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 (HIPPA), Your privacy is important to us. We will not share any of your medical information without your express permission as outlined in the HIPPA privacy act. If you ever have any questions or concerns regarding the use or the dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the Neuro Integration Services Notice of Privacy for Health Information.

____

Patient Name Date

____

Patient Signature Date

____

Patient Representative Printed Personal Representative Signature

I authorize Eileen King and her representative to contact me by phone, text, or email. From time to time, Eileen King may need to disclose your protected health information to outside sources, such as other doctors. We never do so without your written permission.

____

Patient Signature Date

CONSENT TO RECEIVE NEUROLOGICAL INTEGRATION SYSTEM
WAIVER AND RELEASE OF LIABILITY FORM

I ____, have sought services from Ms. Eileen King, RN related to non-medical, non-invasive therapeutic treatment, referred to as "neurological integration system." I hereby authorize her to treat me in accordance with my request, and consider this consent, waiver and release to be ongoing and continuing until expressly revoked in writing to Ms. King. I have been advised that neurological integration system requires Ms. King or her designee to place her hand or hands on certain parts of my body, the locations of which she will discuss with me prior to performing the treatment. Once her hands are placed on my body, she will highlight neurological pathways and then test for muscle strength. Ms. King will not place her hand or hands at or near areas I have identified as wounded, or where she observes peeling or blistering skin, an open wound, a rash, or where she observes redness, swelling, warmth, or any discharge unless I specifically consent. I expressly agree that the services performed by Ms. King are NOT considered massage therapy or chiropractic treatment, and Ms. King has not held herself out as a Massage Therapist or a Chiropractor. I have fully informed Ms. King of my complete and detailed medical history. I have discussed neurological integration system with my physician and he/she has not advised against neurological integration system. I understand the risks associated with the treatment which include, but are not limited to tenderness, fatigue, sensitivity, and soreness. I also understand that neurological integration system and the techniques associated with it are unregulated by the State of Texas, and therefore I consent to treatment knowing that unregulated practices are inherently dangerous, and come with unknown and uncertain risks.

I desire that this Consent, Waiver and Release be governed by Texas law.

In consideration of the foregoing, I persist in my desire to receive treatment from Ms. King and therefore, I HEREBY ASSUME ALL OF THE RISKS OF PARTICIPATING IN AND RECEIVING THREATMENT FROM MS. KING.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A WAIVER AND I SIGN IT OF MY OWN FREE WILL.

____
Releasor's Signature

Patient name if minor

____
Releasor's Name

Relationship to Patient

____
Witness

____
Date

Confidential Patient Health Record

DATE

Personal Information

Name: ______________________ Address: _____________________________________

City: _______________________ State/Prov: _________ Zip/Postal Code: ___________

Home Phone: ________________ Birth Date: _________ Age:_____ Sex: [ ]M [ ]F [ ]Other

Cell Phone: __________________ Email Address: ________________________________

Name and Number of Emergency Contact: _____________________________________

Occupation: ____

Circle One: Married Single Widowed Divorced Separated

Name(s) and Age(s) of Children: ____

Current Health Condition

Health Condition: ____

Other Doctors Seen For This Condition: [ ] Yes [ ] No Who?: ___________________________

Types of Treatment: _____________________________ Results: __________________________

When Did This Condition Begin?: ____

All Current Medications Taken: ____

____

Past Health Conditions

Past Health Conditions: ____

____

Surgeries/Operations: ____

____

Major Accidents/Falls: ____

____

Hospitalizations (Other Than Above): ____

____

Other Information

Any other information that will be helpful to your practitioner to know: ________________

____

____

Other Questions or Concerns: ____

____

Check any of the following that apply:

NEUROLOGICAL

[ ] A.D.D./A.D.H.D.
[ ] Anxiety
[ ] Balance Problems
[ ] Blurry Vision
[ ] Light Sensitivity
[ ] Cold hands/feet
[ ] Concussion
[ ] Dental Problems
[ ] Depression
[ ] Dizziness
[ ] Drug/Alcohol Addiction
[ ] Eating Disorder
[ ] Epilepsy/Seizure Disorder
[ ] Eye Problems
[ ] Facial Pain/Twitching
[ ] Fainting
[ ] Fatigue
[ ] Headache/Migraine
[ ] Irritability
[ ] Learning Disabilities
[ ] Loss of Taste or Smell
[ ] Memory Issues
[ ] Mental Illness
[ ] Numb Arms or Legs
[ ] O.C.D.
[ ] Paralysis
[ ] Tinnitus(Ringing in Ears)
[ ] Hearing Loss

