Office Use: __Demo ___Scan
___Ins ___Phys ___Note

Infant/Child Intake

DIRECTIONS : *fill out completely; there are multiple pages*

Childs Name: _____ Today's Date: ___ /___ / ___

Date of Birth:___/___/_____ Social Security Number: _____-_____-_____

Address:_____

City:_____ State:_____ Zip Code:_____

Contact Cell #:_____ Contact Email: _____

Parent(s) Names:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Pregnancy and Birth History:

Hospital: _____ OB Provider: _____ Birth weight: ___ lbs ___ oz

Was the baby premature? *(circle one)* YES NO

Was the baby born by C-section? YES NO

Were there any health problems during pregnancy, labor, and/or delivery? YES NO

Explain any YES answers. _____

_____

Current Health Conditions:

Known ALLERGIES: _____

Is the baby breast feeding? YES NO

Does the baby have colic? YES NO

Does the baby experience reflux? YES NO

Has the baby had any ear infections? YES NO

If YES, how many? _____

How is the baby sleeping (how many times, for how long, etc.)?

_____

_____

Informed Consent

When a patient seeks chiropractic health care with our facility and we accept a patient for such care, it is essential for both to be working for the same objective as a team to help you in attempting to reach health goals. This will prevent any confusion or disappointment on either end. We are **very successful** in helping a variety of conditions because our patients are held to a certain standard. If you are not compliant with doctor recommended care we reserve the right to dismiss your case and refer you elsewhere immediately. You have the right, as the legal guardian of the patient, to be informed about the condition of your childs health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo our unique chiropractic/rehab/medical protocols after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.** An adjustment is the specific application of force to correct and/or reduce vertebral subluxation (misalignment that alters physiology). Our chiropractic method of correction is by specific adjustments of the spine and physical rehab. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. All questions regarding the doctor's objective pertaining to my childs care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____

Patient Signature **Date**

Appointment Policy

No-shows, Cancellations, and Rescheduling Appointment Policy

We reserve the right to charge a $20 missed appointment fee for **no-shows or cancellations** with less than **8-hours** notice.

Authorization to Release Information/Records

I hereby authorize JP Chiropractic to:

- release any information necessary to lawyers and other health care providers regarding medical history, bills and treatments (past or present)

Financial Responsibility

All professional services rendered are charged to the patient's legal guardian and are due at the time of service unless other arrangements have been made in advance with our business office. Our office policy states that payment is due when services are rendered. It is understood that visits will **not** be billed to insurance, all visits will be self-pay. Insurance deems chiropractic care for infants to be **not** medically necessary and will not pay for services.

- Cash/Check/Credit Card: Payment is due in full when services are rendered with the exception of care packages purchased- pursuant to that agreement.

I have requested medical services from JP Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient Signature **Date**

Privacy Practices

In this document, "I" and "my child" refer to the patient, and "Chiropractor" refers to JP Chiropractic.

I consent to the use or disclosure of my childs protected health information to the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to my child, obtaining payment for health care bills or to conduct healthcare operations of Chiropractor. I understand that analysis, diagnosis or treatment of my child by the Chiropractor may be conditioned upon my consent as evidenced by my signature below. I also consent to receiving correspondence from JPC in the form of text, social or otherwise.

I understand that I have the right to request a restriction as to how my childs protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. If Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including my childs demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or healthcare clearinghouse. This protected health information relates to my child's past, present or future physical or mental health or condition and identifies my child, or there is a reasonable basis to believe the information may identify my child.

I reserve the right to request a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices before signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my child's treatment, payment of my child's bills or in the performance of healthcare operations of the Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 1012 Physicians Drive Suite 102, Charleston, SC 29414. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy to be sent by mail or asking for one at the time of my next appointment.

_____ _____

Patient Signature **Date**

Minor Consent for Evaluation and Treatment (under 18)

I, _____, the parent or legal guardian of _____, have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care. I also consent to Dr. Pero treating my child if a legal guardian is not present.

_____ _____

Signature **Date**