Pediatric New Patient Form

As a family chiropractic office, we focus on the health of your entire family. Our goals are first, to address the cause of any issues that brought your child into this office. And second, to offer your child the opportunity to improve their health potential and wellness. We focus on the specific type of chiropractic care that we refer to as corrective care. Through chiropractic adjustments, we remove interference that is preventing your child from expressing optimal health, allowing the body to regulate and heal as intended. We encourage you to ask questions and learn as we proceed. We look forward to serving you and your family.

Patient Name ____________________________Name of Parents/ Guardians ____________________________

Address ___________________________________City _______________ State ______ Zip Code _________

Home Phone __________________________________ Cell Phone ____________________________________

Patient Birth Date ____/____/_______ Sex ____ Weight ______ Height _______ Number of Siblings _______

Who may we thank for referring you? ____

If your child has no symptoms or complaints, and is here for wellness, please check this box ☐

Otherwise, please briefly describe the reason for your visit:

____

Has your child ever suffered from (in the past or currently): (Check all that apply)

☐ Dizziness	☐ Walking problems	☐ Heart trouble	☐ Ear infections
☐ Diabetes	☐ Arm/ leg pain	☐ Asthma	☐ Colic
☐ Neck pain	☐ Headaches	☐ Allergies	☐ Constipation
☐ Back pain	☐ Digestive disorders	☐ Sinus trouble	☐ Diarrhea
☐ Joint problems	☐ Poor appetite	☐ Frequent congestion	☐ Stomach aches
☐ Broken bones	☐ Bed wetting	☐ Sugar cravings	☐ Persistent gas
☐ Growing pains	☐ Fainting	☐ Behavioral problems	☐ Other ______________

Previous Chiropractor _________________________________ Date of last visit ____/____/____

Name of Pediatrician _________________________________ Date of last visit ____/____/____

Authorization for care of minor

I hereby authorize this office to administer to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed____ Date________________________

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Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeable give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE Santangelo Family Chiropractic TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Print: ____

Sign: ____ **Date:** _________________

PRIVACY NOTICE & NOTICE OF INFORMATION PRACTICES

Protecting your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can gain access to this information.

Any disclosures for the purpose of treatment, payment (from your insurance company or coverage provider) or practical operations will be made only as necessary after informing you. You may request restrictions of disclosures. If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We will also share your information if state or federal laws require it and/or in response to a court of administrative order, or in response to a subpoena.

Disclosures of protected health information are limited to the minimum necessary depending on the purpose of this disclosure. This provision does not apply to the transfer of medical records for treatment. You have the right to request a copy of your records and/or this privacy notice at any time and may receive and inspect them within 30 days of your request. There may be reasonable cost-based fee for photocopying, postage, and preparation. Our practice has the right to accept or deny requests to make any changes on your record. *We maintain the history of the persons or entities we've disclosed your protected health information to. You have the right to request such disclosures.*

In the future, we may contact you for appointment reminders, announcements related to our practice, and/or to handle any financial concerns. Please note that we may use your picture on our social media platforms or website after obtaining your verbal consent.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in this office.

You may file a complaint about privacy violations by contacting our Office Manager or the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/.

By printing and signing my name below, I state that I have read and understood the terms that have been presented in this Privacy Notice/ Notice of Information Practices.

Print: ____

Sign: ______________________________ **Date:** ______________

SIGNATURE ON FILE

- ✔ I authorize use of this form on all my insurance submissions.
- ✔ I authorize release of information to all my insurance companies.
- ✔ I understand that I am responsible for my bill.
- ✔ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- ✔ I authorize payment direct to my doctor.
- ✔ I permit a copy of this authorization to be used in place of the original.

Print: ____

Sign: ______________________________ **Date:** ______________