Confidential Infant/Child Patient Data

(Ages 0 to 7 Years)

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

(Fill out forms in Blue ink only; Do not use pencil)

PATIENT INFORMATION

Today's Date: _____ /_____ /_____

Name: _____ **Preferred Name:** _____

Date of Birth: _____/_____/_____ **Age:** _____ **Sex:** ☐ Male ☐ Female

Child is: ☐ Biological ☐ Adopted **Child resides with:** ☐ Both Parents/Guardians ☐ Mother ☐ Father

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

Home Phone: _____ **Work Phone:** _____ **F/M Cell #:** _____

Names of Parents/Guardians: _____

Parent/Legal Guardian Email: _____

Parents/Guardians Social Security # (not the child's): _____-_____-_____ ☐ **Mother** ☐ **Father**
(Provide Social Security #)

2nd Address: _____ _____ _____ _____
(if applicable) STREET CITY STATE ZIP

Referred to this Office by: ☐ Friend/Family Member- Name? _____ ☐ Clinic Location

☐ Insurance Company ☐ Google ☐ Website ☐ Facebook ☐ Instagram ☐ Other: _____

☐ Pediatrician Name: _____ ☐ Medical Physician Name: _____

Reason for your child seeking chiropractic care: _____

Other Doctors seen for this condition? If any, describe/specialty: _____

Prior treatment and outcome: _____

Antibiotics your child has taken:
In the last six months: _____

Total during his/her life: _____

Prescription medications your child has taken:
In the last six months: _____

Total during his-her life: _____

Emergency Contact Information:

Name: _____ Number: _____ Relationship: _____

Name: _____ Number: _____ Relationship: _____

Pt. #: _____

Patients Name: _____ **Date**: _____ /_____ /_____

DETAILED HISTORY
Please check all that apply

Feeding History	**Yes**	**No**	**Details & Comments**
Breastfed?	☐	☐	How long?
Formula?	☐	☐	How long?
Introduced to solids at how many months?	☐	☐	
Introduced to cow's milk at how many months?	☐	☐	
Prenatal History			
Complications during pregnancy?	☐	☐	Describe:
Ultrasounds during pregnancy?	☐	☐	How many:
Medications during pregnancy/delivery?	☐	☐	Please list:
Cigarette/alcohol use during pregnancy?	☐	☐	
Location of birth			Hospital ☐ Home ☐ Other ☐
Birth interventions			Forceps ☐ Vacuum extraction ☐ C-Section ☐
Delivery complications?	☐	☐	Describe:
Birth stats			Weight: Length: APGAR score:

CHILDS MEDICAL HISTORY

Symptoms: Please check any current/past problems your child has/had, on the list below

Check	**Condition**	**Check**	**Condition**	**Check**	**Condition**	**Check**	**Condition**
☐	ADD/ADHD	☐	Cough/Wheeze	☐	Hypertension	☐	Scoliosis
☐	Allergies	☐	Diabetes	☐	Insomnia	☐	Sinus Trouble
☐	Anemia	☐	Diarrhea	☐	Itchy Eyes	☐	Sprains/Strains
☐	Asthma	☐	Dizziness	☐	Neuritis	☐	Stomach Aches
☐	Bed Wetting	☐	Fainting	☐	Nightmares	☐	Tuberculosis
☐	Behavioral	☐	Fever/Chills	☐	Pain Urinating	☐	Unusual Moles
☐	Blood disorders	☐	Frequent Colds	☐	Paralysis	☐	Long Covid
☐	Broken bones	☐	Growing pains	☐	Poor Appetite	☐	Alpha Gal
☐	Chest Pain	☐	Headaches	☐	Poor Memory	☐	
☐	Chronic Earaches	☐	Heart Condition	☐	Rashes	☐	
☐	Constipation	☐	Hernias	☐	Rheumatic Fever	☐	
☐	Convulsions	☐	Hyperactivity	☐	Runny Nose	☐	

Pt. #: _____

Patients Name: _____ **Date**: _____ /_____ /_____

HEALTH HISTORY:

Pediatrician: _____ Date of last visit: _____ /_____ /_____

Reason for visit: _____

Medications and conditions being treated: _____

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts, etc.)

If yes, describe (Sprain, Broken Bone, Head Trauma, etc.)_____

_____

Has your child ever fallen head-first from (Changing Table, Bed, Stairs, etc.)