MUSCULOSKELETAL

[ ] Neck Pain
[ ] Arm Pain
[ ] Joint Pain/Stiffness
[ ] Pain Between Shoulders
[ ] Low Back Pain
[ ] Walking Problems
[ ] Difficulty Chewing/Lockjaw
[ ] General Stiffness

GENERAL

[ ] Allergies
[ ] Asthma
[ ] Arthritis
[ ] Anemia
[ ] Autoimmune
[ ] Bed Wetting
[ ] Diabetes
[ ] Cancer
[ ] Obesity
[ ] Heart Problems
[ ] Irregular Heartbeat
[ ] Bronchitis
[ ] Circulatory Problems
[ ] Stroke
[ ] Cold Sores/Herpes
[ ] Lung Problems
[ ] Environmental Sensitivities
[ ] Bladder/Kidney Disease
[ ] Liver/Gallbladder Disease
[ ] Blood Pressure Problems
[ ] Osteoporosis
[ ] Chronic Fatigue Syndrome
[ ] Sleep Issues

GASTROINTESTINAL

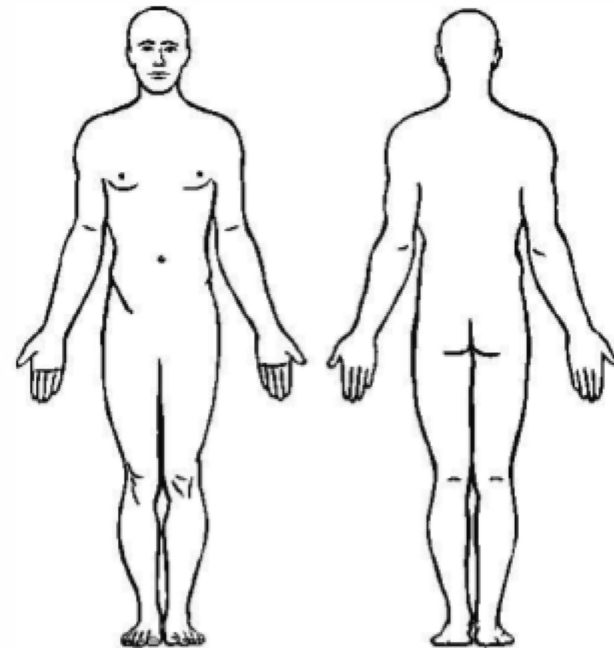
[ ] Poor/Excessive Appetite
[ ] Excessive Thirst
[ ] Celiac
[ ] Colitis
[ ] Constipation
[ ] Abdominal Cramps
[ ] Frequent Nausea
[ ] Vomiting
[ ] Diarrhea
[ ] Diverticular Disease
[ ] Food Intolerance
[ ] Gastroesophageal Reflux Disease
[ ] Hemorrhoids
[ ] Indigestion
[ ] Inflammatory Bowel Disease
[ ] Weight Trouble
[ ] Ulcer

MALE/FEMALE

[ ] Menstrual Irregularities
[ ] Menstrual Cramps
[ ] Endometriosis
[ ] Fibrocystic Breasts
[ ] Breast Cancer
[ ] Benign Prostate Hyperplasia
[ ] Prostate Cancer
[ ] Decreased Sex Drive
[ ] Sexually Transmitted Disease
[ ] Sexual Dysfunction
[ ] Infertility

When was your last period? ______________________

Are you pregnant?
[ ] Yes [ ] No [ ] Maybe



Please outline on the diagram the area(s) of your discomfort

Anything else you think is important for the practitioner to know:

____

____

____

Neuro Integration Services

Fee Schedule

Initial Integration $255

Follow-up Integration $85

Family discounts

3 or more Initial Integrations together will receive $100 off

4 or more Follow-up Integrations per family in a week $75/person

Referral discount

$15 off your next integration after your referral has completed their Initial Integration

Remind your friend to give you credit!!!!

Cancellation fees

Cancelled appointments require 24 hour notice. If less than 24 hours, you will be responsible for your appointment fee.