Child's Health History Hazen Chiropractic

Patient's Personal Information

Child's Name:	Parent's Name(s):
Street Address:	City, Sate, Zip:
Home Phone:	Cell Phone:
Email:	Child's DOB:
Primary Care Physician:	
Please list any drugs/medications/vitamins that your child is taking:	
Is your child receiving care from any other health professionals? -If yes, please provide their name and specialty:	
How did you hear about our office?	

Current Health Conditions

What health condition(s) bring your child to be evaluated by a chiropractor?	
When did it start?	How did the problem start? ☐ Sudden ☐ Gradually ☐ Post-Injury ☐ Accident
Has your child ever received care for this condition before? ☐ Yes ☐ No If yes, by whom?	
What makes this problem better?	What makes this problem worse?

Labor & Deliver History

Child's birth was: ☐ Natural vaginal birth ☐ Scheduled C-section ☐ Emergency C-section
Child's birth was: ☐ At home ☐ At a birth center ☐ At a hospital ☐ Other:
At how many weeks was your child? Doctor/Obstetrician's Name:
Please check any applicable interventions or complications: ☐ Breech ☐ Induction ☐ Pain meds ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps ☐ Other:
Please note any other concerns about child's birth:

Growth & Development History

Is/was your child breastfed? ☐ Yes ☐ No If yes, how long?
Difficulty with breastfeeding? ☐ Yes ☐ No

Did they ever use formula? ☐ Yes ☐ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ☐ Yes ☐ No
-If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ☐ Yes ☐ No
-If yes, please explain:

Did/does your child have any issues with the following: If yes, please explain:

- ☐ Responding to sound
- ☐ Sitting alone
- ☐ Crawling
- ☐ Walking
- ☐ Teething
- ☐ Following an object
- ☐ Holding their head up
- ☐ Vocalization

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Has your child received any antibiotics? ☐ Yes ☐ No
-If yes, how many times and list reason:

Night terrors or difficulty sleeping? ☐ Yes ☐ No
If yes, please explain:

Behavioral, social or emotional issues? ☐ Yes ☐ No
If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet, or phone?

How would you describe your child's diet?
☐ Mostly whole foods (fruits & vegetables) ☐ Pretty average ☐ High amount of processed foods

Parent/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Payment Policy

Hazen Chiropractic

1. Patients are personally responsible for charges. As a non-participating provider, **any portion of services provided, not covered by MEDICARE or your SUPPLIMENTAL insurance, are the responsibility of the patient for the full amount charged.**

2. Our offices file to **MEDICARE ONLY**, provided that industry standard claims process is used. Out of network claims requiring paperwork above and beyond the industry standard process is the responsibility of the patient. Secondary insurance claims will not be processed by our office. Payments are automatically received from cross-over claims processes which are linked between Medicare and secondary insurance companies.

3. The following services/products are standardly denied by insurance companies; the initial exam, ultrasound, laser, pillows, custom orthotics, nutritional consultations, and nutritional supplements.

4. I understand and agree that health policies are an arrangement between my insurance company and me – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports at no charge to assist in collecting from my insurance company.

5. There will be a $35.00 charge for returned checks due to nonsufficient funds (NSF). After one NSFs, checks can no longer be accepted as a method of payment.

6. There is a $2.00 processing fee charged on all Credit/Debit card transactions.

I HAVE READ, UNDERSTAND, AND AGREE WITH THE PAYMENT POLICY:

PATIENT NAME:_____ DATE: _____

PATIENT SIGNATURE: _____ DATE: _____

Terms & Consent to Hazen Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective as this prevents any confusion or disappointment.

The objective of chiropractic health care in our office is to improve and optimize the health and function of the spine and nervous system through the correction of vertebral subluxations[2]. A chiropractic adjustment[1] is the method used for the correction of the vertebral subluxations.

We do not diagnose or treat any disease. We analyze the spine for vertebral subluxations. If, during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Our commitment to your health is to (1) evaluate and monitor your spine and nervous system on each visit to determine if the adjustment and adjusting procedures that will get the best outcome for you and (2) to provide you with supportive education and information so you can get the best results from our care.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Name: _____ Date: _____

Signature: _____

Consent To Share Photo's

1. I consent to my photo or image being used in photograph or video in public media including social media, website, or promotional materials. If I should withdraw my consent, I will notify the office in writing.
2. I consent to my child's photo or image being used in photograph or video in public media including social media, website, or promotional materials. If I should withdraw my consent, I will notify the office in writing.

Please note below any withdrawal of consent to any of the above statements

Name: _____ Date: _____

Signature: _____

1. Chiropractic Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

2. Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Patient Health Information Consent Form

Hazen Chiropractic

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As **an example**, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature Date