If yes, describe: _____

Other traumas not described above? If yes, describe/date of occurrence:_____

_____

Childhood Diseases

Has your Child had any of the following:

Check	Disease	Age
☐	Chicken Pox	
☐	Mumps	
☐	Rubella	
☐	Whooping Cough	

Check	Disease	Age
☐	Measles	
☐	Meningitis	
☐	Tuberculosis	
☐	Other	

Vaccination History:

Has your Child had any of the following:

☐	HBV / Hep B (Hepatitis B)	☐	DTaP (Diphtheria, Tetanus, Pertussis)
☐	DTP	☐	Varicella (Chicken Pox)
☐	HbCV / Hib (H. influenzae type b conjugate)	☐	PCV (Pneumoccocal)
☐	OPV (Oral Polio Vaccine)	☐	IPV (Inactivated Poliovirus)
☐	MMR (Measles, Mumps, Rubella)	☐	My child is not vaccinated

Adverse reactions to any vaccine? Y/N, List: _____

Has your child been diagnosed with Covid? ☐ No ☐ Yes / If yes, was your child hospitalized? ☐ No ☐ Yes

Was your child placed on a ventilator? ☐ No ☐ Yes If yes, how long on the ventilator: _____

Please check the following symptoms that your child had/has:

☐ Fatigue ☐ Brain Fog ☐ Joint Pain ☐ Rapid Heart Rate ☐ Continuous Respiratory Stress

☐ Long Term Residual Effects of Covid - Is your child having any long term covid symptoms: ☐ No ☐ Yes

Diagnosis with long term covid symptoms: ☐ No ☐ Yes If so, Diagnosis by: _____

Has your child had the COVID vaccination? ☐ No ☐ Yes ☐ Chose not to answer

Pt. #: _____

Patients Name: _____ **Date**: _____ /_____ /_____

FAMILY MEDICAL HISTORY

Family	Condition	Family	Condition	Family	Condition
☐	ADD/ADHD	☐	Depression	☐	Muscular dystrophy
☐	AIDS/HIV/ARC	☐	Diabetes	☐	Neck pain
☐	Allergies	☐	Dislocated joints	☐	Nervousness
☐	Alzheimer's	☐	Epilepsy	☐	Numbness
☐	Alcohol/drug abuse	☐	German measles	☐	Polio
☐	Anemia	☐	Headaches	☐	Poor circulation
☐	Anxiety	☐	Heart Condition	☐	Reproductive disorders
☐	Asthma	☐	Heart Disease	☐	Rheumatic fever
☐	Arthritis	☐	Hepatitis	☐	Rheumatism
☐	Autism	☐	High/low blood pressure	☐	Scarlet fever
☐	Back pain	☐	High/Low Blood Sugar	☐	Scoliosis
☐	Bladder trouble	☐	High/low Cholesterol	☐	Seizure
☐	Bone fracture	☐	Indigestion	☐	Serious Injury
☐	Bowel control loss	☐	Kidney disorder	☐	Sickle Cell Disease
☐	Cancer	☐	Menstrual cramps	☐	Sinus trouble
☐	Chest pain	☐	Mental Illness	☐	Stroke
☐	Concussion	☐	Migraines	☐	Tuberculosis
☐	Convulsions	☐	Multiple sclerosis	☐	Venereal Disease
☐	_____	☐	_____	☐	_____

Has your child been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

If yes, describe condition: _____

Date of Last Physical Exam: _____ /_____ /_____

SURGICAL HISTORY (*Please write 'none' or 'N/A' if this question does not apply)*

Surgery	Date	Surgery	Date
1.		**4.**	
2.		**5.**	
3.		**6.**	

Has your child ever had any type of implant? ☐ No ☐ Yes, what kind? _____

Has your child ever sustained a gunshot wound? ☐ No ☐ Yes, where? _____

Accident History:

(Please write 'none' or 'n/a' if this question does not apply):

☐ Auto ☐ Other **1.** _____ **Date:** _____ /_____ /_____

☐ Auto ☐ Other **2.** _____ **Date:** _____ /_____ /_____

Pt. #: _____

Patients Name: _____ **Date**: _____ /_____ /_____

To help us better communicate with your child, please check the best answer
(ONLY CHOOSE ONE PER QUESTION)

1. He/She remembers important things in his/her life by:

   ☐ What he/she sees ☐ What he/she hears ☐ What he/she feels

2. The primary reason he/she brushes their teeth is to:

   ☐ Avoid tooth decay and gum disease ☐ Make sure he/she has healthy teeth and gums

