Pediatric History and Health Form (Ages 0-12yrs)

Patient Demographics Date:

Childs Name: _____ Date of Birth: _____ Current Age: _____

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

Pediatrician/Family MD: _____ City/State: _____

Last Visit: ____/____/_____ Reason for Visit: _____

Family Demographics

Mother's Name: _____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

Mother's Mobile #: _____ Father's Mobile #: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Who is responsible for today's bill? _____

Phone Number: _____ Email: _____

I understand that I am directly and fully responsible to De Melo Chiropractic for all fees associated with the chiropractic care that my child receives at this office.

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 underaged child, for whom I have the legal right to select and authorize health services on their behalf.

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 select and/or authorize this care should change in any way, I will immediately notify the office.

Parent/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Child's Current Problem/Reason for Today's Visit

Child's Name: _____

Purpose of this visit: (Please circle one) Wellness Check Up Injury/Accident Other

Explain: _____

Identify where and for how long your child is/has been experiencing discomfort/pain, if any: _____

_____

Date this problem began: ___/____/____ This problem came on: Gradually Suddenly Unknown

Ever had this problem before? Yes / No If yes, when? _____

Any bowel/bladder issues since this problem began? Yes / No If yes, describe: _____

Have you seen any other doctors for this problem? Yes / No If yes, who? _____

How long ago? _____ What were the results? _____

How is this problem now? (Please circle one) Improving About the Same Worsening On/Off

Please list any medications taken for this problem: _____

Has your child sustained any injuries during organized sports or auto accidents? Yes / No If yes, explain: _____

_____

Has your child suffered from any of the following recently? (Circle all applicable)

Musculoskeletal System:

Arm Issues Backaches Broken Bones Growing Pain Joint Issues

Muscle Pain Leg Issues Walking Issues Hypertension Poor Posture

Headaches Anemia Heart Issues Neck Issues Scoliosis

Respiratory System:

Asthma Sinus Issues Frequent Colds/Flu Allergies: _____

Digestive System:

Reflux Poor Appetite Stomach Aches Digestive Disorders

Diarrhea Bed Wetting Ruptures/Hernia Constipation

Nervous System:

ADD/ADHD Dizziness Fainting Seizures/Convulsions Sleeping Problems

Falls From or Off Of:

Swings Bed/Couch Changing Table Highchair Baby Walker Crib

Slide Bicycle Monkey Bars Skateboard Downstairs Skates

Other:

Colic Chronic Earaches Orthopedic Problems

Parent/Guardian Signature: _____ Date: _____

Family Health History

Patient Name: _____ Date: _____

Directions: Please review the listed symptoms and conditions. Indicate those that are *current* health problems of a family member by writing "C" in his/her column. Indicate those that are *past* health problems of a family member by writing "P" in his/her column. Leave blank those spaces which do not apply. Indicate *deceased* family members with a "D" and the age of death (if known) on the age line.

Condition	**Father** Age:	**Mother** Age:	**Spouse** Age:	**Sibling 1** Age:	**Sibling 2** Age:	**Child 1** Age:	**Child 2** Age:	**Child 3** Age:
Allergies								
Anxiety								
Arthritis								
Back Pain								
Cancer								
Constipation								
Diabetes								
Disc Problems								
Epilepsy								
Frequent Colds/Flu								
Gas/Bloating								
Headaches								
Heartburn								
Heart trouble								
High Blood Pressure								
Low Energy								
Migraine								
Neck Pain								
Nervousness								
Pinched Nerve								
Scoliosis								
Sleep Problems								
Other:								
Other:								

Pediatric Financial Policy

We may bill your child/ward's insurance company as a courtesy to you. Please provide your child/ward's current insurance information at your first appointment. If there are any changes in their insurance information, please alert the staff as soon as possible.

You are responsible to pay the estimated balance that your child/ward's insurance will not cover. This balance is due at the time of service. We accept cash, checks, and debit/credit cards, including HAS.

By signing this document, you are acknowledging that you accept the following terms:

1. Payment for services rendered is due in full on the date of service.
2. Payment for equipment or supplements is due the day the order is made.
3. An interest fee will be added to all overdue balances.
4. An additional fee will be sent to all overdue balances sent to collections.
5. There is a $25 charge on all returned checks with insufficient funds.

Lifetime Insurance Authorization

Please initial all items below:

_____ I understand that De Melo Chiropractic will verify my child/ward's eligibility and benefits information to the best of their ability.

_____ I understand this does not guarantee payment by my child/ward's insurance company or that all information will be correct.

