PEDIATRIC HISTORY FORM

Dear New Patient,

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name:____________________ S.S.#____________

Address:____________________ City:____________

State:__________ Zip:__________ Home Phone:____________

Birth Date:_____/_____/_____ Work Phone:____________

Sex:________ Weight:________ Height:________ Referred by:____________

Names of Parents / Gauradians:____________________

Purpose For Contacting Us? ____________________

Other doctors seen for this condition: _____No _____Yes; Doctors' Names and Prior Treatments:__________

Other Health Problems?____________________

Check any of the following conditions your child has suffered from during the past six months:

___Ear Infections ___Scoliosis ___Seizures ___Chronic Colds ___Headaches
___Asthma/Allergies ___ADHD ___Recurring fevers ___Colic ___Growing/Back Pain
___Bed wetting ___Car Accident ___Digestive Problems ___Temper Tantrums ___Other________

Family History:____________________

Previous Chiropractor:____________ Date of last visit:________ Reason:________

Name of Pediatrician:____________ Date of last visit:________ Reason:________
Are you satisfied with the care which your child has received there? _____No _____Yes

Number of Doses of Antibiotics Your Child has Taken:
During the past six months:________ Total During his / her lifetime:________

Number of Doses of Other Prescription Medications Your Child has Taken:
During the past six months:________ Total During his / her lifetime:________ List:________

Vaccination History:____________________

Prenatal History:

Name of Obstetrician / Midwife:____________________

Complications during pregnancy? ____No ____Yes; List:____________

Ultrasounds during pregnancy? _____No _____Yes; Number:________

Medications during pregnancy / delivery? ____No _____Yes; List:____________

Cigarette / Alcohol use during pregnancy? ____No ____Yes

Location of Birth: _____Hospital _____Birthing Center _____Home _____Other:________

Birth Intervention: _____Forceps ____Vacuum Extraction

_____Ceasarian Section : emergency or planned (please circle)

Complications during delivery? ____No _____Yes List:____________________________

Genetic Disorders or Disabilities: _____No _____Yes List:____________________________

Birth Weight:________ Birth Length:________ APGAR Scores:______,______

Was delivery within 2 weeks of due date? _____Yes ______No # of days premature / late:________

Feeding History:

Breast fed: _____No _____Yes How long?_______

Formula fed: _____No _____Yes How long?_______ Type:____________________

Introduced to solids at: ______months; Cow's Milk at _____months

Food / Juice Allergies or Intolerances: ______No ______Yes List:____________________

____

Developmental History:

During the following times your child is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

________Respond to Sound

________Respond to Visual Stimuli

________Hold Head Up

________Sit Up

________Cross Crawl

________Stand Alone

________Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their 1st year of life (i.e. a bed, changing table, stairs, etc.) Was this the case with your child? ___No ___Yes

Is / Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) _____No _____Yes List:____________________

Has your child ever been involved in a car accident? _____No _____Yes List:____________________

Has your child been seen on an emergency basis? ____No ____Yes List:____________________

Other traumas not described above? ____No ____Yes List:____________________

Prior surgery: ____No ____Yes List:____________________

Menarche: _____No _____Yes Age:_________

Childhood Diseases:

Chicken Pox N / Y Age_________

Rubella N / Y Age_________

Rubeola N / Y Age_________

Mumps N / Y Age_________

Whooping Cough N / Y Age_________

Other:__________ N / Y Age_________

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL, AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care for my son / daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: ______________________________ Relationship to patient:____________ Date:______/______/______

Office Fee Schedule and Financial Policy

Service	Fee
Chiropractic Adjustment	$40**
Mechanical Distraction	$20
Manual Therapy	$30
Assessment/Computerized Spinal Scans	$50 to $150 each
X-Rays (3 view cerv, 2 view thor, 2 view lumbar)	$155

****There is a cash discount adjustment fee of $35 if you do not have insurance benefits or choose not to have us file your insurance claims. Our costs are significantly reduced if we do not file your insurance claims and we pass the discount on to you.**

Financial Policy and Adjustment Packages

- We are committed to providing you & your family with exceptional Chiropractic care & service in a healing environment & have established our financial policies to achieve that goal. In the event you do not have insurance that contributes to Chiropractic care, or if your benefits have been exhausted, we have Adjustment Packages available for purchase for everyone interested in getting the most out of Chiropractic and moving toward full expression of life. These packages are designed to help you & your family take strides in growing stronger and more amazing each day with Chiropractic care. Your options will be discussed in your Chiropractic report.

- If you have insurance that will contribute to your Chiropractic care, we will file your insurance claims for you, as a courtesy, however, keep in mind that **your agreement is between you and your insurance** company & payment for any portion of your financial responsibility is expected in a timely manner. Verification of insurance coverage is NOT a guarantee of payment. We do not base your care recommendations on your insurance coverage & neither should you. It is not uncommon for your insurance coverage to stop in the middle of a care plan. **You are also responsible for keeping track of your visits (how many are covered) for insurance purposes, and when your coverage stops.** For this reason, we have Adjustment Package options to fit various needs, because your health is important to us! It is also important for your family to enjoy the many benefits of Chiropractic-just ask about our Adjustment Packages to make this possible for your family. The investment you make in yourself and your family will pay lifelong dividends.

