

McKinzie Wellness Center

Lonny R. McKinzie, D.C.

3325 Chandler Hwy., Tyler, TX 75702 903-531-2243

PATIENT INFORMATION SHEET

Please Print and Fill Out Completely

Date _____

Patient Name _____ Nickname _____
(Last) (First) (MI)

Address _____ City _____ State _____

Zip _____ Home Phone _____ Work # _____ Cell # _____

Sex: M F Marital Status: S M D W Birth Date _____ Age _____

Spouse Name _____ # of Children _____ E-mail address: _____

Circle best method to contact you: phone (mobile, home, work)/answering machine, mail, or e-mail or **all**:

Persons & relationship authorized to access your records _____

Name & phone of nearest relative (not spouse): _____

Student? Yes No Name of Parent or Guardian if a Minor _____

Occupation _____ Patient Employer _____

Employer Address _____ City _____ State _____ Zip _____

Mobile or Alternate Phone _____ Full time or Part time Employment

Describe Major Complaint _____

Injury due to Accident? Auto Work Home Other _____ Date of Injury/Illness _____

Similar Symptoms? Y N When? _____

Other accidents in: (circle one) Past 12 months 1-5 yrs. 5 yrs. or over Describe accident _____

Describe any other condition _____

Allergies _____ Surgeries/Dates _____

Previous Chiropractic Care? Y N Dr. Name, Location, Dates? _____

Similar or different condition _____

How did you find our office? Ad _____ Phone Book _____ Office Sign _____ Webpage _____ Other _____

Friend/Relative Name _____ Dr or staff contact _____

Current Medications: _____

Please indicate all the conditions you have (H) had or now (N) have with the appropriate letter:

Headaches ____	Sore Muscles ____	Thyroid Problems ____	Ulcers ____
Neck Pain ____	Dizziness ____	Gout ____	Gall Bladder ____
Neck Stiffness ____	Arthritis ____	Diabetes ____	Asthma ____
Mid back Pain ____	Heart attack ____	Cancer ____	Depression ____
Mid back stiffness ____	High blood pressure ____	Painful urination ____	Sinus ____
Low back pain ____	Allergies ____	Constipation ____	Nervousness ____
Low back stiffness ____	Numbness in arms R L	Numbness in legs R L	Migraine headache ____
Women only: Are you pregnant now? Y N	Previous pregnancies, Y N	How many? ____	Miscarriages Y N

**OFFICE POLICY AND CONSENT TO TREAT
PAYMENT IS EXPECTED AT THE TIME OF VISIT**

PLEASE NOTE! This office operates on a **CASH BASIS**.

- I understand that I am responsible for payment of all services rendered and agree to the above office policy. I also understand that all files and x-rays remain the property of the office but that copies of my records can be obtained for an additional charge.
- Dr. McKinzie/McKinzie Wellness Center is not a participating provider/"In Network" for any Insurance Company. Payment is expected at the time services are received. Payment options may be available with prior approval. We will provide you with a receipt so that you may file with your insurance for reimbursement.
- Since our Office Visit fees are at or near the average insurance co-payment, the patient usually has very little additional out of pocket expense. In addition, our Exam and X-ray fees are at a discounted rate.

TERMS OF ACCEPTANCE-PLEASE READ CAREFULLY: The scope of this practice is the detection and correction of the **vertebral subluxations** (spinal misalignments) along with addressing health issues that interfere with that correction. However, if during the chiropractic spinal examination and history, we observe unusual findings, we will advise you. If you desire advice, diagnosis or treatment for findings outside the area of conservative care, we will recommend that you seek the services of a health care provider who specializes in those areas. We care for patients with pain but the overall focus of our practice is to correct underlying problems that affect your ability to stay healthy.

