IMPACT chiropractic

Child - Personal Information

Child's First Name: _____ Last Name:_____ M.I.____

Parent(s) Name(s): _____

Address: _____

City:_____ State:_____ Zip:_____

Phone #: _____ Work #:_____

Email: _____

Child's Birth Date : _____/_____/_____ Child's Sex: M / F / unassigned

Siblings Names: _____ Age: _____ M / F / unassigned

_____ Age: _____ M / F / unassigned

_____ Age: _____ M / F / unassigned

Parent(s) Occupation(s): _____

_____

Who can we thank for referring you to our office? _____

Reason For Child's Care

What is your primary reason for seeking care? _____

_____

When did this begin? _____ Suddenly / Gradual

What did you first notice? _____

_____

What is this affecting that is MOST important to your child's life? _____

_____

Please check boxes in other areas you would like addressed or child has had in the past:

☐ Optimal Nervous System	☐ Milestone Check-Up	☐ Congestion / Allergies
☐ Sleeping Concerns	☐ Reflux / Colic	☐ Frequent Sickness
☐ Constipation	☐ Bed Wetting	☐ Autism/Asperger's
☐ Diarrhea / Vomiting	☐ Weight Concerns	☐ Lip / Tongue Tie
☐ Asthma / Bronchitis	☐ Ear Infections	☐ Diabetes
☐ Growing Pains	☐ Eczema/Skin Conditions	☐ Food Sensitivities
☐ Neck / Back Pain	☐ Learning Disabilities / ADHD	☐ Headaches

Please further describe any conditions checked above: _____

_____

_____

Has your child seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

Primary care physician/pediatrician: _____

Other providers or care physicians for your child:_____

_____

Prenatal History

Location of birth: Home Birth Center_____ Hospital:_____ Other: _____
Maternal age at delivery: _____
Did any of the following happen during delivery:
__Vaginal delivery __ C-section delivery __Anesthesia __ Labor was induced __ Unmedicated
__ Forceps/vacuum extraction __Doctor pulled/twisted baby __ Special medical procedures/tests
__ Full term delivery (_____weeks) __ Premature delivery (_____weeks)
Any other complications during delivery: _____
Medications during labor/delivery: _____
Illnesses during pregnancy? Yes No if yes, explain: _____
Medications during pregnancy? Yes No if yes, explain: _____
Any complications during pregnancy? Yes No if yes, explain:_____
Any complications after pregnancy? Yes No if yes, explain: _____
Medications given to child at hospital: Yes No if yes, explain: _____
Did you breastfeed the baby? Yes No if yes, how long: _____
Did you formula-feed the baby? Yes No if yes, how long: _____
Age which you introduced: Solids: _____ Cow's Milk: _____

Lifestyle Habits

Any allergies? Yes No if yes, explain: _____
Suspected food allergies/sensitivities: Yes No if yes, explain: _____
Select the foods most commonly in your child's diet:
__ dairy (milk / yogurt / cheese) __ carbohydrates (bread / pasta / cereal)
__ meat (chicken / fish / red meat) __ vegetables (potato / greens / carrots)
__ fruits (banana / apple / berries) __ snacks/sugary foods and/or drinks
Does your child exercise daily? Yes No How much: _____
Does your child have difficulty sleeping? Yes No explain: _____
Does your child have positive self-esteem or self-image? Yes No

Health Status

Medications the child currently takes: _____
Supplements the child currently takes: _____
Any major injuries and/or surgeries we should know about? _____
_____
Select if your child has ever done any of the following:

__ Falls as a baby	__ Fall from bed/couch/changing table	__ Fall off swing/slide
__ Fall off bicycle	__ Fall from highchair	__ Fall down stairs
__ Fall off monkey bars	__ Fall off skateboard/skates	__ Walking difficulties
__ Broken bones	__ Been in a car accident	__ Plays contact sports

Explain the selected instances: _____
Has your child received all recommended vaccinations? Yes No Explain:_____

Impact Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Martin Rigney at (970) 690-9899. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Right200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201

I have received a copy of Impact Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient's Guardian Signature	Date	
_____	_____	
Witness	Date	

FINANCIAL & APPOINTMENT POLICIES

As outlined in our mission statement, we are committed to providing the very best care for you and/or your family. Part of the process of providing this care involves a financial relationship between you, and us, the Chiropractic provider. In an effort to make your visit with us as comfortable as possible, we have provided for you, prior to your first visit, a description of our financial policy. Please take the time to review our financial policy below and gain an understanding of your financial obligation for your Chiropractic care. If you should have any questions, please ask the front office team member.