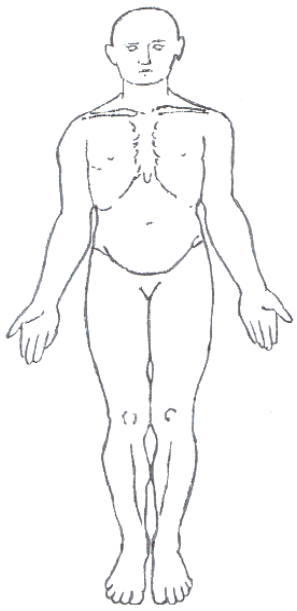
3. When he/she makes decisions, they generally:

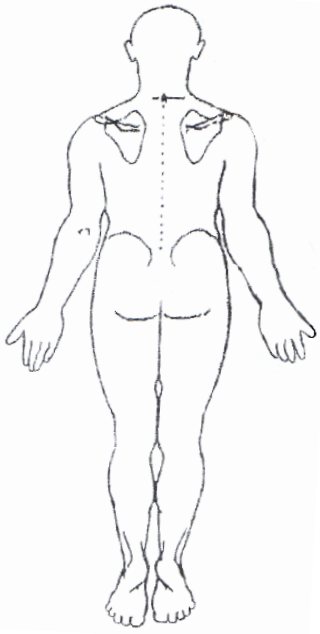
   ☐ Gather facts and weigh the evidence ☐ Make the right choice instantly

   ☐ Consult their friends and family ☐ Depends upon how they "feel" about it

Please <u>mark an X</u> on the anatomy man below to indicate where your child has pain or other symptoms:

RT LT LT RT





Pt. #:_____

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INTENTIONALLY

FOR DOUBLE-SIDED

PRINTING

Patients Name: _____ **Date**: _____ /_____ /_____

HEALTH REVIEW QUESTIONNAIRE

(Please check all that apply)

Skin/Hair/Nails
☐Eczema
☐Itchy skin
☐Dry scalp
☐Hair loss
☐Oily scalp
☐Rough, scaly skin
☐Dry skin
☐Oily skin
☐Psoriasis
☐Yellowing skin
☐Bruise easily
☐Paper thin nails
☐Pale skin
☐Nail biting
☐~~Baldness~~

Eyes
☐Blurring of vision
☐Double vision
☐Eyes fatigue easily
☐Excessive tearing
☐Lack of tearing
☐Light sensitive eyes
☐Excessive itching
☐Pain in eyeball

Ears
☐Loss of hearing
☐Pain in ears
☐Discharge from ears
☐Vertigo
☐Ringing in ears

Nose/Nasopharynx/Sinuses
☐Unusual nasal discharge
☐Nose bleeds
☐Pressure over eyes
☐Pressure under eyes
☐Obstruction of nose
☐Frequent colds
☐Sinusitis
☐Nasal allergies
☐Loss of sense of smell

Mouth & Throat
☐Pain in mouth
☐Pain in throat
☐Bleeding gums
☐Cavities
☐Abscessed teeth
☐Dentures
☐Difficulty swallowing
☐Changes in voice

Respiratory
☐Shortness of breath
☐Cannot breathe laying down
☐Cannot sleep lying down
☐Dry cough
☐Productive cough
☐Coughing up blood
☐Wheezing

Gastrointestinal
☐Poor appetite
☐Constant ribbing
☐Difficulty swallowing
☐Indigestion
☐Cannot eat some foods
☐Nausea and vomiting
☐Jaundice
☐Abdominal pain
☐Change in bowel habits
☐ Diarrhea
☐Constipation
☐Hemorrhoids

Venereal Disease
☐HIV / ☐AIDS
☐Chlamydia
☐HPV
☐Syphilis
☐Gonorrhea
☐Herpes
☐Other: _____

Genitourinary
☐Frequent urination
☐Infrequent urination
☐High urine volume
☐Low urine volume
☐Disrupted sleep due to need to urinate
☐Intense desire to urinate
☐Difficulty starting urination
☐Dribbling urine
☐Blood in urine
☐Cloudy urine
☐Lack of bladder control
☐Abdominal pain

Social History
☐~~Smoking~~
☐~~Other tobacco use~~
☐~~Alcohol use~~
☐Drink coffee/tea/sugary beverages

Diet is:
☐Balanced
☐Not balanced

Rest is:
☐Sufficient
☐Not sufficient

Recreation is:
☐Sufficient
☐Not Sufficient

Family Stress is:
☐Severe
☐Moderate
☐Minimal
☐None

Pt. #: _____

Patients Name: _____ **Date**: _____ /_____ /_____

School Stress is:
☐Severe
☐Moderate
☐Minimal
☐None

Nervous System
☐Nervousness
☐Irritability
☐Fatigue
☐Depression
☐Generally run-down
☐Crave sweets
☐Crave salt
☐Numbness
☐Paralysis
☐Dizziness
☐Fainting
☐Headaches/Migraines
☐Jerking muscles
☐Convulsions
☐Forgetfulness
☐Concussion
☐Insomnia

