ABUNDANT HEALTH
CHIROPRACTIC

Pediatric Patient Information

Date: _____

Name: _____ Nickname**:** _____

Street Address: _____

City:_____ State: _____ Zip code: _____

Female: ____ Male: ____ Date of Birth: _____

SSN: _____-____-_____ Referred by:_____

Name of Parent:_____Phone_____Cell Phone Carrier_____

Purpose for Contacting Us?

_____

_____

_____

Other Doctors Seen for this Condition:_____N_____Y Doctors' Names and Prior Treatments:

_____

_____

Please check conditions your child currently has or has had in the past 6 months:

- ☐ Allergies
- ☐ Asthma
- ☐ Attention Problems/ADD/ADHD
- ☐ Back Pain
- ☐ Bed Wetting
- ☐ Bronchitis/Upper Respiratory Infections
- ☐ Chronic Colds
- ☐ Colic
- ☐ Constipation/Diarrhea
- ☐ Digestive Problems
- ☐ Ear Infections
- ☐ Ear Infections
- ☐ Eczema/Skin Problems
- ☐ Growing Pains
- ☐ Headaches
- ☐ Recurring Fevers
- ☐ Car Accident
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sinus Trouble
- ☐ Temper Tantrums
- ☐ Other

_____

_____

Previous Chiropractor:_____

Date of Last Visit: ___/___/____ Reason:_____

Name of Pediatrician:_____

Date of Last Visit:___/___/____

Are you satisfied with the Care your Child has Received There? ____N ____Y

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Vaccination History:
_____
_____
_____

Please list any medications or vitamins/supplements your child may be taking:

Medications	Vitamins/Supplements
_____	_____
_____	_____

 # Of doses of antibiotics your child has taken: _____6 months _____ during lifetime

Were there any complications in the pregnancy or birth of this child?
_____

Ultrasounds During Pregnancy?____N____Y, Number: _____
Medications During Pregnancy/Delivery? _____ N____Y, List:_____
Cigarette/Alcohol Use During Pregnancy: _____N____Y

Location of Birth_____ Hospital_____Birthing Center_____ Home
Birth Intervention_____Forceps_____ Vacuum Extraction____ Caesarian Section, Emergency or Planned?_____
Complications During Delivery?____N_____Y, List:_____
Genetic Disorders or Disabilities:____N____Y, List:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____

Feeding History:

Breast Fed:_____N_____Y, How long:_____

Formula Fed:____N_____Y, How long:_____

Introduced to Solids at:___Months, Cows' Milk at _____ Months

Food Intolerances_____N_____Y, List:_____

Any other dietary preferences/restrictions your child may have:
_____
_____

Does your child consume any of the following? Please check:

☐ Juice	___glasses/day	☐ Sugar	___/day
☐ Soda	___/week	☐ Processed Food	___/week
☐ Milk	___glasses/day	☐ Sweeteners	
☐ Fast Food	___/week	☐ Other _____	

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Developmental History:

During the following times your child's spine 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 first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child ? _____N _____Y

Is / has your child been involved in any high impact or contact type sport (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____ N _____Y, List:

_____

Has your child ever been involved in a Car Accident? _____ N _____ Y, List:

_____

Has your child been seen on an Emergency Basis? _____ N _____ Y, List:

_____

Other Traumas Not Described Above? _____ N _____ Y, List:

_____

Prior Surgery: _____ N _____ Y, List:

_____

Menarche: _____ N _____ Y, Age: _____

Childhood Diseases:

Chicken Pox	N☐ Y☐ Age_____	Mumps	N☐ Y☐ Age _____
Rubella	N☐ Y☐ Age_____	Whooping Cough	N☐ Y☐ Age _____
Rubeola	N☐ Y☐ Age_____	Other	N☐ Y☐ Age _____

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ABUNDANT HEALTH
CHIROPRACTIC

Consent to Chiropractic Services for a Minor

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

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. 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. The objective of chiropractic health care in this office is ***to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations***.

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.Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.

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.

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

Outcomes and options relative to care have been discussed and noted. All questions regarding the doctor's objectives pertaining to my child's care in this office have been answered to my complete satisfaction.
I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary:

_____ _____
(signature) (date)

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Financial Policy

Payment in full is expected in all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing. **The cash fee for a new pediatric patient should not exceed $128, which includes the initial consult, a chiropractic exam, x-rays and if applicable the first adjustment.**

If your insurance company covers Chiropractic care and you would like us to assist you in the billing process please fill out the "insurance permission" section below.

Returned checks and balances over 30 days will be subject to additional collections fees and interest charges. (Past due account will be sent to collections after 60 days). I understand that I am responsible for any charges and fees from the collections agency.

Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regards to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

I have read, understand & agree to financial policies for Abundant Health Chiropractic.

Signed _____ Date_____

Witness _____ Date_____

Insurance Permission

As a courtesy to you we will bill your insurance company. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 60 days, payment is still not received, you will be responsible for payment. We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company:
"I authorize Abundant Health Chiropractic to release to my insurance company any medical or other information necessary to process my insurance claims."
"I authorize payment be made directly to Abundant Health Chiropractic. I permit a copy of this authorization to be used in place of the original."

Signature: _____ Date _____

Also, if you are <u>not</u> the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process. Thank you.

Subscriber's name: _____ Subscriber's date of birth: _____

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Appointment Reminders and Health Care Information Authorization

The following office procedures allow Abundant Health Chiropractic to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not to be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We require 24 hour notice to cancel an appointment. Any missed appointments without notice will result in a $10 fee.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including postcards) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- When you refer anyone to us, we would like to directly thank you and publicly thank you on our office announcement board.
- We would like to be able to refer others to speak with you about your experience at Abundant Health Chiropractic.
- We often take and post photos of our practice members/patients in the office and in our newsletters.

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Abundant Health Chiropractic.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

We at Abundant Health Chiropractic 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 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Abundant Health Chiropractic's *Notice of Privacy Practices for Protected Health Information.* Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

_____	_____
Patient name printed	Date
_____	_____
Patient Signature	ABC representative

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NOTICE OF PRIVACY PRACTICES:

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include exams and therapy.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting written requests to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1st, 2018 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Service
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices Acknowledgement, but could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)