- I do hereby authorize the doctor or whomever he designates to perform upon me the necessary exams and x-rays for the detection and correction of the vertebral subluxation as well as any other diagnostic and therapeutic procedure for augmenting the chiropractic adjustment.
- I authorize you to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred or to any doctor who you require us to forward records to.
- I have read and fully understand the above Terms of Acceptance and acknowledge that no guarantee has been made as to the results that I might expect with regard to my condition.
- I also understand that questions as to the nature of the care I will receive will be answered to my complete satisfaction or I am under no obligation to proceed with care. I understand that certain risks have been associated with chiropractic care, those being stroke in 1 in 1.5 million where cervical rotation type adjustments are used. The methods of care used in this office are typically specific instrument adjustments, therefore the risk is essentially zero.
- I therefore accept chiropractic care for myself (or minor child) on this basis.
- I also have been given/read the "Notice of Privacy Practices" (Version/Effective Date: v. 1, April 15, 2003)
- By my signature below, I agree to the above terms and conditions, Office Policy and Consent to Treatment statements.

Signature _____ Date _____

HIPAA Policy Required Authorizations

Patient Name: _____ Date of Birth: _____ M or F

Patient's Mailing Address: _____ City _____ St./zip _____

Social Security Number: _____

I authorize the release, disclosure and use of health information obtained on the above individual for the purpose of continuing care and treatment by:

Lonny R. McKinzie, D.C.
3325 Chandler Hwy, Tyler, TX. 75702
Phone: 903-531-2243, fax: 903-531-2248.

This information is to include:

- ___ most recent date of treatment,
- ___ most recent discharge summary or for dates _____,
- ___ most recent history and physical or dates _____,
- ___ most recent Operative Report or dates _____,
- ___ lab results,
- ___ pathology reports,
- ___ radiology and imaging reports or dates _____,
- ___ other tests (specify) _____,
- ___ Entire Medical Records for dates _____,
- ___ pictures.

I understand that the information used or disclosed pursuant to this authorization form may include information relating to HIV or AIDS; treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand the authorization is valid indefinitely unless otherwise stated. I understand that I may revoke this authorization at any time and that if I revoke this authorization, I must do so in writing to Dr. McKinzie at the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization.

You have the right to withdraw authorization in writing at any time.

I have read and understand the above stated authorizations and agree to those that have been checked.

X _____
Signature of Patient or Qualified Personal Representative

Printed Name

Authority to act on behalf of patient (Parent/Guardian, executor, etc.)

Signature of Witness

Printed Name of Witness

Date

PLEASE INITIAL EACH ONE YOU GIVE US PERMISSION TO USE:

_____ I give my permission for Lonny R. McKinzie, D.C. and McKinzie Wellness Center to send me via mail or e-mail the following:

- A. Birthday or Christmas cards, Thank you cards, or notices of special events or a Patient Appreciation Day. In these cards we may offer you a discounted service or product.
- B. Patient's newsletters about our office, upcoming products and services or general information.

_____ We may use your name on a "Thank You" referral board in the waiting area or in printed material.

_____ We have your permission to use your child's (first) name, picture or drawing in our office or in printed material.

Address to use for mail (if different from above): _____

Email address: _____

This is to inform you that we also may call you to remind you of appointments or to check to see how you are feeling after treatment.

We may need to send through mail or e-mail reminders of appointments, missed appointments, or the need for additional information.

If you wish to change the address or phone number where you can be reached, you may do so in writing, by calling the office or request an update form from the office.

Please be aware that we have an open office adjusting setting. If you have a private matter you need to discuss regarding payment or treatment, please inform the front desk or the doctor in order to make arrangements for a more secure area to discuss private matters. For your protection, our employees or business associates must sign a confidentiality agreement regarding our office procedures and the use of your private health information. Staff only has rights to your information needed to perform their job duties. An example of a business associate can be anyone who we contract out to do transcriptions, record copying, a management company, or collection agencies. We have implemented agreements, policies and procedure to assure the protection of your privacy.

IMPORTANT: If you wish to allow a spouse or family member access to health information you must sign to give permission. Only those listed below will have access to your records.

"I give the following person or person's permission to access my health information:

(Names of those who have access to your records) _____

I have read and understand the above stated authorizations and agree to those that I have initialed.

X _____
Signature

Printed Name

Date