Cardiovascular
☐General swelling
☐Swelling in legs
☐Swelling in face
☐Swelling around eyes
☐Chest pain
☐Pounding heartbeat
☐Blue/purple skin
☐Blue/purple nail beds
☐Fainting
☐Hypertension

Vertibrobasilar
☐Double vision
☐Loss of coordination
☐Irregular muscle movement
☐Memory loss
☐Ringing in ears
☐Heart attack
☐High blood pressure
☐Irregular heartbeat
☐Hardening of the arteries
☐Muscle weakness
☐Dizziness with nausea
☐Dizziness without nausea
☐Blurred Vision
☐Fainting spells
☐Stroke
☐Diabetes
☐Pain over the heart
☐Cold hands/feet
☐Areas of numbness
☐Arthritis in neck
☐Previous neck or head injury
☐Inability to form words
☐Periods of blindness in one eye
☐Area of abnormal sensations (burning)
☐Blood vessel disease
☐Cigarette/tobacco use
☐Family members who have had a stroke
☐Currently on birth control

Musculoskeletal System
☐Broken bones
☐Hip pain
☐Trouble walking
☐Weak muscles
☐Arm problems
☐Leg problems
☐Swollen joints
☐Painful joints
☐Stiff joints
☐Sore muscles

Low Back
☐Low back pain
☐Feels out of place
☐Muscle spasms

Office Use Only
Time in: _____:____ / Time out: _____: _____

Mid Back
☐Mid back pain
☐Pain between shoulder blades
☐Sharp stabbing pain
☐Dull ache
☐Pain from front to back
☐Pain over the kidneys
☐Muscle spasms

Shoulders
☐Pain in shoulders (right/left)
☐Pain across shoulders
☐Tension in shoulders
☐Muscle spasms
☐Can't raise arm over shoulder
☐Cannot raise arm over head

Neck
☐Pain in neck
☐Neck pain with movement
☐Swelling in neck
☐Stiff neck
☐Pinched nerve in neck
☐Neck feels out of place
☐Muscle spasms
☐Grinding sound in neck
☐Popping sound in neck
☐Limited neck movement

Extremities
☐Pain in upper arm
☐Pain in forearm
☐Pain in hands
☐Pain in fingers
☐Numbness in fingers
☐Cold hands
☐Swollen/sore joints in fingers
☐Loss of grip strength
☐Pain in buttocks
☐Pain in knee
☐Pain going down leg
☐Leg cramps
☐Numbness in legs
☐Swollen feet/ankles
☐Numbness in toes

Pt. #: _____

Patients Name: _____ **Date**: _____ /_____ /_____

OPEN-DOOR POLICY

The Patient Authorization regarding chiropractic care being provided in an "open-door" adjusting environment and agreement to this activity. **Please sign below that you understand the "open-door" adjusting policy.**

If you desire a copy of the OPEN-DOOR POLICY, please request a copy.

X_____ _____ /_____ /_____
Parent/Legal Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICES (HIPAA)

As required by the Health Insurance Portability and Accountability Act (HIPAA), this office will follow the rules of HIPPA. We are required to give you a copy of the Notice of Privacy Practices for Healthy Life Chiropractic. **Please sign below that you understand the Privacy Practice (HIPPA).**

If you desire a copy of the Privacy Practice (HIPPA), please request a copy.

X_____ _____ /_____ /_____
Parent/Legal Guardian Signature **Date**

APPOINTMENT REMINDER INFORMATION

Healthy Life Chiropractic uses the Demand force program for our patient reminders and newsletters. You will receive a welcome letter via text message and/or e-mail for you to opt-in or opt-out of receiving appointment reminders. If you choose to opt-out, you will not receive appointment reminders. **Please remember, if you choose not to have a form of appointment reminder and fail to show for an appointment without a 24-hour notification. This will result in a No-Show Fee. The fee amount is based on the service the appointment is scheduled for and ranges between $50.00 to $150.00. These fees will be enforced for: New Patient visit, ROF, Re-Evaluation, Neuromuscular Re-Education (Massage), Decompression, HBOT, and HRT appointments.** Please see the office policy for additional information.

