PRECISION
CHIROPRACTIC

PEDIATRIC NEW PATIENT HEALTH HISTORY FORM

We are pleased to welcome your family to ours!

As your child begins care, you will see many changes. Better health, improved athletic performance, fewer sick days and missed school days, just to name a few.

Please take a few minutes to fill out this form as completely as you can.
If you have questions about this paperwork, or our procedures, please ask us.
We look forward to working with you in improving and maintaining your health.

Your health is your most valuable asset, so remember –

Be Healthy By Choice, Not By Chance!

PATIENT INFORMATION

Child Name_____ Start Date_____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female (check one)

Social Security Number: _____-___-_____

Whom may we thank for referring you? _____

Patient attends : School/ Daycare/ Preschool/ At Home (please circle one) Grade: _____

Person responsible for payment: _____

Payment By: Cash/ Check/ Credit Card/ Insurance (please circle one) *If using insurance, we will need to make a copy of your card.

Parent(s)/Guardian: _____

Siblings: _____ Special Circumstances: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Child: _____

PATIENT HISTORY

Birth Weight: _____ pounds Birth Length_____ APGAR Scores_____ Current Weight: _____pounds

Rate Patient Health 1-5 Scale: _____ (1 being excellent/5 being poor)

Rate Patient Diet 1-5 Scale: _____ (1 being excellent/5 being poor) Amount of Sleep per Night: _____ Quality of Sleep: Good/ Fair/ Poor (please circle one)

Sleeping Position: Back / Side /Stomach (please circle one)

Check all that apply:

____ Sleeps with more than 1 pillow

____ Carries bag / backpack on one side

____ Uses a waterbed / very soft mattress

Significant Family History: Cancer / Stroke / Heart Disease / Diabetes / Epilepsy / Migraines /

Arthritis / Thyroid Conditions/ Other: _____

Past Chiropractic Care: Yes / No (circle one)

Reason for this visit: _____

Type of Birth: Vaginal / Breech / C-Section (circle one)

Pregnancy Complications: _____

Delivery Complications: _____ Pediatrician/Primary Doctor: _____

Facility: _____ Phone Number: _____

Reason for last visit:_____ Number of antibiotics child has taken: past 6 months_____ total during life_____

Number of other prescription medications taken past 6 months_____ total during life_____

Vaccination history: None- signed waiver As recommended by MD

Feeding history: Breast fed? Yes/No If yes, how long?_____ Introduced to solids at _____ months Introduced to cow's milk at _____ months.

Location of Birth? Hospital/Home/Other_____ Was it chemically induced? Yes/No Doctor or Midwife Assisted? Medications During Labor? Yes/No Whatkind?_____

Were you lying down? Yes/No Did doctor have hands on the infant? Yes/No Birth intervention? Forceps/Vacuum Extraction/Caesarian Section/Hands On

Was a family member present? Yes/No Who?_____

Was the baby premature? Yes/No How many weeks?_____

Please circle all that apply: Fractures / Falls / Dislocations / Head Injuries / Car Accidents /

Surgeries / Seizures / Hospitalizations / Other: _____

Suffered with: Colic / Reflux / Constipation / Allergies / Asthma / Ear Infections / Chicken Pox/ Whooping Cough/ Rubella/Mumps/ADHD/Digestive Problems/Temper Tantrums/Headaches/Bed Wetting/Chronic Colds/Scoliosis/Recurring Fevers/Other: __ _____ Past Medical Conditions: _____

