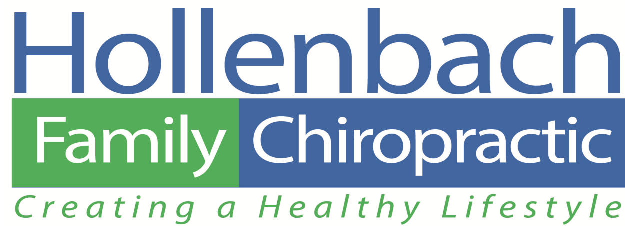

TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has one important goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, 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 subluxations.

CONSENT TO CARE

I do hereby authorize the doctors of HOLLENBACH FAMILY CHIROPRACTIC to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments or any other procedure which is advisable and necessary for my health.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, ____ have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Signature: ____ Date: ___________________________________

Consent to evaluate and adjust a minor child (under 18 yoa):
I, _______________________________, being the parent or legal guardian of ______________________
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

____ __________________
Parent or Legal Guardian's Signature Date

NOTICE OF PRIVACY PRACTICES
FOR PROTECED HEALTH INFORMATION

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health providers. An example of this would include a physician examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payments.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointments reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

To have the following rights with respect to your health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information. Including those related to disclosures to family members, other relatives, close personal friends, or any person identified by you. We are however, not required to agree to a request restriction. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquires, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257/Toll Free: 1-877-696-6775

I, ____ have read and understand these guidelines above.

Patient Signature: ____

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the Federal policy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Hollenbach.

This notice is effective as of ___________________________________. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

____ Name (Please Print)

____ Signature

_________________________ Date

If you are a minor or if you are being represented by another party:

____ Personal Representative Name

____ Personal Representative Signature

_________________________ Date

____
Description of the authority to act on behalf of the patient.

Pediatric History Form

Dear New Patient,

It is a pleasure to welcome you to our family of healthy and happy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: ____ Email: ____

Sex: M ☐ F ☐ Weight: ______Height:______ Date Of Birth: ___________________ SS#: __________________________

Address: ____ City: ____

State: _____________________ Zip: _________________________ Home Phone: ____

Referred by: ____

Name of Parents/Guardians: ____ Parent/s Work Ph #: ______________________________

Purpose for contacting us: ____

Have other Doctors been seen for this condition? ☐ No ☐ Yes If yes, Doctors' Names and Prior Treatments:

____

Other Health Problems?

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma / Allergies	☐ Digestive Problems	☐ ADD / ADHD	☐ Recurring Fevers	☐ Growing/back pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ Other

Family History: ____

Previous Chiropractor: ____

Date of Last Visit:__________________ Reason: ____

Name of Pediatrician: ____

Date of Last Visit: ___________________ Reason: ____

Number of antibiotics your child has taken in: ____

Past 6 months: ___________________ Total during his/her lifetime? ____

Number of doses of other prescription medications your child has taken in: ____

Past 6 months: _________________________ Total during his/her lifetime? ____

Vaccination History: ____

Prenatal History:

Name of Obstetrician / Midwife: ____

Complications during pregnancy: ☐ No ☐ Yes List: ____

Ultrasounds during pregnancy: ☐ No ☐ Yes List: ____

Medications during pregnancy / delivery: ☐ No ☐ Yes List: ____

Cigarette / alcohol use during pregnancy: ☐ No ☐ Yes List: ____

Location of Birth: ______________________________ ☐ Hospital ☐ Birthing Center ☐ Home

Birth intervention: ☐ Forceps ☐ Vacuum extraction ☐ Caesarian:- ☐ Emergency ☐ Planned

Complications during delivery: ☐ No ☐ Yes List: ____

Genetic disorders or disabilities: ☐ No ☐ Yes List: ____

Birth weight: __________________________ Birth Length: ______________________ APGAR Scores: _____________________

Feeding history:

Breast fed: ☐ No ☐ Yes How long: ____________ Formula fed: ☐ No ☐ Yes How long: _______________

Introduced to solids at: _________ months Cows milk at: ___________ months

Food/juice allergies or intolerances: ☐ No ☐ Yes List: ____

Developmental history:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to sound: ________________ Respond to visual stimuli: ____________________________________

Hold head up: ____________________ Sit up: ____

Cross crawl: ______________________ Stand Alone: ____

Walk alone: _______________________

According to the National Safety Council, approximately 50% of all children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs etc.). Was this the case with your child? ☐ No ☐ Yes

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)?

☐ No ☐ Yes List: ____

____

Has your child ever been involved in a car accident? ☐ No ☐ Yes When? ____

Has your child been seen on an emergency basis? ☐ No ☐ Yes When/why? ____

Other traumas not described above? ☐ No ☐ Yes List: ____

Prior surgery? ☐ No ☐ Yes List: ____

Menarche: ☐ No ☐ Yes Age: ____

Childhood diseases:

Chicken Pox: ☐ No ☐ Yes Age: ____________ Mumps: ☐ No ☐ Yes Age: __________

Rubella: ☐ No ☐ Yes Age: ____________ Whooping cough: ☐ No ☐ Yes Age: __________

Other: ☐ No ☐ Yes Age: __________

Rubeola: ☐ No ☐ Yes Age: ____________

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results.

Authorization for care of a minor

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

Name of Insurance Company: ________________________________ Policy #: ____

Signed:: ____ Witnessed: ____

Date: ____