PEDIATRIC APPLICATION FOR CARE AT INFINITE CHIROPRACTIC

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

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

Mother's Full Name: _____ Birthdate: _____-_____-_____

Mother's Phone: Home: _____ Work: _____ Mobile: _____

Father's Full Name: _____ Birthdate: _____-_____-_____

Father's Phone: Home: _____ Work: _____ Mobile: _____

Emergency Contact Name: _____ Relationship to child: _____

Phone Number: _____ Alternative phone number: _____

Who is responsible for this bill? _____

☐ Father's Social Security #: _____-_____-_____ ☐ Mother's Social Security #: _____-_____-_____

☐ Father's Driver's License #: _____ ☐ Mother's Driver's License #: _____

☐ Other *(please explain)*: _____

Pediatrician/Family MD: _____ City/State: _____

Last Visit Date: _____-_____-_____ Reason for Visit: _____

May we communicate with your family doctor regarding your child's care if necessary? ☐ Yes ☐ No

Other Health Care Professionals (Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Massage Therapist, etc):

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?

☐ He/She is continuing care from another chiropractor.
☐ I recently had my spine checked and understand the value in getting my child checked.
☐ I have concerns about his/her health and I'm looking for answers.
☐ He/She has a specific condition and I've learned that chiropractic may be able to help.
☐ I want to improve my child's immune function.

CHILD'S CURRENT COMPLAINT

Purpose of this visit: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other

Please explain: _____

If your child is experiencing **pain/discomfort, please identify where, and for how long:**

_____

_____

When did the complaint first begin? Date: _____-_____-_____ ☐ Unknown ☐ Gradual ☐ Sudden

Has this complaint occurred before? ☐ No ☐ Yes If yes, when? _____

Any bowel or bladder problems since this problem began? ☐ No ☐ Yes **If yes,** describe: _____

_____

Have you seen any other health professionals for this complaint? ☐ No ☐ Yes **If yes**, whom? _____

How long ago? _____ Days _____ Weeks _____ Months _____ Years

What treatment did they use and what were the results of past treatment? _____

_____

How is this complaint NOW?

☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On and Off

Please list any medication(s) taken for this complaint: _____

Has your child had X-Rays in relation to the current complaint before? ☐ No ☐ Yes **If yes,** date X-rays taken: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

HAS YOUR CHILD EVER SUFFERED FROM - *Check all that apply*

Please mark: **P** for in the **Past** **C** for **Currently** have

___ Headaches/Migraines	___ Orthopedic Problems	___ Digestive Disorders	___ Behavioral Problems
___ Dizziness	___ Neck Problems	___ Poor Appetite	___ ADD/ADHD
___ Fainting	___ Arm Problems	___ Stomach Aches	___ Ruptures/Hernia
___ Seizures/Convulsions	___ Leg Problems	___ Reflux	___ Muscle Pain
___ Heart Trouble	___ Joint Problems	___ Constipation	___ Growing Pains
___ Chronic Earaches	___ Backaches	___ Diarrhea	___ Asthma
___ Sinus Problems	___ Poor Posture	___ Hypertension	___ Walking Trouble
___ Scoliosis	___ Anemia	___ Colds/Flu	___ Sleeping Problems
___ Bed Wetting	___ Colic	___ Broken Bones	___ Fall off swing
___ Fall in baby walker	___ Fall from bed or couch	___ Fall from crib	___ Fall down stairs
___ Fall off bicycle	___ Fall from high chair	___ Fall off slide	___ Respiratory Issues
___ Fall from changing table	___ Fall off monkey bars	___ Fall off skateboard/skates	___ Eczema
___ Food Sensitivities	___ Head Tilt/Torticollis	___ Tip Toe Walking	___ ADD/ADHD
___ Autism	___ Tremors/Ticks	___ Asymmetrical Crawling/Gait	___ Sensory Processing Issues

___ Allergies to _____

___ Other: _____

PHYSICAL TRAUMAS

Has your child ever fallen from any high places? ☐ No ☐ Yes If yes, explain:_____

Has your child ever been involved in a auto accident? ☐ No ☐ Yes If yes, explain:_____

Has your child broken any bones? ☐ No ☐ Yes If yes, explain:_____

Has your child had any previous hospitalizations? ☐ No ☐ Yes If yes, explain:_____

Has your child had any previous surgeries? ☐ No ☐ Yes If yes, explain:_____

Does your child use a tablet, computer, or video game? ☐ Never ☐ Rarely ☐ Daily ☐ Several hours/day

Does your child watch TV? ☐ Never ☐ Rarely ☐ Daily ☐ Several hours/day

Does your child exercise? ☐ No ☐ Daily ☐ Weekly

Does your child play contact sports? ☐ No ☐ Daily ☐ Weekly

Has your child ever sustained an injury playing organized sports? ☐ No ☐ Yes **If yes,** please explain: _____

