CONFIDENTIAL CHILDREN'S HEALTH REVIEW

(18 years of age or younger)

Child's Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Hm: ( )_____ Cell: ( )_____

Birthday: ____/____/____ Age:_____ Social Security Num:_____

Parent (s)/ Guardian (s): _____

Family Doctor/ Pediatrician: _____

Date Of Last Visit: ____/____/____ Reason:_____

Date of Last General Physical Examination? ____/____/____ ☐ Never

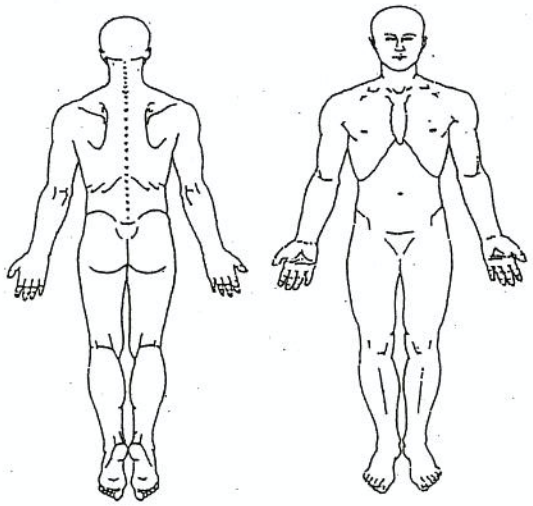
How was your child referred to Chiro+Plus Clinic? _____

Has your child seen another chiropractor before today? ☐ Yes ☐ No

If so, when? ____/____/____ For what condition? _____

Date of last spinal examination? ____/___/___ ☐ Never

Mark on the drawings where your child has trouble or feels pain.



Describe the problem that brings him/her to our office.

_____

_____

_____

When did the problem begin? _____

What caused the pain or trouble? _____

_____

Has the problem changed since it began? ☐ Yes ☐ No

What makes the Pain/Trouble worse? _____

_____

What makes it better? _____

Frequency of problem? ☐ Constant ☐ Often ☐ Some ☐ Rare

Has he/she ever had a similar symptom before? ☐ No ☐ Yes

If Yes, when? _____

Describe any treatments you have received for this problem so far? _____

_____

_____

If in school / pre-school, is there any problem with:

Attention Span? ☐ No ☐ Yes

Sitting still? ☐ No ☐ Yes

Interaction with other children? ☐ No ☐ Yes

Physical co-ordination? ☐ No ☐ Yes

What does your child prefer to be:

☐ Active (IE: sports, games) ☐ In-active (IE: reading, puzzles)

Is there any indication of ongoing or frequent colds, ear infections, asthma, bronchitis?

☐ No ☐ Yes If yes, please describe: _____

Is there any complaint of a spinal problem? ☐ No ☐ Yes

If yes, please describe: _____

Is there any complaint of joint problems? ☐ No ☐ Yes

If yes, please describe: _____

Does your child have brothers or sisters? ☐ No ☐ Yes

Brothers (age): _____

Sisters (age): _____

Do any of your child's siblings have any health problems? ☐ No ☐ Yes

If yes, please explain? _____

_____

_____

STATEMENT OF MINOR TREATMENT AUTHORIZATION

My minor son / daughter has my permission to undergo chiropractic examination and treatment with Chiro+Plus Clinic · Fort Worth, Tx

_____ Date: ___/___/___

(Printed Parent / Guardian Name)

_____ Date: ___/___/___

(Parent / Guardian Signature)

Documentation of Health Information

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Patient Acknowledgment

Patient Name(s):

_____

_____

_____

Thank you very much for taking time to review how we are carefully using your heath information. If you have questions, please let us know. If not ,we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

_____ *Date*___/___/___

Patient Signature

Thank You For Your Trust and Confidence

HIPAA HAPPENINGS

This notice describes how your health information may be used and ho you can gain access to this information. Please review it carefully.

Our Promise To You our Valued Patient....

This is not meant to alarm you. Quite the opposite. We want to assure you that v take the new Federal HIPPA (Health Insurance Portability and Accountability Ac laws seriously. These laws were written to protect the confidentiality of your heal information. We trust you will never delay treatment in our offices because of fe that your personal health information might be unnecessarily disclosed to othe outside our office.

Why A Privacy Policy Now?

The most significant variable that has motivated the Federal government to legal enforce the privacy of health information is the rapid evolution of the use electronic technology in the administration of health care business. Th government has appropriately sought to standardize and protect the electron exchange of your health information. This has challenged us to review not on how your information is used within our computers but also with the Interne phones, fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for ou practice to assure that your personal or health information will be shared only a required and only for the purpose of administering your case. Our office is subje to State and Federal laws regarding the confidentiality of your health informatio We will assure our adherence to those laws and we want you to understand ou procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of conductin health care business and obtaining payment for services. Be assured that witho your written permission, your health information will not be used for any othe purpose.

How Your Health Information May Be Used To Provide Treatment

Within our office, your health information will be used to provide you the best car and services possible. This may include administrative and clinical procedure designed to optimize scheduling and coordination between you and all offic personnel. In addition, we may share this information with referring physician clinical pathology laboratories or other health professionals providing yo treatment.

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIENS AND AUTHORIZATION

("Agreement")

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and or other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, illnesses past or future ("condition") to pay directly to and exclusively in the name of Chiro+Plus Chiropractic Clinics ("ChiroPlus" or "office") such sums as may be owing to Chiro+Plus for charges incurred by me, including but not limited to charges for treatment , narrative reports, depositions, testimony, and any other charges incurred by me at the office ("charges"). I further grant a contractual lien to Chiro+Plus with respect to any charges, applicable to all payers; however, I understand that nothing in this Agreement shall be construed as an election by Chiro+Plus to claim protection under any statuary lien law. For the purpose of this Agreement "benefits" shall include, but shall not be limited to proceeds from any settlement, judgment, or verdict as well as any proceeds relating to commercial health or group insurance, disability benefits, workers compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements and any other benefit or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that in the event a payer refuses to pay Chiro+Plus, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Chiro+Plus to the extent of my charges, as well as any and all causes of action that I might have against such payer to prosecute such causes of action either in my name or in the offices name, and to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a Letter of Protection to this office regarding my charges. Upon issuance I hereby agree that such letter(s) of protection cannot be revoked or modified without expressed written consent of this office. I further direct each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such funds to the office upon its request.

I hereby direct all payers to release to Chiro+Plus any information regarding my coverage or benefits which I may have including, but not limited to, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this office to file a copy of this agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Chiro+Plus to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payment of an amount relating to me, my spouse, or my dependents, regardless of whether these charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to Chiro+Plus for their services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take action to collect an outstanding balance on my account, I will be responsible for payments and will reimburse Chiro+Plus for all for all costs of collection efforts, including, but not limited to all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual consent of Chiro+Plus and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of these authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interests of Chiro+Plus and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print):_____

Patient Signature:_____ Date:__/__/__

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature:_____