***D*evelopmental History:** At what age was your child able to:

Respond to sound_____ Respond to visual stimuli_____ Hold head up_____

Sit up_____ Crawl_____ Stand alone_____ Walk alone_____

1. Onset

What date did your major complaint(s) begin?_____

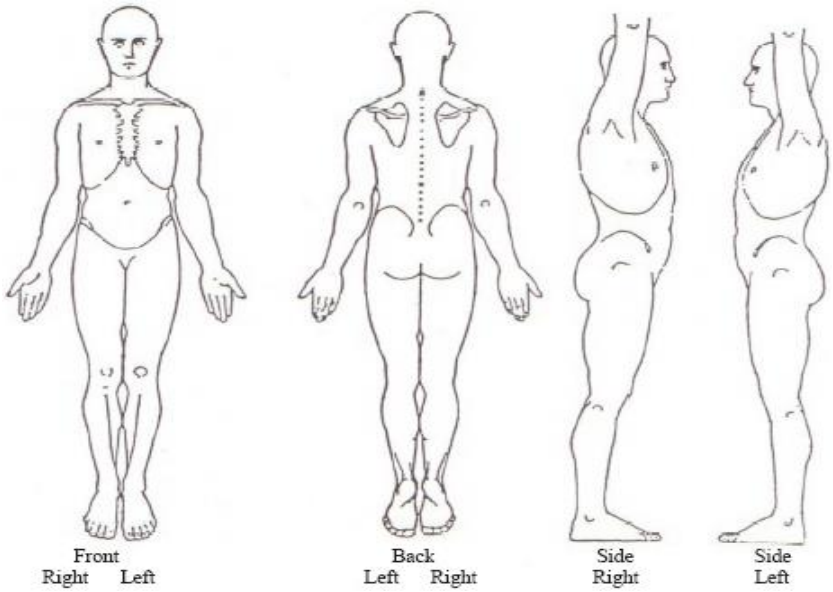
2. Pallitative

What makes the patients complaint(s) better: _____
What makes your complaint(s) worse: _____

3. Quality

On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters.

A: ache	**B: burning pain**	**K: cramping**
D: dull pain	**R: throbbing pain**	**N: numbness**
T: tingling	**S: sharp or stabbing pain**	**U: nonspecific pain**
RP: radiating pain	**H: hot**	**C: cold**



4. Radiation

Does the pain the patient is experiencing travel to any other part of their body? (If yes, please describe)

_____
_____

5. Severity

On the scale below, please **circle the severity** of the patient's **main complaint** (At Its Worst)

No pain 0 . . . . . I . . . . . I . . . . . I . . . . . I . . . . . I . . . . . I . . . . . I . . . . . I . . . . . I . . . . . 10 Intolerable

6. Time

On the scale below please circle the **percentage of time** the patient is experiencing their **main complaint:**

Occasional **Intermittent** **Frequent** **Constant**

_____I_____I_____I_____I_____I_____I_____I_____I_____I_____I__

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

When does the patient notice their complaint(s) the most? ☐ AM ☐ PM ☐BOTH

How long does it last? _____Minutes _____ Hours

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Has the patient had this problem in the past? ☐ Yes ☐ No (check one)

Because of this problem the patient has. . . ☐ been hospitalized ☐ been treated by another chiropractor
☐ been treated by another specialty provider ☐ never received care for this problem.

Activities patient is having trouble performing:

__________ No pain 0 . . . . . 1 . . . . . 2 . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 . . . . 10 Intolerable

__________ No pain 0 . . . . . 1 . . . . . 2 . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 . . . . 10 Intolerable

__________ No pain 0 . . . . . 1 . . . . . 2 . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 . . . . 10 Intolerable

__________ No pain 0 . . . . . 1 . . . . . 2 . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 . . . . 10 Intolerable

__________ No pain 0 . . . . . 1 . . . . . 2 . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 . . . . 10 Intolerable

The statements made on this form are accurate to the best of my recollection & I have left nothing out.

In the event that your insurance will not cover, you are responsible for your bill. Thank you.

____ ________________________

Signature of Parent/Guardian **Date**

In the event your child needs to be seen outside of office hours there is an additional $25.00 fee (beyond that of the appointment itself).

Patient Signature ____Date __________________

<u>For Doctor's Use Only</u>

Additional Notes: ____

____

____

____

____

____

Doctor's Signature____ Date ______________________

PRECISION
CHIROPRACTIC

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. In addition to how your PHI will be used, office policies regarding payment and collections, and consent to treat are listed below. By signing at the end of these policies, you agree to all stipulations.

1. The patient understands and agrees to allow Precision Chiropractic to use their PHI for the purpose of treatment payment, health care operations, and coordination of care.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections.
The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A Patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Precision Chiropractic to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care

8. Precision Chiropractic reserves the right to charge 18% interest on all outstanding balances over 90 days and from this day forward.

