# Patient Information:

Date:_____ Patient Name:_____ Date of Birth: ___/___/___
Age:_____ Gender: M/F Approximate Height:_____ Approximate Weight:_____
Parent/Guardian Name(s):_____ _Siblings:_____
Address:_____ City: _____ State:_____ Zip:_____
Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____
Email address:_____
May we: ☐ Text ☐ Call ☐ Email or ☐ None to remind you of your appointments?
Referred By:_____(may we thank them for referral? Y/N)

# Previous Providers:

Midwife/Obstetrician:_____
Pediatrician/Family MD:_____
Date of last visit:___/___/____ Purpose:_____
Immunization History:_____
Number of doses of antibiotics your child has taken: During the past 6 months____ During lifetime___
Has your child been to a chiropractor before?: ☐ Yes ☐ No
If yes, who was the physician?:_____
Reason for leaving:_____
Is your child currently seeing any other physician or healthcare professional?: ☐ Yes ☐ No
If Yes, who is the provider:_____
Date of last visit:___/___/___ Reason for visit:_____

# Consent to treat:

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named_____ as the examining/treating doctor deems necessary.
I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.
Parent/Legal Guardian Signature:_____ Date:___/___/___
Parent/Legal Guardian Name:_____
Witnessed By:_____

# Current Health and Habits:

(Please fill out the following to best ability)
I would describe my child's overall health as (check one box): ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Reason you are seeking care for your child at Atlee Chiropractic Center: _____
_____
***(Many children begin chiropractic care as a form of wellness/preventative care, simply to help their child function the best they can. If this is the case, you can skip down to the "Past Health History" part of this intake.)***
What are the symptoms being experienced:_____
When did they begin:_____
Has anything like this occurred before?: ☐ Yes, when_____ ☐ No
Did this happen gradually or suddenly:_____
Have you found anything to make it better or worse?_____

Since it began, are symptoms getting better, worse, or no different?:_____
Has your child been seen by another healthcare provider for this condition?: ☐Yes ☐ No
If Yes, who_____
What was the treatment:_____
What were the results:_____

# Past Health History:

Has your child ever been hospitalized: ☐ No ☐ Yes, why: _____
_____
Has your child had any surgeries? ☐ No ☐ Yes, why: _____
_____
At what age, if ever, did this child suffer from the following childhood diseases?
Chickenpox_____ Mumps_____ Measles _____ Rubella_____
Roseola _____ Whooping Cough _____ Other _____
Is your child vaccinated? ☐ No ☐ Yes, on a delayed or alternate schedule ☐ Yes, on schedule
If yes, has there been any reactions to the vaccinations:
☐ None ☐ Fever ☐ Rash ☐ Pain at injection site ☐ Diarrhea ☐ Vomiting
☐Fatigue ☐ Excessive Crying ☐ Seizures ☐ Developmental delays or regression
☐ Other: _____

Has this child ever suffered from: ☐ None

| | | | | |
|---|---|---|---|---|
| □ Headaches | □ Colds/Flu | □ Problems Latching | □ Constipation | □ Growing Pains |
| □ Dizziness | □ Colic | □ Scoliosis | □ Diarrhea | □ Allergies |
| □ Fainting | □ Muscle Pain | □ Walking Trouble | □ Diabetes | □ Allergies |
| □ Seizures | □ Neck pain | □ Broken Bones | □ Hypertension | □ Allergies |
| □ Heart Trouble | □ Arm problems | □ Digestive Issues | □ Anemia | □ Allergies |
| □ Chronic earaches | □ Leg Problems | □ Poor appetite | □ Bed Wetting | □ Other |
| □Sinus Trouble | □ Joint problems | □ Stomach Aches | □ Behavioral Issues | □Other |
| □ Asthma | □ Backaches | □ Reflux | □ ADD/ADHD | □ Other |

Delivery/Birth History: ☐ Pre-term, weeks gestation_____ ☐ Full Term
Was birth: ☐ Induced ☐ Pitocin ☐ IV Pain Meds ☐ Epidural ☐ Antibiotics
How long was Active Labor:_____ How long was pushing:_____
Were there any complications?: ☐ No ☐ Yes,_____
Type of Birth: ☐ Vaginal ☐ Forceps/Vacuum Extraction ☐ Planned Cesarean ☐ Emergency Cesarean
Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Other
Presentation of child: ☐ Vertex (head down) ☐ Breech, type_____ ☐ Transverse ☐ Face/Brow
APGAR Score at Birth:_____ APGAR Score at 5 minutes:_____
Was there presence at birth of : ☐ Jaundice (yellow skin color) ☐ Cyanosis (blue skin color ☐ None
Birth Weight:_____ Birth Length:_____