We offer two forms of appointment reminders. Please choose ONE or BOTH

☐ Please email me my child's appointment reminders at: _____

☐ Please text me my child's appointment reminders at: _____-_____-_____

Pt. #: _____

CONSENT FOR TREATMENT OF MINOR FOR CHIROPRACTIC CARE

We, the undersigned, parent(s)/person having legal custody/legal guardianship of _____ (child's name) a minor (under the age of 18), do hereby authorize Healthy Life Chiropractic as agent(s) for the undersigned to consent to any x-ray, examination, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above-described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

X_____
Parent/Legal Guardian (**print name**)

X_____
Child/Minor Name (**print name**)

X_____
Parent/Legal Guardian Signature

_____ /_____ /_____
Date

X_____
Witness

_____ /_____ /_____
Date

CONSENT TO TREATMENT OF MINOR FOR NEUROMUSCULAR THERAPY

We, the undersigned, parent(s)/person having legal custody/legal guardianship of _____ (child's name) a minor, do hereby authorize Healthy Life Chiropractic as agent(s) for the undersigned to consent to neuromuscular therapy treatment, which is deemed advisable by a licensed therapist, be rendered under the general or special supervision of any licensed therapist.

It is understood that this authorization is given in advance of any specific treatment being required but is given to provide authority to the above-described agent(s) to give specific consent to any and all such treatment which therapist, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

X_____
Parent/Legal Guardian (**print name**)

X_____
Child/Minor Name (print name)

X_____
Parent/Legal Guardian Signature

_____ /_____ /_____
Date

X_____
Witness

_____ /_____ /_____
Date

Pt # _____

Patients Name: _____ **Date**: _____ /_____ /_____

FINANCIALLY RESPONSIBLE PARTY
THIS MUST BE COMPLETED FOR BILLING

Name: _____ _____ _____
LAST FIRST MI

Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Home Phone #: _____-_____-_____ **Cell #:** _____-_____-_____

SS#: _____-_____-_____ **Relationship:** _____ **DOB:** _____/_____/_____
(Provide Social Security #)

INSURANCE INFORMATION
THIS MUST BE COMPLETED FOR BILLING

I. Primary Insurance Company: _____

Policy Holder: _____ **Policy Holders DOB:** _____/_____/_____

Member ID#: _____ **Group # / Enrollment Code:**_____

Your Relationship to the Policy Holder: □ **Self** □ **Spouse** □ **Child** □ **Other:** _____

Employer of Policy Holder: _____

Payment for Services will be: ☐ **Cash** ☐ **Check** ☐ **Credit Card**

☐ **Health Insurance** ☐ **Automobile Insurance**

II. Secondary Insurance Company: _____ **Policy Holder:** _____

DOB: _____/_____/_____ **Member ID#:** _____ **Group #:** _____

Employer of Policy Holder: _____

Payment for Services will be: ☐ **Cash** ☐ **Check** ☐ **Credit Card**

☐ **Health Insurance** ☐ **Automobile Insurance**

It is Healthy Life Chiropractic's policy that all fees are due at the time services are rendered, whether by check, cash, or credit card unless prior arrangements have been made. We discuss services and fees at the time of treatment in order to avoid any misunderstandings. We are happy to file your insurance for you, however, regardless of insurance coverage; you are responsible for payment of your account within the credit policy of this office. If fees are incurred in order to collect delinquent accounts, those fees will be the responsibility of the patient. I authorize the release of any medical information necessary to process this claim and authorize payment of medical benefits to be made directly to Healthy Life Chiropractic. After all insurance payments have been paid; I fully understand that I am responsible for the remaining balance on my account.

Signature of Parent/Legal Guardian: _____ **Date:** _____/_____/_____

Pt. #: _____

Patients Name: _____ **Date**: _____ /_____ /_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

Authorization to Release Information

I authorize the Doctor and their staff named below to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that photostatic copy of agreement shall serve as the original.

X_____
Parent/Legal Guardian Signature

Notice of Assignment

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctors named below as payment toward the charges for professional services rendered. This payment will not exceed my indebtedness the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

If patient is a Medicare Beneficiary, we do not take assignments on Medicare services. DO NOT sign the section below.

X_____ - **DO NOT SIGN if patient is a Medicare Beneficiary**
Parent/Legal Guardian Signature

Notice of Insurance Payments

I understand that all insurance will be verified and billed directly from this office, although this is not a guarantee of payment. I also understand that if I should receive a check from my insurance company for services rendered in this office, I am to bring the check with a copy of the original explanation of benefits to our office so that my account will be accurate.

X_____ _____ /_____ /_____
Parent/Legal Guardian Signature **Date**

_____
Witness

Assignment and/or release authorization is granted to:
Healthy Life Chiropractic, Inc.