As a condition of providing care for you by this office, all fees must be paid at the time the care is provided. Payment for our services may be in the form of cash, check, MasterCard, Visa or Discover. We also accept CareCredit (a medical/dental credit card).

For our patients with insurance, we will be happy to check your benefits for you if we have received all of your insurance information on the day of the appointment. On your first visit to our office, please bring your insurance card or other insurance information. You must be familiar with your insurance benefits, as any amount not covered by your insurance company is payable at the time services are rendered and these fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. As your insurance plan is a contract between you, your employer, and the insurance company, some carriers will not reimburse our office. In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly. We are happy to provide a super bill for you to submit to our insurance for reimbursement.

Please understand that we do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. Your employer chooses your particular policy and if you are unhappy with its coverage, you should speak with your Human Resources Department. Only your employer can adjust benefits.

You are responsible for any balance on your account after 30 days, whether insurance has paid or not. Any account balance exceeding (90) days in age may be forwarded to a collection agency and/or attorney. All costs incurred in collecting unpaid fees will be charged to your account. These fees often exceed 50% of the unpaid balance.

You are responsible for payment for your care.
In the case extra adjustments are needed outside of your recommended frequency, you will be assessed an adjustment fee the day the service is rendered. Please be prepared to pay this fee on the day of service.

The doctors' treatment recommendations are based upon what they believe is in your best interest rather than on what your insurance covers.

A $35.00 fee will be assessed for any "returned check."

No call/No shows will be subjected to a $25 fee.

Please note: For those insurance carriers that Impact Chiropractic does not participate with, the claim check may be mailed directly to you. In these cases, you agree to and are responsible for signing and forwarding the check to our office.

I have read the above financial policy and understand my financial options and obligations as described.

_____ _____

Signature of Parent/Responsible Party Date

OFFICE POLICIES

____(initial) **Appointment Scheduling**:, We ask that you **pre-schedule** your future appointments. To keep your progress on schedule, rescheduled appointments must be made up **within 24 hours**. Pre-scheduling your appointments in advance will help ensure that you get the appointment time you need. You MUST have an appointment scheduled before seeing the doctors. **No Call No Show appointments will be charged a $25 fee. Please call at least 1 hour before your scheduled appointment to avoid this charge.**

____(initial) **Children/Family Wellness:** We offer family corrective care and wellness plans at a discounted rate. If your family members have not had their spines checked, please schedule their appointments ASAP.

____(initial) **Pet Policy:** We love your furry children, but out of advisement from our attorney and insurance agent – we sadly ask that you leave them at home. *If they do come in for a visit, your signature on this form states that **you take full responsibility** for any accident, incident, damage, loss, or bite that may occur on Impact Chiropractic's premise.* Service animals are allowed.

____ (initial) **Solicitation:** We realize that there are several good products on the market; however, solicitation of goods or services to our patients or staff is unacceptable. We desire to create a comfortable, healing, and non-pressure environment in our office.

____ (initial) **Guarantees:** We do not guarantee that we can prevent or cure any illness, injury, or disease. In this office we find and remove spinal subluxation, so that your nervous system will function optimally and so that your spine does not degenerate prematurely.

____ (initial) **Photography Release:** We frequently take photos/videos for our social media accounts. By initialing here, you authorize Impact Chiropractic, LLC and those acting under its permission to copyright, use and publish the video/photo/audio taken in our office. You agree that Impact Chiropractic has the unrestricted right to use this video/photo/audio in whole or in part, commercially or non-commercially, for all online/internet purposes, including the rights to publish and display for advertising and publicity, and to edit and make derivative works, all without additional review or compensation. You are of legal and have read this Authorization and Release, prior to its execution, and are fully familiar with its contents.
In the event that video/photo participant is a minor, his/her parent has read, understood, completed, and signed this Authorization and Release for his/her minor child. *We will always ask your permission before taking any photos/videos.*
____ I DO NOT wish to have photos/videos taken at any time.

____ (initial) **Guest Speaker:** Our doctors are also available to come to your work or social gathering to educate employees/friends on several different health topics – managing stress, health essentials, nutrition, pediatrics, to name a few! *We will provide a FREE, healthy lunch to everyone attending!* There is no fee for this service; however, there is a minimum of 5 people required to attend. Please 'check' if interested: □
Contact for setting up an event (Name): _____ Phone: _____

___ (initial) Under the terms and conditions of a divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

I have read and understand the above policies and agree to abide by them.

PATIENT NAME(S) _____

GUARDIAN SIGNATURE _____ DATE: _____