# Growth and Development:

At what age did the child:
Respond to sound_____ Follow an object with his/her eyes_____
Hold head up_____ Sit Alone_____ Crawl_____ Stand _____

Has your child experienced trauma (motor vehicle accidents, broken bones, falls off beds/changing tables/down stairs, or other accidents)?: _____
_____

Has your child ever suffered the following spinal traumas?: ☐ None

| | | |
|---|---|---|
| □ Fall in baby walker | □ Fall from bed/couch | □ Fall off skateboard/skates/skiis |
| □ Fall from crib | □ Fall off swing | □ Fall off bicycle |
| □ Fall from highchair | □ Fall off slide | □ Fall down stairs |
| □ Fall from changing table | □ Fall off monkey bars | □Other |

Is/has your child been involved in any high impact or contact sports (soccer, football, gymnastics, cheerleading, basketball, baseball, martial arts, etc)? ☐ Yes ☐ No
Has your child ever been seen on an emergency basis? ☐ No ☐ Yes, explain:_____
_____
Females only (if applicable):
Date of first menstrual cycle:_____ Date of last menstrual cycle:_____
Painful Menstration: ☐ Yes ☐ No

# Eating Habits and Activity Level:

Has your child been breastfed?: ☐ Yes, currently ☐ Yes, but not anymore ☐ No
If Yes, how long:_____ Any difficulties?:_____
If No, what type of formula is used:_____
What are your child's favorite foods?:_____
Does your child eat:
☐ Dairy ☐ Gluten/Wheat ☐ Sugar ☐ Eggs ☐ Soy ☐ Caffeine
Does your child drink water? ☐ Yes ☐ No How much?:_____
Does your child play outside? ☐ Yes ☐ No How long?:_____
What are your child's favorite activities?:_____
Does your child watch TV?: ☐ Yes ☐ No How many hours/day?:_____
Number of hours Sleeping per night:_____
Quality of Sleep: ☐ Good ☐ Fair ☐ Poor
Number of naps per day:_____ Length of naps:_____
Quality of Sleep: ☐ Good ☐ Fair ☐ Poor
Is there a preferred sleeping position?:_____

Is there anything else you would like to discuss with us at this point?:_____
_____
_____
_____
_____

# HIPAA Notice of Privacy Practices

Atlee Chiropractic Center
9173 Atlee Road, Mechanicsville, VA 23116
804-730-7010

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:**
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:**
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:**
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply) –** Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information –** This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to request to receive confidential communications –** You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information –** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures –** You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

**COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

## Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

***Office Use Only***

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

# Atlee Chiropractic Center
# Payment Agreement

Payment: Your insurance policy requires our office to collect payment for copays and deductible amounts at time of service. Not adhering to these terms could be a violation of our contract with your insurance company and risk reimbursement for services provided. We can accept payment from you in the form of cash, credit card or check (returned checks are subject to a fee.)

Benefits: We verify benefits as a courtesy to you, however, our office does not accept responsibility for any incorrect information given by your insurance carrier regarding coverage and the copays or deductible payments for which you are responsible. As a courtesy, we bill your insurance company for their portion of your billed services. Please feel free to ask us questions once you receive the "Explanation of Benefits" (EOB) from your insurance provider.

A note about maintenance care: Your doctor will determine your initial course of treatment. After you are released from this Active treatment phase, you will be moved to Maintenance. More and more health insurance companies don't see maintenance chiropractic care as medically necessary - *even if you have visits remaining on your plan*. They prefer to only pay for treatments that help people recover from a specific illness, injury or other situation, but not for treatment after someone hits a plateau and stops showing signs of improvement. Once your doctor determines you have reached this phase, usually by performing an exam, our staff can discuss the many options available to you to continue chiropractic care at our office.

Please verify that you understand your financial responsibility by signing and dating below.

Patient Signature: _____

Print Name: _____ Date: _____

Staff Initials: _____