mention of patient name) to analyze for research purposes.

By Signing below I agree to all statements in the Financial Policy, Insurance Assignment and Insurance Authorization and Release above.

_____	_____	_____
Patient's Printed Name	**Signature of Patient** (***If patient is a minor, Parent or Guardian signs***)	**Date**

NOTICE OF PRIVACY PRACTICES AND PATIENT'S RIGHTS AND RESPONSIBILITIES

PLEASE CHECK THE BOX, SIGN, AND DATE below to acknowledge receipt of the HIPAA Privacy Practices and Patient Rights and Responsibilities:

☐ I have read and/or was offered a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities by Kaizo Health.

_____	_____	_____
Patient's Printed Name	**Signature of Patient** (***If patient is a minor, Parent or Guardian signs***)	**Date**

Kaizo Clinical Research Institute

The Kaizo Clinical Research Institute (formerly the Sport and Spine Rehab Clinical Research Foundation) is a non-profit research organization created by the founders of Sport and Spine Rehab/Kaizo Health. They would like to invite you to provide permission to include de-identified information about your condition in a larger research database. It is important you read and understand the information below before you agree to be a participant. Your relationship with Sport and Spine Rehab/Kaizo Health will not change if you decline.

Part of Kaizo Health and the Kaizo Clinical Research Institute's goal is to ensure our doctors are providing the best treatments and maximizing clinical outcomes. Clinical outcomes are pain, disability, and quality of life measures. This information is collected in the form of a questionnaire at the start and end of your therapy.

The Foundation would like permission to include your information in a study database. The purpose of this database is to track the outcome measure results of Kaizo Health's treatment programs. Your records will be assigned a random number instead of using your name. This allows all information to be kept private. Only members of the research team will have access to the password protected database.

Please ask questions about what you do not understand before agreeing to take part, as this is voluntary. You may withdraw and stop participating at any time without affecting your care. If at any time you wish to withdraw your consent please let any member of the research or clinic staff know.

Statement of Consent: I have read the information above. I have had the chance to ask questions and have them answered. I agree to allow my information to be added to an outcome measures database.

Participant's Name	Date
Participant's Signature	Date
Parental/Guardian Signature (under 18)	Date

Kaizo Clinical Research Institute

9300 Livingston Rd
Suite 100
Fort Washington, MD 20744

Phone: 240-760-0300 x 835
Fax: 301-251-1829
E-mail: jslaski@kaizo-health.com

KAIZO HEALTH
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CONSULTATION FORM

Patient Name: _____ Gender: ○M ○F

Current Symptoms (Be specific) _____

When did the symptoms first appear?_____ Rate your symptoms on a scale from 0-10 _____

What makes the symptoms worse or increase? _____

What makes the symptoms better or decrease?_____

What are the top 1-3 goals to consider your care a success?

1._____ 2._____ 3._____

What will help you be most accountable to your careplan to achieve those goals? _____

Have you seen another health care provider for this problem? ○YES ○NO If yes, who? _____

The symptoms are:

☐ constant	☐ mild	☐ sharp	☐ dull	☐ achy
☐ frequent	☐ moderate	☐ burning	☐ stiffness	☐ swelling
☐ occasional	☐ severe	☐ numbness	☐ tingling	☐ other_____

Review of Current Symptoms: Do you Currently have any….	YES	NO
Generalized symptoms such as weakness, fatigue, fever, chills, night sweats, fainting, change in sleep pattern, unexplained weight loss/gain or others? (circle symptom if listed)	○	○
Skin problems such as rashes, itching, dryness, sores, changes in skin color, changes in moles, changes in hair, changes in fingernails, or others? (circle symptom if listed)	○	○
Lung problems such as coughing, phlegm, shortness of breath, difficulty breathing, wheezing, congestion, coughing blood, or others? (circle symptom if listed)	○	○
Heart problems such as a murmur, palpitations, rapid heartbeat, extremity swelling, chest pain, cold extremities, high/low blood pressure, or others? (circle symptom if listed)	○	○
Gastrointestinal problems such as stomach pain, nausea/vomiting, diarrhea, gas/bloating, constipation, rectal bleeding, change in appetite/thirst, change in stools or others? (circle symptom if listed)	○	○
Genitourinary problems such as painful urination, blood in urine, frequent urination, incontinence, urgency, change in urine appearance or others? (circle symptom if listed)	○	○
Musculoskeletal problems such as muscle pain, muscle weakness, muscle twitching, joint stiffness, joint pain, joint swelling, hot joints or others? (circle symptom if listed)	○	○
Neurological problems such as numbness, tingling, weakness, paralysis, loss of memory, loss of sensation, difficulty with coordination, dizziness, difficulty with speech or others? (circle symptom if listed)	○	○
Psychiatric problems such as depression, anxiousness, hallucination, drug addiction, suicidal thoughts, difficulty sleeping or others? (circle symptom if listed)	○	○
Eye, nose or throat problems such as blurred vision, double vision, eye pain, hearing loss, ringing in ear, vertigo, sinus problems, loss of smell, hoarseness, difficulty swallowing or others? (circle symptom if listed)	○	○