_____ I request that payment of authorized benefits from my child/ward's insurance policy or program be made to me or, on my behalf, to De Melo Chiropractic for any products/services furnished and provided to my child/ward.

_____ I authorize any holder of medical information about my child/ward at this office to release any information needed to determine these benefits or benefits for related services.

_____ I understand that I as the parent/guardian am financially responsible for all charges, whether or not paid for by my child/ward's insurance company.

_____ I understand that it is not the responsibility of De Melo Chiropractic to inform me when my child/ward's insurance benefits run out, and that I will be financially responsible for all services and products not covered by my child/ward's insurance company once their benefits run out.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____

OUR OFFICE POLICIES

Welcome to De Melo Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for and the various methods we offer to facilitate payment for that care. Please read each policy carefully so that there is no misunderstanding as to what you can expect as a patient of this practice and what we expect in return. Once you have read "Our Office Policies", if you have any questions or if any of these policies are unclear to you and you would like further explanation before submitting your ***Application for Care***, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interest to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic care so that an informed decision can be made whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open setting, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about. You are encouraged to keep this document.

- **Patient Privacy** – Since the majority of patient care takes place in an open setting, it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter that you wish to discuss, please let us know and we will schedule a time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.
- **Your Care** – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at ***De Melo Chiropractic*** rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Thompson Drop Technique, Activator Methods, and Palmer Diversified Chiropractic. It is important that you understand both the objective and the method(s) so that there is no confusion or disappointment. Tremendous progress has been made in the rehabilitation and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief through three distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.
- **First Things First** – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.
- **Patient's Report of Findings** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case. Because the results of your X-Rays and all examinations, as well as the doctor's recommendations for care, will be discussed at that time, we strongly urge new patients to invite spouses or significant others to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

OUR OFFICE POLICIES

(signature page)

I have retained pages 1 of 2 of the 'Office Policies' document.

Patient or Guardian's Initials: _____

I hereby acknowledge receiving a copy of De Melo Chiropractic's 'Office Policies', a two-page document, the first page of which I have read and retained. This second page is recognized by me as the Signature Page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____

Patient's Name DOB

_____ _____

Patient or Authorized Person's Signature Date

_____ _____

Witness Signature Date

OUR PATIENT PRIVACY NOTICE

De Melo Chiropractic

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of our Personal Health Information (PHI). In addition, we must provide you with written notice concerning your rights to gain access to your PHI, and the potential circumstances under which, by law or as dictated by our Office Policy (see accompanying documents), 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, it will be provided to you. In addition, you will find we have placed several copies in report folders labeled **HIPAA** on tables in the reception area. Once you have read this notice, please sign the last page, and return it to our front desk receptionist. You are encouraged to keep this first page for your personal records.

Permitted Disclosures:

1. Treatment Purposes – discussion with other health care providers involved in your care.
2. Inadvertent Disclosures – open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so that we can place you in a private consultation room.
3. Payment Purposes – to obtain payment from your insurance company or any other collateral source.
4. Workers Comp. Purposes – to process a claim and/or aid in an investigation.
5. Emergency Purposes – to notify a family member in the event of a medical emergency.
6. Public Health and Safety – in order to prevent or lessen a serious or eminent threat to the health and/or safety of a person or general public.
7. Gov. Agencies/Law Enforcement – to identify and/or locate a suspect, fugitive, material witness or missing person.
8. Benefit Purposes – for military and national security members, prisoners, and government workers.
9. Deceased Persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Notifications – we may call, text or email 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 that 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 Patient Privacy Notice.
3. To request mailings to an address other than your residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, and to request amendments to information, 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 is provided.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-Rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made, we will happily accommodate you. However, you will be responsible for costs.
7. To file a formal complaint about how we handle your health information.

Complaints: If you wish to make a formal complaint about how we handle your health information, you can request the doctor's contact info at the front desk. If either is unavailable, you may make an appointment with our receptionist to see them 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

OUR PATIENT PRIVACY NOTICE

(signature page)

I have retained pages 1 of 2 of the 'Patient Privacy Notice' document.

Patient or Guardian's Initials: _____

I hereby acknowledge receiving a copy of De Melo Chiropractic's Patient Privacy Notice, the first page of which I have read and retained for my personal records. This second page is recognized by me as the Signature Page and will be retained by the practice as evidence of my receiving and understanding this 'Notice' I understand my rights, as well as this practice's duty to protect my PHI, 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 'Patient Privacy Notice' at any 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 several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any information I have received.

_____ _____

Patient's Name DOB

_____ _____

Patient or Authorized Person's Signature Date

_____ _____

Witness Signature Date