Whom may we thank for referring you to this office → _____?

Maximize Chiropractic – PEDIATRIC HEALTH HISTORY FORM

Today's Date: _____ HR#: _____

ABOUT THE CHILD

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Names and Ages of Siblings: _____

Height: _____ Weight: _____

PARENT A

Name: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

PARENT B

Name: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Maximize Chiropractic can address for your child? _____

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Birth Trauma ❑ Home Injury ❑ Other _____

Please describe how these concerns are affecting your child's quality of life. _____

_____

Check all that apply

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

PREGNANCY AND BIRTH

During pregnancy, did the mother (Check all that apply):

❑ Use any form of fertility treatment? If so, what treatment: _____
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol? _____

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____
Approximately how long did labor last? _____
Was labor artificially induced? ❑ No ❑ Yes _____
Was it determined that the child was breech or otherwise mispositioned? ❑ No ❑ Yes _____

Please check which, if any of the following were administered or used during labor and birth:

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck _____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

APGAR Score _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure ❑ Loss of a loved one ❑ Bullying ❑ Relocation
❑ Lifestyle change ❑ Parents' divorce ❑ Loss of a pet ❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT_____ ❑ MMR _____ ❑ Other _____
❑ Polio_____ ❑ Chicken Pox_____
❑ Hepatitis _____ ❑ Flu _____

Please describe any and all reactions to vaccine(s)_____

Please check all that apply and give any necessary details:
❑ Child exposed to second hand smoke.
❑ Has taken antibiotics. Explain _____
❑ Currently taking medication. Explain _____
❑ Currently taking supplements. Explain _____
❑ Has allergies. Explain _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to?: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other

Please check all that apply to your child and give any necessary details:

❑ Uncoordinated/Accident prone_____
❑ Has been hospitalized. _____
❑ Had a severe trauma. _____
❑ Been in an automobile accident. _____
❑ Has fractured a bone or dislocated a joint. _____
❑ Has/had a chronic illness. _____
❑ Has had surgery. _____

What physical activities does your child participate in? _____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted, or do you regularly consult any of the following providers for your child?

Check all that apply
❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason _____

_____

I hereby authorize payment to be made directly to Nicholl Chiropractic Inc., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Nicholl Chiropractic Inc. for any and all services that are rendered at this office.

Cancellation Policy
24 hour notice must be given to cancel all scheduled appointments.
Appointments cancelled with less than 24 hour notice will automatically generate a $65 fee.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

Nicholl Chiropractic Inc. NOTICE OF PRIVACY PRACTICE

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call 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 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 comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, 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.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. 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 be happy to accommodate you. However, you will be responsible for this cost @ $25.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call the office at (916) 594-7630. If she/he is unavailable, you may make an appointment with our receptionist to see her /him 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

I have received a copy of Nicholl Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, 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 'Notice of Privacy Practice" at an 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 of the information I have received.

Patient's Name	DOB	HR#

Patient signature	Date

Witness	Date

Total Family Health
Maximize Chiropractic

Pediatric

Office Fee Schedule:

Consultation & Initial Exam	$65.00
First Adjustment:	$65.00
X-rays:	$87.00 - $200.00
Ancillary Procedures:	$30.00 - $60.00

Financial Policy:

You will be expected to pay for your chiropractic care at the time service is rendered unless discussed with the office prior to your appointment.

Cash- Cash patients are able to obtain upwards of a **60% discount** under representation from Compliant Coupons. Every patient will be automatically enrolled with Compliant Coupons. Average cost for the 1st appointment is $130.

Health Insurance- Every patient is asked to place a $130 deposit for services rendered on the 1st appointment. Once a diagnosis code is established by the doctor, office staff will obtain detailed information on coverage opportunities in the office. If insurance covers care, the deposit will be returned to patient or applied towards co-pays and deductibles. If no coverage is present, no additional charges will be placed for the 1st visit. We will accept your assignment of benefits; however, you must remember you are directly responsible for your bill.

If my health insurance company denies payment, I agree to be personally and fully responsible for payment."

- Some Chiropractic insurance plans will **NOT** cover services for non-musculoskeletal conditions. for minors, 12 years of age or younger.

Cancellation Policy:

24 hour cancellation for scheduled appointments must be respected or appointment will be charged $65.

_____

Patient's Name (Print)

_____ _____

Parent or Guardian Signature Date

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.
Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Nicholl Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ *Witness Initials*

Patient or Guardian Signature Date

REGARDING: X-rays/Imaging Studies

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my child's case.

_____ ____/____/____ *Witness Initials*

Patient or Guardian Signature Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages: Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me: [ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Consent to Treat a Minor

The undersigned hereby requests and authorizes Dr. Tim Nicholl to perform diagnostic testing and render chiropractic adjustments to _____, who is a minor.

This authorization extends to radiographic examination.

If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse or former spouse or another parent is not required.

Patient Name: _____

Parent/Guardian signature_____ Date: ____/____/_____