

RESTORATION CHIROPRACTIC CO.

Welcome to our office! We are sure that you and your family will be provided the most appropriate and professional chiropractic care possible. Our most important goal is the constant improvement and maintenance of your family's health. Before we get started with today's examination procedures, which will determine how we can help your child, we want you to understand what we do and why we are going to do it.

The goal of our office is to allow your child's body to function at its highest potential, free from interference and stress which causes dysfunction, disease, and eventually symptoms and sickness. When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential they are both working towards the same goals.

Most importantly, you must understand that chiropractic is not a substitute for medical treatment of any kind, in any way, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to be treated for whatever symptoms or conditions are bothering them. This is symptom, sickness, and disease care, and it is necessary in emergency situations. Chiropractic recognizes that you develop symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is true healthcare, focusing on the optimum function of the individual, and it's what we do in our office.

The purpose of chiropractic is to restore and maintain the integrity of the spine, spinal cord, and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine called vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called **SUBLUXATIONS**. Subluxations are the most common cause of nerve system interferences (pinched nerves) and cause dysfunction to the tissues and organs these nerves supply.

With appropriate chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nervous system is the foundation to good health.

The information we receive from you about your child is important. We use your child's health history, x-rays when necessary and age appropriate, computerized muscle assessment, and palpatory examination to locate subluxations. For this reason, please fill out our history forms completely and to the best of your ability. It will save us from doing unnecessary tests and give us the most accurate information.

Please feel free to ask any questions at any time of the staff or doctors in our office and again, welcome. We look forward to a healthy relationship with you and your family.

Sincerely,

Dr. Ian McCann & Restoration Chiropractic Co. Staff

CHILD MEMBER HEALTH RECORD

ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
GENDER:	
HEIGHT:	WEIGHT:

ABOUT THE PARENT

PARENT'S NAME:	
ADDRESS:	
CITY:	ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
NUMBER OF CHILDREN:	
EMPLOYER'S NAME:	
EMPLOYER'S ADDRESS:	ZIP CODE:
EMPLOYER'S CITY:	
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S DATE OF BIRTH:	

VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD?
____ YES ____ NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED:
____ DPT ____ MMR ____ CHICKEN POX ____ HEPATITIS ____ OTHER
DESCRIBE ANY AND ALL REACTIONS TO THE VACCINE(S):

CHILD'S CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
DID YOU SEE OR HEAR OF OUR OFFICE BECAUSE OF (ALL THAT APPLY): ____ NEWSPAPER ____ SIGN ____ YELLOW PAGES ____ MAILING ____ COMMUNITY EVENT ____ OTHER _____
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ____ YES ____ NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR OF CHIROPRACTIC'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?
HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO : ____ SPORTS ____ AUTO ____ FALL ____ HOME INJURY ____ OTHER
PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: ____ GOTTEN WORSE ____ STAYED CONSTANT ____ COME AND GONE
DOES THIS CONDITION INTERFERE WITH : ____ SLEEP ____ DAILY ROUTINE ____ OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? ____ YES ____ NO
PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ____ YES ____ NO
DOCTOR(S) NAME(S):
TYPES OF TREATMENTS:
RESULTS:

MOTHER'S PREGNANCY & LABOR

DURING PREGNANCY DID YOU USE:

☐ DRUGS/MEDICATIONS ☐ TOBACCO/ALCOHOL

IF YES, PLEASE EXPLAIN:

DESCRIBE YOUR DELIVERY:

☐ LABOR WAS CHEMICALLY INDUCED ☐ FORCEPS/VACUUM☐ PREMATURE DELIVERY ☐ C-SECTION DELIVERY☐ LABOR WAS DOCTOR ASSISTED☐ DOCTOR PULLED OR TWISTED THE BABY

PLEASE EXPLAIN:

DID YOU EXPERIENCE ANY ILLNESS(ES) WHILE PREGNANT?

DO/DID YOU NURSE YOUR BABY? ☐ YES ☐ NODO/DID YOU EXPERIENCE FEEDING PROBLEMS? ☐ YES ☐ NODOES/DID YOUR BABY HAVE COLIC? ☐ YES ☐ NOVACCINATIONS? ☐ YES ☐ NO**CHILD'S HEALTH HISTORY**

INSTRUCTIONS: 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, care plan and the possibility of

<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> IRRITABILITY
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> SKIN PROBLEMS
<input type="checkbox"/> ATTENTION PROBLEMS	<input type="checkbox"/> EAR PROBLEMS	<input type="checkbox"/> SLEEP DISORDERS
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> VISION PROBLEMS
<input type="checkbox"/> BREATHING PROBLEMS	<input type="checkbox"/> FREQUENT COLDS	<input type="checkbox"/> TUBES IN THE EARS
<input type="checkbox"/> COLIC	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> OTHER:

CHILD'S CURRENT HEALTH STATUS

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?