_____

BIRTH EXPERIENCE

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Center Other: _____

How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____

Medications during labor/delivery (including IV antibiotics): ☐ No ☐ Yes If yes, explain:_____

Was Pitocin used to induce / speed up labor? ☐ No ☐ Yes

Was the child at any time during pregnancy in a constrained position? ☐ No ☐ Yes ☐ Unsure

If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation

Was the delivery vaginal or C-section? ☐ Vaginal ☐ C-Section If C-Section, was it planned or emergency?: _____

If it was vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

Were any of the following interventions used? ☐ Forceps ☐ Vacuum Extraction ☐ Other: _____

Were there any complications during delivery? ☐ No ☐ Yes

If yes, please specify: _____

Was the baby born with any purple markings / bruising on their face or head? ☐ No ☐ Yes If Yes, where: _____

Was the baby ever admitted to the NICU? ☐ No ☐ Yes If yes, for how long and why?_____

Any concerns about mis-shapen head at birth? ☐ No ☐ Yes

Were there any medication given to the child at birth? ☐ No ☐ Yes ☐ Unsure

If yes, what medication and why? _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

POST NATAL & INFANT HISTORY

Was your child exclusively breastfed? ☐ No ☐ Yes If yes, how many months: _____

Was your child exclusively formula fed? ☐ No ☐ Yes If yes, how many months: _____

Was your child breastfed + formula fed? ☐ No ☐ Yes If yes, how many months: _____

If formula feed, did your child show any sensitivities to formula (reflux, eczema, arching back)? ☐ No ☐ Yes

Has your child been vaccinated? ☐ No ☐ Yes If yes, ☐ Full ☐ Partial ☐ Delayed ☐ Other: _____

Did your child have any reactions to vaccines? ☐ No ☐ Yes If yes, describe: _____

HEALTH GOALS

Do you feel your child is developmentally appropriate for their age?

Intellectually: ☐ Yes ☐ No If no, explain: _____

Emotionally: : ☐ Yes ☐ No If no, explain: _____

Physically: : ☐ Yes ☐ No If no, explain: _____

What is your primary goal for your child in this office?_____

CONSENT

I understand that I am directly and fully responsible to Infinite Chiropractic for all fees associated with chiropractic care my child receives. The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

I hereby authorize payment to be made directly to Infinite Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Infinite Chiropractic for any and all services my minor child receives at this office.

Under the terms and conditions of my 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.

_____ _____ - _____ - _____

Parent or Legal Guardian's Signature Date Completed

_____ _____ - _____ - _____

Doctor's Signature Date Form Reviewed

PATIENT'S NAME: _____ HR#: _____ DATE: _____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my child's assessment.

Minor Child Name: _____ Date of Birth: _____

Parent / Legal Guardian Name: _____

Parent / Legal Guardian Signature: _____ Date: _____

Witness Initials: _____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this practice:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my child's care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Minor Child Name: _____ Date of Birth: _____

Parent / Legal Guardian Name: _____

Parent / Legal Guardian Signature: _____ Date: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your X-rays in our files. **The fee for copying your x-rays is $15.00. This fee must be paid in advance.** Digital X-rays on cd will be available within 72 hours of prepayment on any regular practice hours day.

Please note: X-rays are utilized in this office to help locate and analyze **vertebral subluxations**. These X-rays are not used to investigate for medical pathology. The doctors of restoration family chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Minor Child Name: _____ Date of Birth: _____

Parent / Legal Guardian Name: _____

Parent / Legal Guardian Signature: _____ Date: _____

FEMALES ONLY

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my minor child's case. To the best of my knowledge, I believe my minor child is not pregnant at the time x-rays are taken at Infinite Chiropractic.

Minor Child Name: _____ Date of Birth: _____

Parent / Legal Guardian Name: _____

Parent / Legal Guardian Signature: _____ Date: _____

Witness Initials: _____

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 a copy labeled **'HIPAA'** in the reception area. 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 patient records at no charge, when timely notice is provided of at least 72 hours. Additional patient records may be requested for $0.15 per page and will be made available within 72 hours of prepayment. **X-rays** are digital but a CD must be made separately with your X-ray records, therefore there is a $15.00 fee for each request of your records X-rays which must be paid in advance and will be available 72 hours after prepayment has been received on regular practice hour days.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call the Practice Director at (843)352-3420 If she is unavailable, you may make an appointment with the doctor 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 Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Infinite Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of Infinite Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's 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 a 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 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 Signature	Date

Witness	Date

PATIENT'S NAME: _____ HR#: _____ DATE: _____

Medical Information Release Form (HIPAA Release Form)- Minor Child

Patient Name: _____ **Date of Birth:** _____

Release of Information:

☐ I authorize the release of information on my minor child including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____
- ☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages:

Please call ☐ my home ☐ my work ☐ my mobile number: _____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (*day*) _____ between (*time*) _____

Parent / Legal Guardian Name:_____

Parent / Legal Guardian Signature: _____ Date: _____

Witness: _____ Date: _____