GREEN HILLS
Chiropractic Clinic

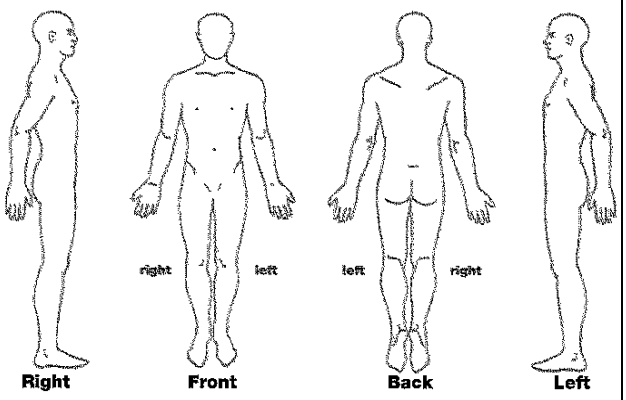
Adolescent Patient History

Patient Name: _____ Nickname:_____
Last First MI
Birthdate:_____/_____/_____ Age:_____ SSN:_____ Male Female
Mailing address:_____
City State Zip
Phone:_____ Cell:_____ Referred by:_____

Are you in pain? Y N
Were you injured in school? Y N
Were you injured playing sports? Y N
If yes, what sports do you play? _____
Is this a new injury? Y N
How long have you been in pain? _____
Please explain what happened: _____
_____
Is the pain getting worse? Y N
Has this ever happened to you in the past? Y N
If yes, explain: _____
Have you seen a medical doctor for this condition? Y N
If yes, where?: _____
Have you ever been treated by a chiropractor before? Y N
If yes, where?: _____

Is it constant? Y N Is it dull? Y N
Is it sharp? Y N Does it burn? Y N

Please ***circle*** any areas of pain or discomfort



Are you on any medications? Y N If so, what? _____
Do you now or have you ever had any of the following diseases or conditions? (Circle all that apply)

Neck pain	Ear infections	Heart murmur	Digestive problems
Back pain	Chronic colds	Heart defects	Kidney problems
Headache	Asthma	Anemia	Bed-wetting
Arm pain	Allergies	Seizures	ADHD
Leg pain	Sinus problems	Cancer	ADD

Please list any other conditions/diseases not listed above: _____
_____
Please list any serious accidents or surgeries with dates: _____
_____
Family health history: _____
_____

Authorization for Care of a Minor

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Insurance Company: _____ Policy #: _____
Signed: _____ Date: _____

PARENT/GUARDIAN INFORMATION

Child's Name _____ Date _____ Patient # _____

Parent Name _____

DOB _____ Male Female

Address _____

_____

City State Zip

Cell phone _____

Home Phone _____

Email _____

Status: single married divorced other _____

Employer Information:

Employer _____

Address _____

_____

City State Zip

Parent Name _____

DOB _____ Male Female

Address _____

_____

City State Zip

Cell phone _____

Home Phone _____

Email _____

Status: single married divorced other _____

Employer Information:

Employer _____

Address _____

_____

City State Zip

INSURANCE INFORMATION

Company Name _____ Insured ID# _____

Include alpha prefix please

Insured's Name _____ Relation _____

Insured's DOB _____ Group # _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for my balance not paid by my insurance company.

EMERGENCY CONTACT

Contact Name _____ Primary Phone _____

Relation to Patient _____ Secondary Phone _____

Signature _____ **Date** _____

HIPAA Notice of Privacy Practices

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral inmates, and required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 165.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights.
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will NOT retaliate against you for filing a complaint.**

This notice was published and becomes effective on/before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number listed at the top of the first page of this notice.

Signature on the following page is only acknowledgement that you have received this Notice of Privacy Practices.

GREEN HILLS
Chiropractic Clinic

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This is acknowledgment of receipt of Notice of Privacy Practices from Green Hills Chiropractic Clinic. I understand that my protected health information may be used by the Practice as described in the notice.

Patient Name (Please Print):_____

Patient Signature:
_____**Date**:_____

Responsible Person (if patient is a minor):
_____

Witness Signature:
_____Date:_____

Office Use Only

I made a *good faith* effort to obtain patient/responsible person's signature in acknowledgment of Notice of Privacy Practices from Green Hills Chiropractic Clinic, but was unable to do so as documented below.

Date: _____ Staff Signature: _____

Reason:

GREEN HILLS
Chiropractic Clinic

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

GREEN HILLS
Chiropractic Clinic

Informed Consent

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE GREEN HILLS CHIROPRACTIC CLINIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED THIS ____ DAY OF _____, 20___

_____ **_____**
Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

Remarks:

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need and the payment plan that fits best for you. We ask that you read and understand our policy as it applies to your situation.

PATIENTS WITHOUT INSURANCE: We request that 100% of the first visit be paid at the time of the visit. In cases of financial hardship, a payment plan may be discussed for follow-up visits. We are happy to accept cash, check, MasterCard, American Express or Visa as payment for the services provided at our office.

GROUP OR INDIVIDUAL INSURANCE: Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge and file them with your insurance company. It is to be understood and agreed that any services rendered are charges to you directly and you are personally responsible for payment of any non-covered services, deductibles, or co-payments.

"ON THE JOB" INJURY (Worker's Compensation): If you are injured on the job, your care should be paid for under your employer's Worker's Compensation Insurance. You will need to inform your employer of the accident verify that our office is on the panel of doctors authorized to treat you, and provide us with a claim number, name, and address of the insurance carrier. If you do not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS: Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are 2 options available to PI patients:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the MedPay portion of your auto insurance.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately. If you have retained an attorney at any time, you will be responsible for 100% of each visit unless otherwise noted.

MEDICARE: We do not accept assignment from Medicare. The check is usually sent directly to the patient for payment of services that Medicare will cover, which for chiropractic is ONLY the manipulation of the spine. All other services provided are NON-COVERED. These services include, but are not limited to,
x-rays, examinations, therapies, and supplements. Medicare patients are fully responsible for charges of non-covered services. Our office completes and files Medicare at no additional charge.

INSURANCE FORMS AND PAYMENT: If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up-to-date as possible. Occasionally, either by mistake or due to provisions on your policy, the check issued by the insurance company for payment of services rendered in our office may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to verify whether the check represents payment of for the services you received in our office.

Collection Fees: If patient account is sent to collections, the patient is responsible for any and all collection fees.

_____ Please initial that you have read and understand the above policy