Healthy Life Chiropractic

Your Child's Facts

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Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **Apartment #:** _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____

Email: _____

How did you find us? Patient *(who)*: _____ Doctor *(who)*: _____ Staff *(who)*: _____

(circle one) Promotion/Event Internet Newspaper Signage Business Insurance Other: _____

Your preferred method of communication for patient appointment reminders (*circle one*): Email No Reminder

Do you know your height and weight? (height): _____ (weight): _____

Child's Date of Birth: ____/____/____ **Child's Gender** (*circle one*): Male Female

Employer: _____ **Work #:** _____ **Ext:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Primary Care Physician (PCP): _____ **Phone #** (PCP): _____

Are you currently taking any medications?

Medication Name	Dosage and Frequency

Do you have any allergies?

Allergen	Reaction

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Are you currently taking any supplements?

Supplement Name	Dosage and Frequency

Please list your major health goals:

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my medical information by Healthy Life Chiropractic and/or the affiliate practioners that operate within Your Wellness Connection, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of HLC. I understand that diagnosis or treatment of me by HLC may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. HLC is not required to agree to the restrictions that I may request. However, if HLC agrees to a restriction that I request, the restriction is binding on HLC. I have the right to revoke this consent, in writing, at any time, except to the extent HLC has taken action in reliance on this consent.

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review HLC's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of HLC.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of HLC. This Notice of Privacy Practices also describes my rights and the duties of HLC with respect to my medical information. HLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ **Today's Date:** ____/____/____

Patient or Personal Representative Signature:

_____

Printed Name of Patient or Personal Representative:

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Your Child's Life

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

Mother's Health at Birth:

- Morning sickness ☐
- Indigestion ☐
- High or low blood pressure ☐
- Swollen ankles ☐
- Back pain ☐
- Groin pain ☐
- Diabetes ☐
- Anemia ☐
- Abnormal bleeding ☐
- Trauma/fall/vehicle accident ☐
- Hospitalized during pregnancy ☐
- Prescribed bed rest ☐
- Smoked ☐
- Consumed alcohol ☐
- Used over the counter drugs ☐

List: _____

_____

- Used prescription medication ☐

List: _____

_____

Birth to 3 Months:

Mark those that apply to your child as an infant.

- Medicated at birth ☐
- Vaccinated at birth ☐
- Formula fed ☐
- Other source ☐

List:

_____

_____

_____

- Nursing difficulties ☐

List:

_____

_____

_____

- One side feeding preference ☐
- Frequent spit-up after feeding ☐
- Smoker in household ☐
- Sleeps easily ☐
- Preferred sleeping position ☐
- Excessive crying/colic ☐
- Intestinal gas ☐
- Trauma, fall, accident ☐
- Noise when breathing ☐

4 Months and Up:

Mark those that apply to your child to age 2 years.

- Digestive problems ☐
- Food allergies ☐
- Takes vitamin supplements ☐
- Frequent respiratory infections ☐
- Tubes in ears ☐
- Frequent nightmares ☐
- Sleep walking ☐
- Trauma, fall, accident ☐
- Injuries, fractures, burns ☐
- Trips, falls easily ☐
- Medications ☐

List:

_____

_____

_____

_____

_____

_____

_____

Birth History:

Check if you had any of the following.

- Hospital birth ☐
- Home birth ☐
- Planned C-section ☐
- Emergency C-section ☐
- Induced birth (Pitocin) ☐
- Forceps used ☐
- Vacuum extraction used ☐
- Epidural anesthesia ☐
- Other painkillers ☐

_____

Infant Presentation

- Head ☐
- Face ☐
- Breech ☐
- Full term ☐
- Premature ☐

Weight: _____

Length: _____

Conditions:

List conditions in order of concern:

_____

_____

_____

_____

_____

_____

_____

_____

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Your Child's History

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

Health History

Issues
Mark those that apply:

- Back pain ☐
- Neck pain ☐
- Leg pain ☐
- Arm pain ☐
- Torticollis ☐
- Headaches ☐
- Ear infections ☐
- Tubes in ears ☐
- Recurring respiratory infections ☐
- Colic as an infant ☐
- Asthma ☐
- Allergies ☐
- Constipation ☐
- Bed-wetting ☐
- Skin problems (eczema, rashes) ☐
- Childhood diseases ☐
- Other ☐
- List: _____

Trauma
Mark those that apply:

- Fall from bike, scooter ☐
- Fall down stairs ☐
- Fall from significant height ☐
- Motor vehicle accident ☐
- Trips and falls easily ☐
- Injuries (fracture, burn) ☐
- Other: _____

Nutritional
Mark those that apply:

- Is a good eater ☐
- Likes all food ☐
- Has food allergies ☐
- Takes vitamin supplements ☐
- Is/was breast feed ☐
  - Length of time: _____
- Drinks cow's milk ☐
- Three favorite foods: _____