Pt. #:_____

HEALTHY LIFE CHIROPRACTIC STATEMENT OF PATIENT OFFICE POLICIES

Welcome to Healthy Life Chiropractic. Please read and sign this policy statement below. Our staff will be happy to assist you with any questions or concerns you may have. Our focus is for you, our patient and your family to have an extraordinarily positive experience. We believe that a clear definition of your prescription of care to regaining your health, setting measurable goals (Activities of Daily Living) and maintaining your health is critical. Following your prescription of care is vital to your success. We also believe that clear definition of office policies will allow you, the patient; and Healthy Life Chiropractic to concentrate on the big issue—**REGAINING AND MAINTAINING YOUR HEALTH**.

Your prescription of care is based on medical necessity as deemed appropriate by the Doctor of Chiropractic. As such, Re-evaluations are completed in this office to measure progress of care and medical necessity, regardless of insurance coverage, insurance carrier or no insurance coverage. If you are out of care for three (3) or greater months, a re-evaluation will be required to correctly assess a possible change in adjusting technique and/or an underlying health issue that would change your prescription of care. It is the policy of this office to re-evaluate through x-ray every two (2) years, to correctly assess a possible change in adjusting technique and/or an underlying health issue that would change your prescription of care. Any outside products are NOT allowed to be brought into the office for use during any service. This is due to other patients and/or employees having allergies and sensitivities. Only in-house products may be added to the service. Please notify a staff member in the event you have a sensitivity or allergy. **Patient/Legal Guardian Initials: _____**

CHIROPRACTIC, NEW PATIENT, RE-EVALUATION, RE-ESTABLISH EVALUATION, ROF, COLD LASER, HEALTH RESPONSE TESTING (HRT), HBOT, DECOMPRESSION, EAR CONING & IONIC FOOTBATH APPOINTMENT CANCELLATION POLICY & APPOINTMENT REMINDERS:

Appointments have been scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note that it is the *frequency* of visits that counts, and not the days. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to speak to the front desk assistant. We require 24-hour notice for any cancelled or rescheduled appointments. **Failure to show for any scheduled appointment without a 24-hour notification will result in a $50.00 charge payable by YOU, not your insurance company**. You are expected to re-schedule missed appointments in order to comply with your prescribed treatment plan. Please keep in mind that re-scheduling an appointment is always subject to availability. **Our office utilizes email and/or text messaging to remind you of upcoming appointments. Not confirming your appointment via call, text, or email, does not constitute a canceled appointment. Please refrain from using a cell phone in all areas of the office. If necessary to take a call, please step outside after informing the front desk. Patient/Legal Guardian Initials: _____**

NEUROMUSCULAR RE-EDUCATION (MASSAGE) APPOINTMENT CANCELLATION POLICY & APPOINTMENT REMINDERS:

Appointments have been scheduled for your convenience. Children are not allowed to be in the room during your appointment. **We require a 24-hour notice for any canceled or re-scheduled appointments**. **Failure to show for an appointment without notification will result in a $75.00 (1 hour) $112.50 (1.5 hour) or $150.00 (2 hour) charge payable by YOU, *not your insurance company*. Not confirming your appointment via call, text, or email, does not constitute a canceled appointment.** If you are more than 20 minutes late for your neuromuscular re-education (massage) appointment you will be subject to continuing with the service based on appointment book availability, possibly rescheduling, or charged the **above** cancelation fee schedule. Should you have a scheduled massage appointment and are unable to complete "your entire scheduled time" you are still financially responsible for the total scheduled time allocated for you during your scheduled appointment. Should you be billing insurance for this visit, your insurance company is not responsible for cancelation fees or time not utilized by the patient, so therefore, the lost scheduled time is payable by you. If at any time during the session the therapist is uncomfortable with your behavior the therapist reserves the right to end the session and the full time allotted will be billed to you. **It is unethical and illegal for this office to bill your insurance company for services not rendered on the date in question. Our office utilizes email and/or text messaging to remind you of upcoming appointments for Neuromuscular Re-Education (Massage). Not confirming your appointment via call, text, or email, does not constitute a canceled appointment. Please refrain from using a cell phone in all areas of the office. If necessary to take a call, please step outside after informing the front desk. Patient/Legal Guardian Initials: _____**

PRODUCTS, SERVICES AND PACKAGES SOLD IN THE OFFICE:

All products that are sold in the office have a **NO RETURN/NON-REFUNDABLE POLICY**. (Supplements, Pillows, Oils, CBD, Neck Collars, Foam Rollers, ETC.) Orthotics can be returned to the company under Foot Levelers guidelines. Once a particular service package is purchased, they are **NON-REFUNDABLE AND NON-TRANSFERABLE** and may not be applied to any other purchases and/or services within the office. This applies to all services and packages. Packages cannot be split between patients, there is a **ONE year expiration** on package cards and gift certificates. Should you terminate your care and/or move from the region with package visits or services untendered, please request a refund and allow thirty (30) from date of request for refund to be processed. **ALL SALES ARE FINAL. Patient/Legal Guardian Initials: _____**