- **Payment will be expected at the time services are rendered, unless you have arranged an Adjustment Package in advance. If you are paying on a per visit basis, it is an office policy to allow a patient balance of no more than $60 to accrue on an account. We may be able to make flexible payment arrangements with you in advance, but open communication is a must – keep us in the loop and we are happy to discuss it.**

- If you acquire insurance for a special situation, such as Personal Injury, Auto Accident or Worker's Compensation Claim, and choose to utilize that coverage, we will file your insurance claims for you. Personal Injury or Auto Accident claims without PIP coverage will only be accepted on a lien basis if there is Attorney representation. This ensures that you receive the care you need to recover from your injuries and are not left financially responsible for services rendered during care at our office.

I have read, I understand, and I accept the above policies.

Patient Signature ____________________ Printed Name ____________________ Date ____________________

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

______________________________ (signature)   ____________________ (date)

Naturally Chiropractic Family Wellness Center, Inc. PS – 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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Naturally Chiropractic Family Wellness Center, Inc., PS is required by a federal law called the Health Information Portability and Accountability Act, (HIPAA) of 1996, to maintain the privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices with respect to your protected health information. Protected health information means any information that is identifiable to you as your personal information, including information on you health care, condition (past, present and future), and treatment, your name, age, address, phone number and social security number.

This notice takes effect April 14, 2003, and will remain in effect until we replace it.

Use and Disclosures of Protected Health Information:

We use and disclose protected health information about you for your treatment, payment for your care, and our business operations. This information may be used by your doctor(s), our office staff, and others outside our office who are involved in your care, payment of these services, operations of your doctor's practice, and any other use required by law. The following are some examples of how we may use or disclose information about you:

- **Treatment**
  We may use and disclose your protected health information to provide, coordinate or manage your health care, and any related services. For example, your protected health information may be disclosed to a physician to whom you have been referred so that the physician may have the necessary information to diagnose and treat you.
- **Payment**
  Your protected health information may be used to obtain payment for your health care services. For example, your protected health information may be disclosed to your health benefits provider to obtain the approval and information necessary to receive payment for your services from that benefits provider.
- **Operations**
  Your protected health information may be disclosed or used to support the business activities of Naturally Chiropractic Family Wellness Center, Inc., Ps. These activities include, but are not limited to, employee review activities, staff training, licensing of the facility and staff, and conducting or arranging for other business activities. For example, we may use your protected health information to contact you regarding an appointment, we may call you by name in the reception room, we may use a sign-in sheet at the front desk where you will be asked to indicate your name.

Other Uses and Disclosures of Protected Health Information:

- **Marketing**
  We may use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products or services that may be of interest to you. The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care.

- **Incidental Disclosures**
  It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is **NOT** the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

  We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure.

  The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

We May Be Required By Law to Provide Your Information For Legal and/or Governmental Purposes:

- **If required by law by state or federal agencies, including workers' compensation laws & authorities**
- **Public Health & Safety - to prevent a serious threat to your health & safety, that of the public, or to prevent or control disease**
- **Abuse or Neglect – either child abuse and/or neglect, and/or domestic violence**
- **Oversight agencies – such as those conducting audits, examinations, investigations or licensures**
- **Legal Proceedings – by order of a court or administrative agency, in response to a subpoena, discovery request or other lawful purposes**
- **Law Enforcement – in limited circumstances, i.e. : to identify a witness or missing person**
- **Deceased Person Information – to coroners, medical examiners, and funeral directors to carry out their duties**
- **Specialzed Government Functions – national security and intelligence activities authorized by law, and as required by military authorities if you are a member of the armed services**

We DO NOT and WILL NOT sell your non-public information to anyone. Any other uses or disclosures of your protected health information will only be made with your consent, authorization or opportunity to object, unless required by law.

*****PLEASE TURN THE PAGE OVER TO COMPLETE YOUR REVIEW OFTHIS INFORMATION AND TO ACKNOWLEDGE YOUR RECEIPT OF THIS INFORMATION.*****

Your Rights:

The following is a statement of your rights with respect to your protected health information:

- **Your have the right to inspect and copy your protected health information.**
  However, you may note inspect or copy the following records: treatment notes, information compiled in reasonable anticipation or use in a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Your request for inspection and copy must be in writing. Record copying will be accepted at legal copying fees.

- **You have a right to request the restriction of your protected health information.**
  You may ask us not to use or disclose your protected information for the purposes of treatment, payment or operations, or that your information not be disclosed to any of your friends or family members for notification purposes. Your request must be in writing and state the specific restriction and to whom it should be applied.

  Your doctor is not required to agree with your restriction request, if the doctor feels it is in your best interest to use or disclose your information. You then have the right to choose another health care professional.

- **You have the right to request to receive confidential communication from us via an alternative means or location.**
- **You have the right to receive a paper copy of this notice from us, upon request.**
- **You may have the right to have your doctor amend your protected health information.**
  If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of the rebuttal.

- **You have a right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you of any changes by mail. You then have the right to object or withdraw, as provided in this notice.

You may complain to us or to the Department of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not take any retaliatory action should you file a complaint against us.

Security Measures:
We restrict access to non-public information, with federally compliant physical, electronic, and procedural safeguards, to those who need to know that information at levels necessary to conduct our business.

By law, we cannot share your protected health information about care or condition with anyone, including your spouse, without written consent from you. However, we assume that we have permission to leave messages on your answering machine or voicemail, unless you request, in writing, that we do not.

We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our privacy office in person or by phone.

Signature below is only an acknowledgement that you have received this Notice of Privacy Practices.

Printed Name:____________________ Signature:____________________ Date:__________