Emotional
Mark those that apply:

- Sleeps well at night ☐
- Takes daytime naps ☐
- Has nightmares ☐
- Sleep walks ☐
- Frequent temper tantrums ☐
- Cries a lot ☐
- Other: _____

Developmental
Mark those that apply:

- Sit up unassisted ☐
  - (age) _____
- Rolls over ☐
  - (age) _____
- Crawls ☐
  - (age) _____
- Walks ☐
  - (age) _____

Environmental
Mark those that apply:

- Goes to day care ☐
- Smoker in household ☐

Immunizations
Mark those that apply:

- Has been immunized ☐
- Has had a reaction to immunization ☐

Is your child under medical care for a specific condition? ☐ Yes ☐ No Please list the condition and care received. _____

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Consent to Treatment of Minor Child

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

I, (*print parent/guardian name*) _____

hereby authorize: Dr. Shannon Pishny

and whomever she may designate in assistance to administer treatment as deemed necessary to my son/daughter

(*print child's name*) _____

Signature: _____ **Today's Date:** ____/____/____

Printed Name: _____

Witnessed: _____

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Chiropractic Informed Consent

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

Chiropractic evaluation and treatment involves certain inherent risks. There are several benefits associated with performing an evaluation. They include: working diagnosis of present condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. They include: increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, and exercises. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported to a staff member.

Adjustment: Spinal manipulation that involves precise impulses in a specific direction to restore normal motion and position of individual vertebrae.

Interferential current therapy: Small electrical impulses are used to stimulate muscles and relieve tension by reducing nerve irritation. This current promotes the secretion of natural painkillers (endorphins).

Intersegmental traction therapy: This therapy utilizes rollers that slowly travel the length of the spine. By stretching individual joints, it promotes increased mobility and blood flow that leads to faster healing.

Exercise: The entire body benefits from this therapy, both physically and psychologically. Exercise improves digestion, increases energy levels and promotes the reduction of stress.

Risk factors have been reduced to the best of our ability. Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatment program.

Signature: _____ **Today's Date:** ____/____/____

Printed Name: _____

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Healthy Life Chiropractic

Our Financial Policy

It is the policy of this office that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments, regardless of whether or not this office accepts insurance assignment.

1. Patients without insurance:

All payments are expected at the time of service unless a prearranged payment plan established. **Personal balances should not exceed $200 at anytime unless a pre-arranged payment improved.**

2. Patients with insurance:

Deductibles, co-insurance and all co-payments are expected at the time of service present on a payment plan. **Your patient responsibility balance should not exceed $200 unless you could arrange payment plan.**

It is the policy of this office to extend to our clients the courtesy of assigning chiropractic Insurance benefits directly to us. We are happy to extend this credit to you so that you can follow through with all the care required. The following are important points of consideration to be aware of:

1. The privilege of insurance assignment begins in our office receives and verifies your insurance information.

2. Clients whose treatment visitation schedule is once per month or longer no longer be eligible for insurance assignment at this level of care is rarely covered by insurance. Our office offers numerous wellness plans to allow you to continue needed care.

3. No one can predict what insurance company won't pay for the usual and customary charges for services rendered. If we participate on your plan, you will not counter balance billing above stated the schedule schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.

4. Should you discontinue care for any reason other then discharge by the doctor, any and all balances become due and payable at that time. If you were on a predetermined payment plan, that plan will continue to be in effect until your balance zero

5. The goal of this office is to provide you with the finest quality care available. If you have any questions with regard to your healthcare or any of our policies, please let us know.

Signature: _____ **Today's Date:** ____/____/____

Printed Name: _____

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Insurance Data Collection

Last Name: _____ **First Name:** _____

Date of Birth: ____ / ____ / _____

Insurace Verification: FOR OFFICE USE ONLY

Date: ____ / ____ / ____ **Ins. Contact Name:** _____ **Eff. Date of Coverage:** ____ / ____ / ____

Deductibles: In Net: _____ **How much met?** _____ **How much remains?** _____

Co-Pay(s): _____ **Coinsurance %:** _____ **Max Benefits / Year:** _____

Photocopy/scan the front and back of the insurance card in the area below.

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Healthy Life Chiropractic

Notice of Patient Privacy Practices

We are committed to preserving the privacy of your medical information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may require your written consent before we use or disclose to others your medical information for purposes of diagnosing or providing treatment to you, obtaining payment for your health care bills or to conduct health care operations of Your Wellness Connection (YWC).

***Treatment** includes activities performed by a practitioner, chiropractic assistant, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

***Health Care Operations** includes the necessary administrative and business functions of our office.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you nconfidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. This Notice is posted in our lobby. We may revise our Notice from time to time. The effective date at the lower left-hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our Privacy Officer at (913) 962-7408.