CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

Name _____

Home Phone _____ Birthdate _____

Age _____ Gender ❑ M ❑ F

Height _____ Weight _____

Address _____

City/State/Zip _____

Parent's Name _____

Parent's Employer _____

Parent's Work Phone _____

Payment Method ❑ Cash ❑ Check ❑ Credit Card

Crdt Cd. # _____ exp _____

Health Insurance Co. Name _____

Policy Number _____

Policy Holder's Name _____

Policy Holder's Social Security # _____

REASON FOR THIS VISIT

Describe the purpose of this visit. _____

_____

Is the purpose of this appointment related to

❑ sports ❑ auto ❑ fall ❑ home injury

❑ chronic discomfort ❑ other

Explain _____

When did this condition begin? _____

Has this condition

❑ gotten worse ❑ stayed constant ❑ comes and goes

Does this condition interfere with

❑ sleep ❑ daily routine ❑ other activities

Explain _____

Has this condition occurred before? ❑ Yes ❑ No

Explain _____

Have you seen other doctors for this condition? ❑ Yes ❑ No

Dr.'s Name(s) _____

Type of Treatment _____

Results _____

MOTHER'S PREGNANCY & LABOR

During pregnancy, did the mother:

.....take any medication? ❑ No ❑ Yes

Explain _____

.....smoke or consume alcohol? ❑ No ❑ Yes

.....experience any illness? ❑ No ❑ Yes

Explain _____

Approximately how long did labor last? _____ hours

Was labor chemically induced? ❑ No ❑ Yes

Was labor doctor assisted? ❑ No ❑ Yes

Was a C-Section performed? ❑ No ❑ Yes

Were forceps or vacuum extraction used? ❑ No ❑ Yes

Did the delivery doctor pull or twist the baby during delivery? ❑ No ❑ Yes

Was the delivery premature? ❑ No ❑ Yes

If "Yes", at ____ month and _____ weight

Check any of the following if the child experienced it immediately after birth.

❑ Jaundice ❑ Respiratory Problems

❑ Feeding Problems ❑ Displaced or Broken Joints

❑ Other Condition(s)

Explain _____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis

- ❒ Vision Problems
- ❒ Headaches
- ❒ Sleeping Disorders
- ❒ Irritability
- ❒ Skin Problems
- ❒ Allergies
- ❒ Breathing Problems
- ❒ Asthma
- ❒ Hyperactivity
- ❒ Constipation
- ❒ Bed Wetting
- ❒ Pink Eye
- ❒ Ear Problems
- ❒ Tubes in the Ears
- ❒ Attention Problems
- ❒ Frequent Colds
- ❒ Colic
- ❒ Digestive Problems
- ❒ Other _____

_____

_____

CHILD'S CURRENT HEALTH STATUS

Is your child accident prone? ❑ No ❑ Yes

Has your child:

.....been hospitalized? ❑ No ❑ Yes

.....had a severe fall? ❑ No ❑ Yes

.....been in a car accident? ❑ No ❑ Yes

Has your child ever taken antibiotics? ❑ No ❑ Yes

If "Yes", explain _____

Is your child currently taking any medication? ❑ No ❑ Yes

If "Yes, explain _____

Does your child have difficulty interacting with schoolmates or friends? ❑ No ❑ Yes

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? ❑ No ❑ Yes

What changes (if any) in your child's health or behavior would you like accomplished? _____

GOALS FOR MY CHILD'S CARE

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your child's Chiropractic care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❒ **Relief Care** — Symptomatic relief of pain or discomfort

❒ **Corrective Care** — Correcting and relieving the cause of the problem as well as the symptoms

❒ **Comprehensive Care** — Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

❒ I want the Doctor to select the type of care appropriate for my child.

_____

Parent/Guardian's Signature Date

VACCINATIONS

Have you chosen to vaccinate your child? ❑ No ❑ Yes If "Yes", check all vaccinations the child has received.

❑ DPT ❑ MMR ❑ Polio ❑ Chicken Pox ❑ Hepatitis ❑ Other _____

Describe any and all reactions to vaccine(s). _____

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize the Doctors in this Chiropractic office, and whomever they may designate as their assistants to administer Chiropractic care, to work with my child (name) _____ through the use of adjustments and procedures to the spine, as the Doctor deems appropriate.

I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policy holder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

_____ _____

Patient's Name (Print) Parent or Legal Guardian's Name (Print)

_____ _____ _____

Parent/Guardian's Signature Authorizing Care Date (M/D/Y) Witness' Signature

Who should receive bills for payment on this account?

