

PEDIATRIC PATIENT INTRODUCTION

Child's Name: _____

Mother's Name: _____ Father's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Cell Phone: _____ Best Email: _____

How would you prefer to receive appointment reminders? Email or Text to Cell

If text to cell is preferred, please provide the name of your cell phone provider: _____

Birth Date: _____ Age: _____ Sex: _____ Number of Siblings: _____

Who was it that referred you? We'd love to send them a thank you card _____

Birth Weight: _____ Birth Length: _____ Current Weight: _____ Current Length: _____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Date of Last Visit: _____ Purpose: _____

Immunization History (Circle One): Current Delayed Schedule None

Did your child react to them? Y N If yes, how so? _____

Current Medications: _____

Current Supplements: _____

Previous Chiropractor: _____

Other Specialists seen in last 6 months: _____

Has your child ever been treated on an emergency basis? _____ If yes, please explain? _____

Type of Birth: Normal Vaginal _____ Forceps _____ Cesarean _____ Suction/Vacuum _____ Induced Labor _____

Location: Home _____ Birthing Center _____ Hospital _____ Duration of Gestation: _____

Problems during pregnancy: _____

Problems during labor/delivery: _____

Apgar Scores: _____ Was there presence at birth of: Jaundice (yellow)? _____ Cynosis (blue)? _____

Congenital anomalies/defect? _____ If yes, please explain? _____

Has this child ever suffered any major traumas?

Do the child's siblings have any health problems? Y N If yes, please explain? _____

Questions about chemical environmental concerns:

During pregnancy, did the mother:

1. Smoke Y N 2. Drink alcohol? Y N 3. Take supplements/ vitamins? Y N

4. Use Medications or other drugs? Y N If yes, what? _____ 5. Become ill? If so, How? _____

6. Receive invasive procedures? (ie. Amniocentesis, CVS) Y N If yes, explain: _____

Was your child breast fed? Y N If yes, for how long? _____ (weeks months years)

At what month/yr was: 1. Formula introduced? _____ 2. Cow's milk? _____ 3. Solid foods? _____

Has your child had antibiotics? Y N If yes, how many and why? _____

Any pets at home? Y N Any smokers at home? Y N If yes, how much? _____

Questions about psychological considerations:

Any difficulties with lactation? Y N Any problems bonding? Y N

Does your child seem normal to you? Y N

Does your child have any behavior problems? Y N If yes, what? _____

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? _____

Number of hours sleeping per night: _____ Quality of Sleep: Good ____ Fair ____ Poor ____

Did your child go to daycare? Y N From what age? _____

Average number of hours of TV/Computer per week? _____

Questions about traumas:

Any evidence of trauma at birth? Bruises Odd shaped head Stuck in birth canal Fast/Long birth

Respiratory Depression Cord around neck Other _____

Any falls/accidents during pregnancy? Y N If yes, please explain: _____

Any hospitalizations? Y N If yes, Please explain: _____

Does your child play sports? Y N Number of hours per week? _____

Has the child ever sustained injuries in an auto accident? Y N If yes, explain: _____

Approx. hours spent at play per week? _____ hrs

At what age did the child:

Sit alone _____ Crawl _____ Stand _____ Walk Alone _____ Vocalize _____

Did this child suffer from the following childhood diseases?

Chickenpox _____ Mumps _____ Measles _____ Rubella _____

Rubeola _____ Whooping Cough _____ Other _____

Allergies: _____

Other _____

Does your child experience any of these other symptoms?

Headaches	Digestive issues	Behavioral Problems	Dizziness	Neck Problems	Poor Appetite
ADD/ADHD	Fainting	Arm/Leg Problems	Stomach Aches	Hernias	Reflux
Seizures	Cardiac Issues	Constipation	Diarrhea	Growing Pains	Chronic Earaches
Backaches	Sinus Issues	Poor Posture	Diabetes	Asthma	Scoliosis
Asthma	Hypertension	Colds/Flu	Difficulty Walking	Anemia	Colic
Broken Bones	Bed Wetting	Other:			

Expectations for Care

We want to help you meet your health care goals and we also want to meet your expectations. Let us know about past clinical experiences you wish to avoid or replicate:

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. To put these occurrences in perspective, once in a million is about the same chance as get-ting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. The

PhysioTherapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Dry Needling and/or Chiropractic Acupuncture adverse reactions include bruising, numbness or tingling near the needling sites, dizziness or fainting. More rare events include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is a possible risk, though the clinic uses sterile disposable needles and maintains a clean and safe environment.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, physical therapy and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____
(if a minor)

Signature of Witness: _____ Date: _____

Financial/Privacy Policy and Disclaimer

Returned Checks: It is our policy to collect \$25.00 for returned checks. This is to cover any fees that apply from the transaction.

Financial Policy Questions: We are happy to address questions regarding your account at any time. Please direct account questions to our billing administrator.

HIPAA Privacy Policy: Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you. By signing below, you acknowledge that you have received the HIPAA Privacy Policy and that you understand and will comply with our financial policies.

Collection of Patient Balance

*****Please initial the following to acknowledge that you have read each statement.**

_____ **All payments are due at time of service.** (Payments may include co-payments, co-insurance, deductibles, and non-covered services.)

