Patient Information

Date: _____

Full Name: _____ DOB: _____/_____/_____ Address: _____ Preferred Phone: _____ City, State, Zip: _____

Email: _____ Sex: M F Age: _____

Marital Status: ___ Single ___ Married ___ Widowed ____ Divorced

Occupation: _____ Height: _____ Weight: _____

Who is your primary care physician?

_____

Are you seeing any other healthcare provider?

_____

Who may we thank for referring you?

_____

CONSENT TO TREAT

I hereby authorize this office and its doctors to examine and administer care as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all these fees charged by this office for such care.

HIPAA – NOTICE OF PRIVACY POLICIES

The notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment or other healthcare operations. It also describes your rights to access and control your protected health information. “Protected health information” (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health. Please be advised that our office may deem it necessary to discuss your PHI with other treatment facilities, laboratories, or payment centers, among other reasons, with or without your consent. A full explanation of our rights and responsibilities as a healthcare facility and your rights as a patient, under HIPAA requirements, is available upon request.

DISCLAIMER

Please be advised that the nutritional and herbal programs that are administered by our office, and/or Dr. Gregg and Karen Brady are not intended as a primary therapy for any disease, but rather to provide nutritional and herbal support for normal body physiology and repair. Also be advised that any and all testing ordered by our office and/or Dr. Gregg and Karen Bradyl, whether it be by saliva, hair analysis and/or blood work is not used to treat or diagnose any disease. These types of testing simply offer guidance on how to use whole food supplements and herbs to support and balance the body, while dealing with imbalances.

BILLING

We do not bill insurance for body therapy, colonics, nutritional services, or natural supplements. In addition, any chiropractic services that are not covered by NHCS approved insurance companies, you will be responsible to pay separately.

Please sign to confirm that you have read and understand the above information. Patient Signature _____ Date _____

Thank you so much for taking the time to fill out this packet of information. We look so forward to working with and getting to know you. We are dedicated to finding the best individual path for each of our patients.