PEDIATRIC PATIENT INTRODUCTION CARD

Date:_____

Child's Name:_____Age:_____Date of Birth:_____Sex: M F

Street Address:_____City, ST, Zip:_____

Parent's Names:_____

Phone:_____Email:_____

Whom may we thank for referring you to our office?_____

Reason for coming to our office:_____

Name of Person Responsible for the Account:_____

Relationship to Patient:_____Preferred Phone #:_____

Address (if different than above):_____

Insurance Company:_____Name of Insured:_____

Relationship to Patient:_____Date of Birth:_____

Present Health Challenge(s)

For what health challenge(s) is your child here for? When did it begin?

_____

Has your child seen other health care practitioners for this? What did they recommend?

_____

What was the outcome of prior treatment/recommendations?

_____

Is this dysfunction getting progressively worse? ___Yes ___No

Health History

Symptoms: Please check any current or past problems your child has on the list below:

__Anemia
__Arthritis
__ADHD
__Allergies
__Anxiety
__Arm/Elbow Pain
__Asthma
__Autism
__Backaches
__Behavioral Issues
__Bed Wetting
__Blood disorders
__Broken bones:_____
__Chest Pain
__Chronic Earaches
__Colic
__Concussions
__Constipation
__Convulsions
__Cough/Wheeze
__Diabetes
__Diarrhea
__Digestive Problems
__Dizziness
__Eczema
__Fainting
__Fever/Chills
__Frequent Colds
__Growing pains
__Headaches
__Heart Condition
__Hernias
__Hyperactivity
__Hypertension
__Joint Pain
__Insomnia
__Itchy Eyes
__Knee/Foot Pain
__Leg/Hip Pain
__Muscle Pain
__Neck Pain
__Nightmares
__Poor Appetite
__Poor Memory
__Rashes
__Reflux/Spitting up
__Runny Nose
__Scoliosis
__Sinus Trouble
__Sprains/Strains
__Stomach Aches
__Unusual Moles
__Other_____

Name of Pediatrician:_____Date of Last Visit:_____

Current Medications & Vitamins:_____

Past Trauma (falls, sports injuries, accidents, etc)_____

Past Surgeries:_____

Prenatal History

Location of Birth: ___ Home ___ Birthing Center ___ Hospital

Complications during pregnancy: Y - N List: _____

Medications during pregnancy/delivery: _____

Cigarette / Alcohol use during pregnancy: Y - N

Birth intervention: ___ Forceps ___ Vacuum ___ Caesarian

Complications during delivery: Y - N List: _____

Birth weight_____ Birth length_____

Feeding history

Breast Fed: Y - N How long'?_____ Formula fed: Y - N How long'?_____ Type:_____

Introduced to cereal at____months. Solids at _____ months. Cow's milk at _____ months

Food / juice allergies or intolerances Y - N List: _____

Developmental History

Sleep (Hrs per night) _____ Problems sleeping _____

Medical/Vaccination History

Has your child ever had an adverse reaction to a prescription or over-the-counter medication? Y – N

If yes, please

explain:_____

Has your child been vaccinated? Y – N Adverse reactions to any

vaccine?_____

Childhood Diseases

___Chicken Pox : Age ____ * ___ Mumps: Age ____ * ___ Rubella: Age ____ * ___ Whooping cough: Age ____

___ Measles: Age ____ * ___ Meningitis: Age ____ * ___ Tuberculosis: Age ____ * ___ Other: Age ____

CONSENT FOR TREATMENT OF MINOR

I hereby certify that the information I have provided is correct and accurate, to the best of my knowledge.

I, _____ , as the parent/guardian of this child, _____ , hereby grant permission for my child to receive examination and chiropractic treatment as deemed necessary.

_____ _____

Signature of Parent or Guardian Date

Jones Family Chiropractic: Informed Consent

Consent for Purposes of Treatment, Payment, and Healthcare Operations

In this document, "I" and "my" refer to patient, and "Chiropractor" refers to
Jones Family Chiropractic INC, its Associates, or Business Affiliates.

Improving your health is our number one priority. Your understanding of our office policies helps us to serve you better. Thank you for giving us the opportunity to be your partner in health.

_____ We do not offer to diagnose or treat any disease or condition other than a vertebral subluxation. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings we will advise you. If you desire further advice, we will recommend that you seek the services of a health care provider that specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Our only objective is to eliminate vertebral subluxation, which interferes with your nervous system.

_____ I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

_____ I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

_____ My "protected health 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 protected health 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 authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance pay directly to this office any payable benefits. I further understand that I am responsible for any outstanding amount owed this office. Payment is due at time of service and all late payments are subject to a 10% late fee and any returned payment is subject to a $35 fee. After 90 days delinquency my account will be turned over to collections, at that time my account will be charged an additional 25% collection fee.

_____ Chiropractor 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 of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

(Signature of Patient or Personal Representative) **(Printed Name of Patient)**

_____ _____

(Date of signing) **(Description of Personal Representative's Authority)**

Consent to evaluate and adjust a Dependent

I, _____ being the parent or legal guardian of _____ have read and fully understand the above policies and hereby grant permission for my child to receive chiropractic care.

_____ _____

(Signature of Legal Guardian) **(Date)**

Jones Family Chiropractic: Notice Of Privacy

This notice describes how health information about you (as a patient) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy: Our organization is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances: The following circumstances may require us to use or disclose your health information:

1) To public health authorities and health oversight agencies that are authorized by law to collect information.
2) Lawsuits and similar proceeding in response to a court or administrative order.
3) If required to do so by a law enforcement official.
4) When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual, or the public. We will only make disclosures to a person organization able to help prevent the threat.
5) If you are a member of the US or foreign military forces (including veterans) and if required by the appropriate authorities.
6) To federal officials for intelligence and national security activities authorized by law.
7) To correct institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8) For workers compensation and similar programs.

Your rights regarding your health information:

1) Communications. You can request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.
2) You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3) You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Spencer B. Jones, D.C.
4) You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Spencer B. Jones, DC. You must provide us with a reason that supports your request for amendment.
5) Right to a copy of this notice at any time. To obtain a copy of this notice, please contact Spencer B. Jones, D.C.
6) Right to file a complaint. If you believe your rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. All complaints must be in writing and sent to Spencer B. Jones, D.C. You will not be penalized for filing a complaint.
7) Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Clinical Summary Report (CCR): I understand that a clinic summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Jones Family Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon request, that these reports are available to be printed or emailed to me for review.

If you have any questions regarding this notice or our health information privacy policies, please contact Spencer B. Jones, D.C.

I hereby acknowledge that I have been presented with a copy of Spencer B. Jones, D.C. Notice of Privacy Practices.

_____	_____	_____
(Signature of patient)	**(Name of patient)**	**(Date Received)**