☐ YES ☐ NO PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED?

☐ YES ☐ NO PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD A SEVERE FALL?

☐ YES ☐ NO PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?

☐ YES ☐ NO PLEASE EXPLAIN:

IS YOUR CHILD ACCIDENT PRONE?

☐ YES ☐ NO PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY?

☐ YES ☐ NO PLEASE EXPLAIN:

IS YOUR CHILD CURRENTLY TAKING

MEDICATIONS? ☐ YES ☐ NO

PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY

INTERACTING WITH OTHERS? ☐ YES ☐ NO

PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES, OR EXHIBITS ROCKING BEHAVIOR? ☐ YES ☐ NO

PLEASE EXPLAIN:

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

CHIROPRACTIC AWARENESSDOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? ☐ YES ☐ NOTHE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ☐ YES ☐ NOCHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ☐ YES ☐ NOIF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE? ☐ YES ☐ NO**AUTHORIZATION FOR CARE OF A MINOR**

I hereby authorize the doctors in the chiropractic office and whomever they may designate as their assistant to administer chiropractic care to my child through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered by my child 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(s) at Restoration Chiropractic Company, P.A. will not be held responsible for any pre-existing medically diagnosed condition or for any medical diagnosis. I also understand if I suspend or terminate my child's care for any reason, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my child's insurance rights and benefits (if applicable) directly to the provider for services rendered. I authorize the use of this signature to allow the insurance company to pay Restoration Chiropractic Company, P.A. directly any amount payable as my child's assignment of benefits. I authorize the use of this signature on any insurance submissions.

NAME OF CHILD: _____ BIRTHDATE: _____

PARENT OR GUARDIAN AUTHORIZING CARE'S SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosure for the purposes of treatment, payment, or practice parathion will be made only after obtaining your consent:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used or disclosed.

PATIENT'S NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE:

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

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 to the spine.

Health is a state of optimal physical, mental, and social well being, not merely the absence of disease.

Vertebral subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, 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. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:

DATE:

WITNESS' SIGNATURE:

DATE:

PAYMENT AGREEMENT/USE OF INSURANCE AUTHORIZATION

I hereby authorize the Doctor(s) of Restoration Chiropractic Co., PA to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by me 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. Restoration Chiropractic Co., PA will not be held responsible for any preexisting 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 by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Restoration Chiropractic Co., PA for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Restoration Chiropractic Co., PA 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 Restoration Chiropractic Co., PA will be credited to my account upon receipt.

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

- ☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ WORKERS COMP ☐ AUTO INSURANCE
- ☐ MEDICARE ☐ HEALTH INSURANCE

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

Restoration Chiropractic Company PA

Patient Consent & Authorization for Use of Images, Video, and Testimonials

Purpose:

This form allows **Restoration Chiropractic Company PA** to use my image, video, voice, and/or testimonial for educational, promotional, and marketing purposes, including on social media (organic and paid advertising), websites, email campaigns, printed materials, and other digital or physical media. This authorization is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Information

Full Name: _____

Date of Birth: ____ / ____ / ____

Phone Number: _____

Email: _____

Authorization

I hereby authorize **Restoration Chiropractic Company PA**, its employees, contractors, and representatives, to:

1. **Capture** my likeness, image, voice, and/or testimonial in photographs, video, and/or audio recordings.
 2. **Use, reproduce, publish, and distribute** these materials in any format (digital, print, or otherwise) for educational, marketing, or promotional purposes.
 3. **Include** any relevant health information I choose to share verbally or in writing during recording, with the understanding that such information may be considered Protected Health Information (PHI) under HIPAA.
 4. **Edit or modify** the materials as needed, while maintaining their intended meaning.
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HIPAA & Confidentiality

I understand that:

- This authorization is voluntary and I am not required to sign it to receive treatment.
- My Protected Health Information (PHI) may be disclosed through these materials and could be viewed by the general public.
- Once disclosed, PHI may not be protected by HIPAA in the same way as within the clinic setting.
- I may revoke this authorization at any time in writing to **Restoration Chiropractic Company PA**, except to the extent that action has already been taken in reliance on this authorization.

Duration

This authorization will remain in effect **until revoked in writing** by me.

Acknowledgment & Release

By signing below, I release **Restoration Chiropractic Company PA**, its employees, and representatives from any liability arising from the use of my image, video, voice, and/or testimonial as described above.

Patient Signature: _____

Printed Name: _____

Date: ____ / ____ / ____

Practice Witness Signature: _____

Printed Name: _____

Date: ____ / ____ / ____