If you answered Yes to any question above please explain:_____

_____

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PAST MEDICAL HISTORY

Please check (✓) to indicate if you have had any of the following:

☐ AIDS/HIV	☐ Breast Lump	☐ Gonorrhea	☐ Liver Disease	☐ Shingles
☐ Alcoholism	☐ Bulimia	☐ Gout	☐ Migraines	☐ Stroke
☐ Anemia	☐ Cancer	☐ Heart Disease	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Anorexia	☐ Diabetes	☐ Hepatitis	☐ Osteoporosis	☐ Thyroid Problems
☐ Appendicitis	☐ Drug Abuse	☐ Hernia	☐ Pacemaker	☐ Tuberculosis
☐ Arthritis	☐ Emphysema	☐ Herpes	☐ Polio/Post-Polio	☐ Tumors
☐ Asthma	☐ Epilepsy	☐ High Cholesterol	☐ Psychiatric Care	☐ Ulcers
☐ Blood Disorders	☐ Glaucoma	☐ Kidney Disease	☐ Rheumatoid Arthritis	☐ Venereal Disease

PLEASE LIST ANY MAJOR ILLNESSES, INJURIES, FRACTURES, OR SURGERIES YOU HAVE HAD

ILLNESS, INJURY, FRACTURE, SURGERY	DATE	TREATMENT

Please list any allergies you have: _____

Please list any medications you are currently taking: _____

Please list any vitamins/nutritional supplements you are taking: _____

FAMILY HISTORY

List any diseases that run in your family

BLOOD RELATIVE	MAJOR ILLNESS
Father	
Mother	
Brother(s)	
Sister(s)	
Other Relative	

SOCIAL HISTORY

Please check (✓) all that apply.

SMOKING
- ☐ Never Smoked
- ☐ Previously Smoked
- ☐ Presently Smoke

Pack/Wk_____#Years_____

EXERCISE
- ☐ Exercise None
- ☐ Light Exercise
- ☐ Moderate Exercise
- ☐ Heavy Exercise

ALCOHOL
- ☐ No Alcohol
- ☐ Presently Drink Alcohol

Drinks/Week _____
(Includes beer, wine, liquor)

CAFFEINE
- ☐ No Caffeine
- ☐ Yes Caffeine

Cups/day _____
(Includes coffee, tea, soda)

THIS CONFIDENTIAL HISTORY WILL BE A PART OF YOUR PERMANENT RECORDS

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us Compliance@kaizo-health.com
You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care; Share information in a disaster relief situation; Include your information in a hospital directory
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: *Marketing purposes; Sale of your information; Most sharing of psychotherapy notes*

In the case of fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

Treat you - We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization - We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services - We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues - We can share health information about you for certain situations such as: *Preventing disease; Helping with product recalls; Reporting adverse reactions to medication; Reporting suspected abuse, neglect, or domestic violence; and Preventing or reducing a serious threat to anyone's health or safety*

Do research - We can use or share your information for health research.

Comply with the law - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests - We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests - We can use or share health information about you*: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services*

Respond to lawsuits and legal actions - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html
View online at www.kaizo-health.com

Effective 9/23/2013

PATIENT RIGHTS AND RESPONSIBLITIES

You the patient have the right to:

- Be treated with dignity and respect
- Confidentiality
- Participate in the assessment and care planning process
- Be provided service in a timely manner
- Be notified in advance of types of treatment and frequency of treatment being provided
- Be notified of any changes in your plan of care and treatment
- Receive an explanation of the billing process and an explanation of charges
- Express grievance without fear of reprisal or discrimination
- Refuse or discontinue

You the patient are responsible for:

- Providing information when services are rendered
- Following the treatment plan as outlined by the doctor and scheduling for treatment at least 4 weeks in advance
- Notifying practice when you will not be available for treatment or will be late for treatment
- Rescheduling any missed treatment in order to keep on schedule as outlined in your treatment plan
- Performing all the rehab exercises including the prescribed home care program as outlined by the doctor
- Notifying the practice of any change in your condition, physician orders, attending physician, or attorney
- Notifying the practice of any incident involving the staff or equipment
- Payment of all co-payment or deductible applicable per the insurance plan of your choice

PATIENT EMPOWERMENT CHECKLIST

1. COMMUNICATION - If your condition worsens, please contact your Kaizo Health doctor immediately. KH doctors are required to give you their cell phone number, their email or both.

2. FOLLOW UP - Follow up with all of your doctor's self-care advice, such as:

- **Performing all of your home exercise instructions. If you have any problems doing your home exercises, inform your Kaizo Health doctor immediately.**
- **Follow up with your icing instructions.**
- **Watch your ergonomics. Take time to evaluate your work station and how you perform your home related activities and ensure you are always in the "good posture position."**

3. UNDERSTANDING - Ensure you understand all of your available treatment options, both inside and outside of Kaizo Health, which your KH doctor has discussed with you.