Continue on the next page 

APPOINTMENT REMINDERS:

Healthy Life Chiropractic uses a appointment reminder (text and email) program for our patient reminders, sales, promotions and important notifications. You will receive a welcome letter via text message and/or e-mail for you to opt-in or opt-out. If you choose to opt-out, you will not be able to receive appointment reminders. **Please remember this can result in a NO SHOW FEE if you opt-out and do not show up for your appointment**s. **Patient/Legal Guardian Initials: _____**

FINANCIAL RESPONSIBILITY WITH AND WITHOUT INSURANCE:

Charges for treatment are due at the time the service is provided or a product is ordered. Please be aware that some services in this office are not covered by ANY insurance carrier and are excluded from some insurance carriers. This office, to the best of our knowledge, informs our patients of their insurance coverage. However, financial responsibility for services rendered rests with the patient regardless of any insurance coverage. It must be understood that your medical insurance is a contract between ***you*** and ***your*** insurance carrier. The benefits quoted by your insurance carrier are not a guarantee of payment and are subject to review based on the terms of your individual contract. All insurance coverage quotes are merely estimates based on the information quoted by your insurance carrier. All services rendered are ultimately your (the patient's or patient's legal guardian's) financial responsibility and are payable in full. Services quoted and received by you may be quoted as covered but are denied (non-covered) by your insurance carrier will be assigned to you. ***Any balance is due within 30 days of notice***. ***Please note that you are responsible for knowing the limitations of your coverage.*** It is not our policy to enter into a dispute between you and your insurance carrier over any unpaid portion of your bill. Most insurance companies process claims within 30 days of receipt. Should your insurance company send you a check for services rendered that should have been paid to Healthy Life Chiropractic you will have 10 days to pay Healthy Life Chiropractic for those services. If you have an HRA (Health Reimbursement Account) account, it is your responsibility to keep up with your available HRA funds. If you have an HSA (Health Savings Account) you are responsible for your balance at the time of services rendered in the office**. Patient/Legal Guardian Initials: _____**

STATEMENTS:

In an effort to reduce healthcare costs, it is the policy of HLC to mail as few statements as possible. HLC will email statements to the email address on file. Should an email not be provided, and a paper statement has to be sent by postal mail, *each mailed invoice will be assessed with a $2.00 paper statement fee*. If a patient balance is incurred, responsible parties are encouraged to mail the payment directly to HLC upon receiving the EOB (explanation of benefits) from their insurance company. If 30 days have passed after the first generated statement and it is necessary for HLC to mail a second statement (because no payment has been received) a flat interest charge of 12% of the balance, but not less than $5.00 will be added to the account. **If no payment is received within 10 business days after the mail date of the second statement, the account will be reviewed with a 10-day demand letter certified mail to the address on file. If payment is not received following the 10-day period, the account will be turned over to the collection agency or filed with the county court system in the county you reside in. All collection fees and court fees are paid by the patient**. **ALL ACCOUNTS TURNED OVER TO THE COLLECTION AGENCY WILL ALSO BE RESPONSIBLE FOR THE COLLECTIONS AGENCY FEE OF 40% OF THE BALANCE OWED. Patient/Legal Guardian Initials: _____**

RETURNED CHECKS:

There will be a **$50.00 fee** imposed for all checks returned to this office. All returned checks must be taken care of within 10 days of receipt. Any unpaid amounts after 10 days will be referred to our collection agency or filed with the county court system in the county you reside in. **Patient/Legal Guardian Initials: _____**

VOLUNTARY TERMINATION OF CARE:

It is the policy of this office that should you choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be **immediately due and payable**; regardless of your balance is from Self-Pay visits, Insurance visits and/or the UCCAFF agreement. Should you be in a UCCAFF agreement, your charges will be reversed to regular cost and the balance will be due in full. **Patient/Legal Guardian Initials: _____**

PATIENT RECORDS REQUEST:

Any records/documents requested from the office requires ten (10) business days for completion. We do not send any records/documents electronically. Fees may apply**.** Should you need FMLA, and/or Work-Related forms filled out, fees will apply for these forms and are payable by the patient at the time the form is requested to be filled out by the Doctor. Please allow ten (10) business days for this form to be completed. This office does not file disability ratings. This requires a specific certification that HLC does not have. **Patient/Legal Guardian Initials: _____**

I, the Patient (or) Parent/Legal Guardian undersigned below, have read "Statement of Patient Office Policies" (above) and I agree to abide by these policies.

