Who may we thank for referring you into this office? _____

Anchor CHIROPRACTIC

Today's Date: _____ **HRN:** _____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birth Date: ____-____-____ Age: _____

☐ Male ☐ Female Birth Height:_____ Birth Weight:_____ Current Height:_____ Current Weight:_____

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

Mother's Name:_____ DOB:___/___/___ Mother's Mobile:_____

Mother's E-mail: _____

Father's Name:_____ DOB:___/___/___ Father's Mobile:_____

Father's E-mail:_____

Pediatrician/Family MD_____ City/State:_____

Last Visit:___/___/___ Reason for visit:_____

Who is responsible for this bill?_____ ☐ Other (please explain):_____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ___Wellness Check-up ___Injury or Accident ___Other

Please explain:_____

If your child is experiencing **Pain/Discomfort please identify where and for how long: _____**

_____

1. **When did the** Problem first begin? Date ___/___/___ ____Unknown ____Gradual ____Sudden
2. **Ever had** this problem **before**? ___No ___Yes If yes, when? _____
3. Any **bowel or bladder** problems since this problem began? ___No ___Yes If yes, describe: _____

_____

4. Have you seen any **other doctors** for this problem? ___No ___Yes If yes, who?_____
5. How long ago? ____Days ____Weeks ____Months ____Years
6. What were the results of the past treatment? _____
7. How is this problem **NOW**?: ☐ Rapidly Improving ☐ Improving Slowly ☐ About the same ☐ Gradually Worsening ☐ On & Off
8. Please list any **medication taken for this problem**: _____
9. Has your child ever sustained an injury playing organized sports? ___No ___Yes If yes, please explain:_____

_____

10. Has your child ever sustained an injury in an auto accident? ___No ___Yes If yes, please explain:_____

_____

HAS YOUR CHILD EVER SUFFERED FROM: *check all that apply*

☐ ADD/ADHD	☐ Diarrhea	☐ Fall off skateboard/skates	☐ Poor Appetite
☐ Anemia	☐ Digestive Disorders	☐ Fall off swing	☐ Poor Posture
☐ Arm Problems	☐ Dizziness	☐ Fall down stairs	☐ Reflux
☐ Asthma	☐ Fainting	☐ Growing pains	☐ Ruptures/Hernia
☐ Backaches	☐ Fall in baby walker	☐ Headaches	☐ Scoliosis
☐ Bed Wetting	☐ Fall off bicycle	☐ Heart Trouble	☐ Seizure/Convulsions
☐ Behavioral Problems	☐ Fall from Changing table	☐ Hypertension	☐ Sinus Trouble
☐ Broken Bones	☐ Fall from bed or couch	☐ Joint Problems	☐ Sleeping Problems
☐ Chronic Earaches	☐ Fall from high chair	☐ Leg Problems	☐ Stomach Aches
☐ Colds/Flu	☐ Fall from Monkey bars	☐ Muscle Pain	☐ Walking Trouble
☐ Colic	☐ Fall from crib	☐ Neck Problems	
☐ Constipation	☐ Fall off slide	☐ Orthopedic Problems	

☐ Allergies to: _____

☐ Other:_____

FINANCIAL/AUTHORIZATION AGREEMENT

1.I understand that I am directly and fully responsible to Anchor Chiropractic for all fees associated with chiropractic care my child receives. If I do not pay my child's account with Anchor Chiropractic in full, that my child's account may be assigned to a collection agency for collection.

2. I understand that if my account is assigned to a collection agency, that the collection agency will charge a commission or fee that may be as much as 50 percent of the amount I owe to Anchor Chiropractic. I agree that if my account is assigned to a collection agency, that Anchor Chiropractic may add the amount of the collection agency's commission or fee to the amount that I owe Anchor Chiropractic, and I agree to pay that additional amount.

3. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefits of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date

PAIN SCALE

Patient Name: _____ Date: _____

Please Read Carefully:

Instructions: Please circle the number that best describe the question being asked.
0 – Being NO Pain and 10 – Worst Possible Pain

1. What is your pain **RIGHT NOW**?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain lever **AT ITS BEST** (How close to "0" does your pain get at its best)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain lever **AT ITS WORSE** (How close to "10" does your pain get at its worst)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

Other Comments:

_____

_____

Examiner:

Anchor CHIROPRACTIC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all form of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Anchor Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ___/___/___ _____

Patient or Authorized Person's Signature Date Witness Initials

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ___-___-___ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ___/___/___ _____

Patient or Authorized Person's Signature Date Witness Initials

ANCHOR CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstance. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception area.

PERMITTED DISCLOSURES:

1. **Treatment purposes** – discussion with other health care providers involved in your care.
2. **Inadvertent disclosures** – open treating are mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. **For payment purposes** – to obtain payment from your insurance company or any other collateral source.
4. **For workers compensation purposes** – to obtain payment from your insurance company or any other collateral source.
5. **Emergency** – in the event of a medical emergency we may notify a family member.
6. **For Public health and safety** – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. **To Government agencies or Law enforcement** – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. **Decreased persons** – discussion with coroners and medical examiners in the event of a patient's death.
10. **Telephone calls or emails and appointment reminders** – **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. **Change of ownership** – in the event this practice is sold, the new owners would have access to your **PHI**.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call John Morelli, D.C. at (702) 778-8664. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles y9our complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient Name: _____ Date of Birth: _____

ANCHOR CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of Anchor Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Signature Date

MEDICAL RELEASE

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Child(ren):_____

[ ] Other:_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call: [ ] My Home:_____ [ ] My Work:_____ [ ] My Mobile Number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

_____ _____ _____

Patient's Signature Date HR#

_____ _____

Witness Signature Date