Child

Patient Information

Date: _____

Name: _____ Nickname**:** _____

Street Address: _____

City:_____ State: _____ Zip code: _____

Female: ____ Male: ____ Date of Birth: _____

SSN: _____-____-_____

Mother's Name: _____

Mother's Address: _____City: _____ State: ____ Zip: _____
(if different than patient)
Mother's home phone: _____-_____-_____ Cell Phone: _____-_____-_____ Carrier: _____
Email address_____

Father's Name: _____

Father's Address: _____City: _____ State: ____ Zip: _____
(If different than patient)
Father's home phone: _____-____-_____ Cell phone: _____-____-_____ Carrier: _____

Email address_____

Insurance

Cardholder Name: _____

Date of birth of cardholder: ____-____-_____

Assignment and Release

I understand that I am financially responsible for all the charges whether paid or not paid by the insurance company. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of the signature on all insurance submissions.

_____

Responsible party signature

_____

Relationship to patient

Is your child here for a preventative check-up? Yes: _____ No: _____
If no, what is the reason for the visit?
_____
_____
_____

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

___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
___Scoliosis
___Seizures
___Sinus Trouble
___Temper Tantrums
___Other _____
_____

Has your child had any major falls/injuries/surgeries?

_____
_____
_____

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 pregnancy or birth of this child?

_____
_____
_____

Any 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 _____	

Detoxification and Drainage Questionnaire

Point Count	Points
Never or almost never have the symptom	0
Occasionally have it	1
Occasionally have it, effect is severe	2
Frequently have it, effect is NOT severe	3
Frequently have it, effect is severe	4

Emotions	Points
Irritability	
Nervousness	
Mood Swings	
Frequent Crying	
Aggressive behavior, i.r., road rage	
Anxiety	
Fear	
Confusion	
*Depression	
*Suicidal thoughts	
Total Emotion	

Skin	Points
Increased sweating, ear wax, oily skin	
Skin reashes	
Brown spots on hands and face	
Boils	
Skin tags (small hanging warts)	
Acne	
Eczema	
Fever blisters	
Warts	
Total Skin	

Ear, Nose and Throat	Points
Increased salviation	
Mouth Ulcers	
Common cold	
Sunusitis	
Sore Throats	
*Ear infections	
Hay fever	
Loss of Smell	
Cough	
Total Ear, Nose and Throat	

Mind and Brain	Points
Hyperactivity	
Stammering when speaking or problem finding words	
Difficulty in concentration	
Difficulty in making decisions	

Headache	
Poor memory	
Poor coordination	
*Compulsive behavior	
*Sleep disturbance	
Memory loss	
Total Mind and Brain	

Digestive System	Points
Loose stools	
Diarrhea	
Heartburn	
Constipation	
Bloating	
Abdominal Pain	
Intolerance to certain foods	
Nausea or vomiting	
Severe diarrhea with blood or mucous	
Total Digestive System	

Kidney	**Points**
Increase in urination frequency and amount	
Needing to get up in the night to pass urine	
*Urinary tract infections and cystitis	
*Kidney stones	
*Blood in the urine	
Total Kidney	

Joints and Muscles	**Points**
Fleeting muscle aches or joint aches	
Tendonitis (e.g. tennis elbow, golfer's elbow, Achilles tendonitis)	
Gout	
Arthritis	
Fibromyalgia	
Total Joints and Muscles	

Metabolism	**Points**
Feeling of coldness	
Hypoglycemia	
Craving certain foods	
Water retention	
Obesity	
Cellulite	
Total Metabolism	

Grand Total	

*These symptoms are indications of conditions that should not be treated with the Heel Detoxification and Drainage protocols alone.

Consent to Chiropractic Services

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I hereby request and consent to chiropractic manipulations and other procedures including various modes of physical therapy, diagnostic x-rays and / or other tests by Amy Horn, D.C. and her staff who now or in the future treat me while employed by this office. I have had an opportunity to discuss with the doctor and /or with office personnel the nature and purpose of treatment, including but not limited to fractures disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read the above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures, I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and / or employed staff.

Signed_____ Date_____

Witness_____ Date_____

Consent to Treatment of a Minor

I have authority to & do authorize Amy Horn, D.C. to administer chiropractic care as deemed necessary to my:

(Relationship)_____

(Name)_____

Financial Policy

1. It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by the third party payers.

2. You are considered to be a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your policy. The privilege of insurance assignment begins when our office receives your insurance forms. (Claim Forms, etc.)

3. All deductible/co-payments are payable when service is rendered or at the end of each week. A $200.00 co-payment balance must not be exceeded by any patient.

4. I understand that I am financially responsible for all charges whether paid or not paid by my insurance. Since we do not own your policy and occasionally we experience difficulty in collecting from you carrier, we may ask for your active assistance in rectifying this situation.

5. This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

6. This office does submit to secondary insurance companies. If the secondary insurance company does not pay for the amount that the primary did not cover, then I understand that I am liable for those charges.

7. 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.

8. We require 24 hour notice to cancel an appointment. Any missed appointments without notice will result in a $10 fee.

9. If you have a personal injury case with us and it is not settled within 60 days of being released, you will be responsible to start payment towards this balance.

10. 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 the office and financial policies for Integrative Healthcare Center.

Signed_____ Date_____

Witness_____ Date_____

NOTICE OF PRIVACY PRACTICES
(Chiropractic)

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 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 1, of 2016 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.

Please contact us for more information: 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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have read a copy of
(Please print)
this office's Notice of Privacy Practices.

_____
Signature

_____
Relationship to patient

_____
Date

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)