Patient Name (Printed): X_____ **Date: _____ / _____ /_____**

Parent/Legal Guardian Signature: X_____

Pt. #:_____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC
It is important to acknowledge the difference between the health and care specialties of Chiropractic, Osteopathy, and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physician's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS
A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS or VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSES
Although Chiropractic Physicians are experts in chiropractic diagnoses, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your Chiropractic Physician may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the results of the Chiropractic tests, diagnoses, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment, or health care, if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Chiropractic Physician is licensed in a special practice and is available to work with other types of providers.

RESULTS
The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC since there are so many variables; it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.
In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond chiropractically may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

I, the Patient (or) Parent/Legal Guardian undersigned below, have read "The Doctor-Patient Relationship in Chiropractic" (above) and I agree to abide by these policies.

Parent/Legal Guardian Signature: X_____ **Date:** _____ / _____ /_____

CA Signature: _____ **Date:** _____ / _____ /_____

Pt. #: _____

CONSENT AND RELEASE FOR USE OF LIKENESS

(This form is for the consent to use your child's photo(s) for Healthy Life Chiropractic advertisement)

(For Children 0-7)

Effective as of the date shown below, approval for past use and permission for present and future use is being granted to Healthy Life Chiropractic, and Dr. Antonina Z. McKay of 2753 East Highway 34, Suite 1, Newnan, Georgia, 30265, to use a photo or other image of _____. Permission is being given
(Patient Name)
by the undersigned, ***said above patient,*** as more fully explained in this Consent and Release. The undersigned is the Parent or legal guardian of ***said above patient*** (the **"Photographed Party"**) and states that the undersigned has the full legal authority to sign this Consent and Release on behalf of the undersigned, the Photographed Party, and all parties related to the Photographed Party.

For a valuable consideration, receipt of which is hereby acknowledged, the undersigned hereby grants to Healthy Life Chiropractic, Dr. Antonina Z. McKay, its agents, employees, licensees, and successors in interest (collectively, the **"Released Party"**) all ownership rights and the absolute and irrevocable right and permission to copyright, use and publish the photographed likeness of ***said above patient*** (the **"Likeness"**) that has been (or is being) obtained pursuant to this Consent and Release.

The Likeness may be copyrighted, used and/or published individually or in conjunction with other photography or video works, and in any medium (including without limitation, print publications, public broadcast, CD-ROM format) and for any lawful purpose, including without limitation, trade, exhibition, illustration, promotion, publicity, advertising and electronic publication. **The likeness of the undersigned may be tagged or mentioned in the publication. _____ (Patient/Legal Guardian Initials)**

The undersigned represents and warrants that (i) no other party has been granted an exclusive license with respect to the Likeness, and (ii) no other party's authorization or consent is required with respect to the permission granted to the Released Party under this Consent and Release.

The undersigned waives any right that the undersigned, the Photographed Party, or any party related to the Photographed Party may have to inspect or approve the Released Party's copyright, use or publication of the Likeness, or the advertising copy or printed matter that may be used in connection with the copyright, use and/or publication of the Likeness. The undersigned, on behalf of the undersigned, the Photographed Party, and any other parties related to the Photographed Party, releases the Released Party (and all persons acting under its permission or authority) from all claims for libel, slander, invasion of privacy, infringement of copyright or right of publicity, or any other claim related to the Likeness (collectively, **"Claims"**). This release includes without limitation any Claims related to blurring, distortion, alteration, optical illusion, use in composite form, whether intentional or otherwise, or use of a fictitious name, that may occur or be produced in the processing or publication of the Likeness.

THE UNDERSIGNED WARRANTS THAT THE UNDERSIGNED HAS READ THIS CONSENT AND RELEASE PRIOR TO THE SIGNING OF THIS DOCUMENT, THAT THE UNDERSIGNED UNDERSTANDS IT, AND THAT THE UNDERSIGNED FREELY ENTERS INTO THIS CONSENT AND RELEASE.

Signed by _____, the authorized parent of _____, of
(Name of Parent/Legal Guardian) (Patient Name)
_____, Georgia _____ with the intent of being legally bound on ____ /_____ / _____.
(City) (Zip Code) (Date)

Signature of Authorized Parent/Legal Guardian: _____
(Name of Parent/Legal Guardian)

USE THIS BOX ONLY IF YOU ARE OPTING OUT for your child/teen

I_____ choose to OPT OUT of the consent and release for pictures
(Authorized Parent/Legal Guardian)

PT. #: _____