❑ Parent ❑ Personal Health Insurance ❑ Auto Insurance ❑ Medicare ❑ Medicaid

Health Conditions

Please check any conditions that currently exist or have existed in the past:

For women:	
Are you pregnant?	___Yes ___No
Are you nursing?	___Yes ___No
Do you experience painful periods?	___Yes ___No
Do you have irregular cycles?	___Yes ___No
Are you taking birth control?	___Yes ___No
Do you have breast implants?	___Yes ___No

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all expenses incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____

Patient's Signature Date Guardian or Spouse's Signature Authorizing Care Date

Who should receive bills for payment on your account:

____ Patient	____ Spouse	____ Parent
____ Worker's Comp	____ Auto Insurance	____ Medicare
____ Medicaid	____ Personal Health Insurance	

Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-rays are for examination of X-rays only. The X-ray negatives will remain the property of this office. All X-rays will be kept on file where they may be seen at any time while I am a patient of this office.

CONSENT TO TREATMENT OF MINOR

I/we, the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby authorize_____ as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, to be rendered under the general or special supervision of any licensed chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above-described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable. These authorizations shall remain effective until _____, 20_____, unless sooner revoked in writing delivered to the agent(s) noted above.

_____

Parent/legal guardian / Person having legal custody (circle relationship) Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

To locate, analyze, and correct spinal interference to the nervous system.

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

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WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S)
OTHER THAN VERTEBRAL SUBLUXATIONS

WE OFFER NO OTHER TREATMENT OF CONDITION(S) OR DISEASE(S)
OTHER THAN VERTEBRAL SUBLUXATIONS.

WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).

THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!

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I, _____, having read the above statement, and understanding it fully, do undertake chiropractic health care on this basis.

SIGNATURE:_____ DATE:_____

Canyon Chiropractic_____ Dedicated to Quality Care

NEW PATIENT INSURANCE REGISTRATION FORM

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. We work with hundreds of different insurance companies that administer insurance benefits from different employers. Each employer pays an insurance premium for specific chiropractic coverage. Each plan is slightly different depending on how the employer has negotiated benefits with the insurance company. Companies often change insurance companies in an effort to secure better benefits for smaller premiums. We encourage you to become familiar with your policy maximums, percentages, exclusions, deductible and required co-payments.

We do not base your adjustment program on your insurance coverage and neither should you. There are limits to what they will pay. Our goal is to correct your problem in the shortest amount of time and in the most cost-effective manner.

Our courtesy service to you includes:

1. Researching your chiropractic insurance plan to advise you of benefits available to you.
2. Filing your insurance within 14 days of your visit and requesting payment of benefits to our office when possible.
3. Follow up on chiropractic claims to assist with claim processing and payment.

Our expectations of you as the owner of the insurance policy:

1. Payment of fees not covered by your insurance plan.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.
3. Taking responsibility for payment if the insurance company does not pay our office.
4. Keeping our office informed of any changes in your insurance coverage or employment.

To assist us in obtaining your benefits, **please sign the "assignment of benefits"** below to allow us to file your insurance claims.

I hereby authorize Dr. Robert C. Dees to release to my insurance company, information acquired in the course of my chiropractic care. I hereby authorize benefits to be paid to Dr. Robert C. Dees. I understand I am responsible for any unpaid balance.

Signature:_____ **Date:**_____

Provider Privacy Policy

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.

USES AND DISCLOSURES

Treatment: Your health information may be disclosed to other health care professionals for the purpose of evaluating your health and providing treatment. For example, customer service information may be available to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the daily operations and management of Supplier. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to assist in government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Marketing: We may use your oral or written testimony, with your permission, for marketing the benefits of our office.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual rights: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Supplier's duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to revise privacy practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect protected health information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Canyon Chiropractic**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about your privacy practices, you can do so by sending a letter outlining your concerns to:

Canyon Chiropractic
2570 San Ramon Valley Blvd. Suite A106
San Ramon, CA 94583

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact person: The name and address of the person you may contact for further information concerning our privacy practices is:

Robert C. Dees, DC
2570 San Ramon Valley Blvd. Suite A106
San Ramon, CA 94583
(925) 867-1414

The undersigned hereby acknowledges that he/she has read and understood the policies of the supplier.

Signature _____ Date _____ Print Name _____

Effective Date: This notice is effective after January 5, 2011