_____ All balances remaining unpaid after 60 days will be turned over to a collection agency.

_____ Your insurance company can and will be billed, determined by your preference and our current status as in-network or out-of-network with that company. **Capital Chiropractic cannot guarantee your coverage,** even if our office attempts to confirm your benefits and eligibility. Final approval of coverage is based on the explanation of benefits after the claim has been filed.

_____ Any covered and non-covered services are the responsibility of the patient at the rate determined by the insurance company's explanation of benefits. **It is the patient's responsibility to understand his/her insurance policy and the intricacies of coverage.** Capital Chiropractic cannot guarantee exact details of your specific policy at any time.

_____ If unable to make your appointment, please notify our office at least 24 hours' notice out of respect and courtesy to other patients. **After two (2) missed/cancelled visits without 24 hours' notice, you will be charged \$50.00 for each visit that is missed.** You will be responsible for this payment.

Designation of Authorized Representative

- I do hereby designate Capital Chiropractic and Rehabilitation Center to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Capital Chiropractic and Rehabilitation Center. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, health care benefit plan reimbursement and to pursue any other applicable remedies.

- I do hereby authorize Capital Chiropractic and Rehabilitation Center to act on my behalf to pursue claims and exercise all rights in order to collect payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Capital Chiropractic and Rehabilitation Center.

I agree to Financial Policy and have read and agreed to HIPAA documents provided:

Signature of Patient: _____ Date: _____

Release of Protected Health Information

I, _____, give my consent to allow the transfer and/or discussion of my protected health information to be released to this office. I understand that as a patient, my health information is confidential, and will be treated as such by this office, Capital Chiropractic and Rehabilitation Center, PLLC. I understand that any information collected by this office will be for the benefit of care provided, and will remain confidential between this office and the providing practitioner.

To attest to my consent to the release of my information, I hereby affix my signature to this authorization.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian (if a minor): _____ Date: _____

Capital Chiropractic & Rehabilitation Center
Consent to Communicate PHI by Email/SMS

I expressly permit Capital Chiropractic & Rehabilitation Center, PLLC to communicate my Protected Health Information (PHI) via email to the email address indicated on my patient registration form or this form. This permit also applies to any email correspondence that Capital Chiropractic & Rehabilitation Center, PLLC may send to my primary care physician or referring clinician, if appropriate.

EMAIL RISKS AND YOUR RESPONSIBILITY

If you agree to permit Capital Chiropractic & Rehabilitation Center, PLLC to use email to communicate with you, be aware of the following risks and/or your responsibilities:

- As **the internet is not secure** or private, unauthorized people may be able to intercept, read, and possibly modify email you send to or receive from Capital Chiropractic.
- It is solely your responsibility to protect your own email account, password, and computer against access by unauthorized people.
- Since emails can easily be copied, printed, and forwarded, you should be careful regarding to whom you send emails.

CONDITIONS FOR THE USE OF EMAIL

By consenting to the use of email with Capital Chiropractic & Rehabilitation Center, PLLC, you agree that:

- Capital Chiropractic may forward emails, as appropriate, for diagnosis, treatment, reimbursement, and other related reasons. Capital Chiropractic employees and agents, other than the recipient, may have access to emails that you send. Such access will only be to persons who have a right to access your email to provide services to you.
- Capital Chiropractic will not forward emails to independent third parties, except as authorized or required by law.
- You should not use email to communicate with Capital Chiropractic if there is an emergency or when you require an answer in a short period of time.
- If your email requires or asks for a response and you have not received a response within a reasonable time period, it is your responsibility to follow up directly via voice telephone call or in person.
- You should carefully consider the use of email for the communication of sensitive medical information, such as, but not limited to, information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- Capital Chiropractic & Rehabilitation Center, PLLC reserves the right to save your email and include your email or information contained within your email in your medical record.

INSTRUCTIONS

- You should immediately inform Capital Chiropractic if you change your email address.
- If you wish to withdraw this consent to communicate by e-mail, you must send an email to Capital Chiropractic stating such.

Text/SMS Appointment Reminders and Communications

- I understand that if I opt for appointment reminders via text that I will receive text reminders. If I reply to that text message in order to change/reschedule my appointment, I understand that this messaging also utilizes email as a platform to relay communications.

Social Media Communications

- I understand that it is my choice to communicate with Capital Chiropractic & Rehabilitation Center via social media platforms and that if I choose to communicate via social media, I have then consented to utilizing this platform for future communications.

ACKNOWLEDGMENT AND AGREEMENT

Capital Chiropractic & Rehabilitation Center, PLLC will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, Capital Chiropractic & Rehabilitation Center, PLLC **cannot guarantee that email will be confidential**. Additionally, Capital Chiropractic & Rehabilitation Center, PLLC will not be liable in the event that you or anyone else inappropriately uses or accesses your email. Capital Chiropractic & Rehabilitation Center, PLLC will not be liable for improper disclosure of your health information that is not caused by intentional misconduct by agents of Capital Chiropractic & Rehabilitation Center.

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of email and consent to the conditions outlined herein, as well as any other instructions that the Capital Chiropractic & Rehabilitation Center, PLLC may impose to communicate with me by e-mail. Any questions I may have had were answered. I understand that this consent is valid until such time as I revoke the consent as outlined above, except to the extent that a person who is to make a communication has already acted in reliance upon this authorization.

Signature: _____ Date: _____

Printed Name: _____