Patient Signature _____ Date _____

AUTHORIZATIONS, ASSIGNMENTS OF BENEFITS AND CONSENT TO TREAT

To: Precision Chiropractic Doctors, hereafter referred to as OFFICE

1. I authorize, assign and direct my insurance carrier, to pay directly to said OFFICE such sums as may be due and owing the OFFICE of services rendered me, now or hereafter, which are payable under my insurance contract, or contractual agreement

2. Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to the OFFICE. The OFFICE agrees to apply any proceeds to the patient's debt for services rendered

3. I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for expenses not paid by insurance. I understand and agree that either health insurance or automobile insurance may not pay all of the charges of the OFFICE for my treatment. I understand and agree to pay the customary charges of the OFFICE and agree that if my health insurance or automobile insurance does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that Precision Chiropractic reserves the right to charge $30 for missed appointments and that it may be necessary for OFFICE to record a lien on my case to ensure payment. I agree to pay the charges associated with filing of the lien.

4. I understand that if necessary of OFFICE to employ collection counsel and/or an attorney on my bill, I the patient will be responsible for any said collection and/or attorney fees.

5. I agree the OFFICE has the right to call my home or place of employment regarding appointment or insurance issues.

6. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including nutritional assessment, and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or licensed doctors of chiropractic who now or in the future treat me while employed by, or are associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic.

7. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.

8. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) I seek treatment.

9. A photocopy of this form shall be as valid as original

10. In the event you need to be seen outside of office hours there is an additional $25.00 fee (beyond that of the appointment itself).

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Patient's signature Date

_____ _____

Legal guardian if patient is a minor Relationship to min Date

Precision Chiropractic

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective July 21, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
(2) We are required to abide by the terms of this Notice currently in effect.
(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include providing care, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than providing care, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your health records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of health information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization.** Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about care alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare

Communication Barriers and Emergencies: We may use and disclose you protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency care situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of care. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

The most common use of your personal or health information will be to contact you regarding appointment reminders, scheduling or follow-up, office news, marketing, or special events, and health/wellness information. If you prefer that our office is not identified on the exterior of correspondence, that we not identify our office name while leaving a message, or you would like to be excluded from general office mailings, please submit this information to us in writing.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific authorization, which may be revoked at any time. In particular, except to the extent disclosure has been make to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information,** as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for care, Payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation of an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for providing care, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take on e home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

PRIVACY OFFICER
DANIEL LYONS, DC
2920 SOUTH WEBSTER AVE.
GREEN BAY, WI 54301
(920)347-4884

Last Name:_____ **Family Members:**_____

Insurance Coverage:

(Please present your insurance card when returning this form)

☐ Primary Medical Insurance:

Ins. Carrier:_____ Phone:_____

Policy Holder Name:_____

Policy Holder's DOB:_____ Relationship:_____

Policy #_____ Group:_____

(Please present your insurance card when returning this form)

☐ Secondary Medical Insurance:

Ins. Carrier:_____ Phone:_____

Policy Holder Name:_____

Policy Holder's DOB:_____ Relationship:_____

Policy #_____ Group:_____

(Please present your insurance card when returning this form)

☐ Teritiary (Other) Medical Insurance:

Ins. Carrier:_____ Phone:_____

Policy Holder Name:_____

Policy Holder's DOB:_____ Relationship:_____

Policy #_____ Group:_____

(If you are seeking treatment as a result of an accident or injury sustained while on the job- please complete this section)

☐ Workers Compensation Insurance:

Employer:_____ Phone:_____

Address:_____

Did you file an accident/injury: YES or NO Date of report:_____

Date of Accident/Injury: _____Time:_____ Workers

Compensation Carrier:_____

Name of Adjuster:_____Phone#:_____

Claim #:_____

(If you are seeking treatment as a result of an accident or injury sustained while on the job- please complete this section)

☐ Auto Accident/Insurance (or Personal Injury):

Your Auto Ins.
Carrier:_____Phone:_____

Name Of Adjuster:_____ Claim#_____

Their Auto Ins. Carrier:_____

Their Name: _____ Phone #:_____

Name of Their Adjuster:_____ Claim#:_____

Assignment of Benefits: I hereby assign and grant the benefits that I am eligible to receive for professional services rendered in the office of Precision Chiropractic. I authorize the release of any medical information necessary to process and insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance.

Patient Signature:_____ Date:_____