Riverview Family Chiropractic Center

Quality Care for the Entire Family

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10833 Boyette Road
Riverview, Fl. 33569
Office: 813-741-0655 Fax: 813-741-0945

Child's Name_____ Patent's Name_____

Home Address_____

City_____State_____Zip_____

Home Phone_____May we leave a message? YES NO

Parent's Cell Phone_____May we leave a message? YES NO

Parent's Work Phone_____May we leave a message? YES NO

How did you hear about us? _____

Child's Height_____ Child's Weight_____ Date of Birth_____

Sex M F

Previous Chiropractic care? YES NO

Why have you decided to have your child evaluated by a Chiropractor? (mark all that apply)

____ He/She is continuing ongoing care from another chiropractor.

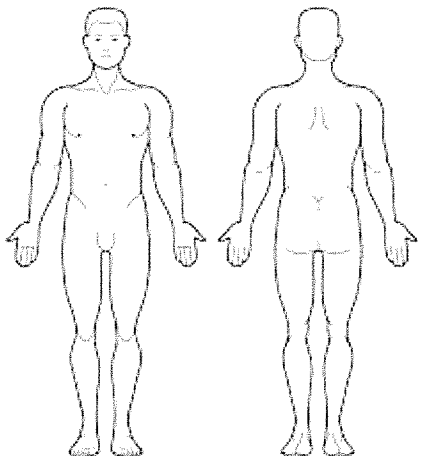
____ I recently had my spine checked and understand the value of getting my child evaluated.

____ I have concerns about his/her health and am looking for answers.

____ He/She has a specific condition, and I've learned that chiropractic care might be able to help.

____ I want to improve my child's immune system.

Please mark where the pain is:



Emergency Contact

Name_____ Relationship to Child_____

Phone Number_____ Alternative Phone Number_____

Family Doctor

Name_____ Professional Designation_____

Clinic Name_____ Date and reason of last visit_____

_____

May we communicate with your family doctor regarding your child's care if necessary? YES NO

Wellness Profile

The human body is designed to be health. The primary system in the body, which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called *Vertebrae*. Many of the common health challenges that adults experience has their origins during the developmental years, some starting at birth. Layers of damage to the spine and nervous system occur because of various traumas, toxins and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system in a condition called *Vertebral Subluxation.* Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation, and impeding your child's ability to heal.

What signals has your child's body been communicating?

('**C**' for Current or '**P**' for Previous, leave bland if neither apply)

___Asthma	___Frequent Diarrhea	___Failure to Thrive / Slow weight gai	___Constipation
___Respiratory Tract Infection	___Sinus Problems	___ Slow or Absent Reflexes	___Flatulence
___Asymmetrical Crawling or Gait	___Ear Infections	___Headaches / Migraines	___Tonsillitis
___Weight Challenges	___Neck Pain	___Bed Wetting	___Strep Throat
___Torticollis / Head Tilt	___Sleep Problems	___Problems feeding on one side	___Night Terrors
___Frequent Colds / Croup	___Recurrent Fevers	___Tip Toe Walking	___Back Pain
___Regression of Milestones	___Growing Pains	___Eczema	___Rashes
___Red, Swollen, Painful Joint	___Scoliosis	___Seizures	___Allergies
___Tremors / Shaking	___Colic	___Food Sensitivities	___ADD / ADHD
___Digestive Problems	___Frequent Crying Spells	___Autism / PDD	

Do you have a specific concern that brings you in?

___No, I am interested in having my child's nervous system assessed to achieve optimal health and functioning.

___Yes, _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____
How long has your child been experience this? _____
Is it getting better, worse or staying the same? _____
Was this a sudden onset or gradual? _____
Have you seen other health professionals regarding this complaint? YES NO
If Yes, who? _____
Treatment used? _____
Has your child taken any medication for this complaint? YES NO
Has your child ever experienced this complaint before? YES NO
Did they receive any treatment at the time? YES NO
Has your child had x-rays in relation to the current complaint? YES NO

Physical Traumas

Has your ever fallen from any high place? YES NO
Has your child ever been involved in a motor vehicle accident? YES NO
Has your child been seen on an emergency basis? YES NO
Has your child broken any bones? YES NO
Has your child needed any previous hospitalization YES NO
Has your child required any previous surgeries? YES NO

Does your child spend time using a tablet, computer or play video games?

___Never ___Rarely ___Daily ___Several hours per day

Does your child watch TV?

___Never ___Rarely ___Daily ___Several hours per day

Does your child exercise?

___Never ___Rarely ___Daily ___Several hours per day

Does your child play contact sports?

___Never ___Rarely ___Daily ___Several hours per day

Does your child sleep on their BACK BELLY SIDES: Both Right Left
Does your child carry a backpack? YES NO
If yes, do they wear their pack on 2 shoulders? YES NO SOMETIMES
Does your child show excessive or uneven shoe wearing out? YES NO
Does your child wear custom orthotics? YES NO
If yes, for what purpose? _____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize **Riverview Family Chiropractic Center** to release my records and any information requested to the following individuals.

1. _____ Relation to Patient:_____ Ph _____
2. _____ Relation to Patient:_____ Ph _____
3. _____ Relation to Patient:_____ Ph _____
4. _____ Relation to Patient:_____ Ph _____

Authorization Regarding Messages (**please check all that apply**)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments
____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information
____ I authorize you to leave a message with anyone who answers the phone
____ Messages may only be left with _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature

CONSENT

Our goals are to provide a detailed assessment of your child's current health status. Also, to provide you the resources for a highly engaged, healthy child whose body is functioning at it's absolute peak potential while they grow.

Essential to this healthy growth is a nervous system functioning free from interference called *subluxations*. You have taken an important step for your child's future through a chiropractic evaluation!

Consent for Evaluation

I, _____, being the parent or legal guardian of
(Print name of consenting adult)
_____, hereby grant permission for my child to
(Print name of minor child)
Receive a chiropractic evaluation. To include his/her medical history, spinal scan, examination, and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____

Consenting Adult's Signature Date

PAYMENT AUTHORIZATION

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to "**Riverview Family Chiropractic Center, PA**" such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness, and any disability benefits, medical payment benefits, no fault benefits, health and accident benefits, workman's compensation benefits, or any other payments which may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds if any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as a assignment of benefits and an assignment of direct payment to the extent of the office's services provided.

In the event my insurance company is obligated to make payments to me upon the charges made by this office for services rendered, refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office, any and all causes of action that I might have or that might exist in my favor against such company, and authorize this office to prosecute said cause of action either in my name or the office's name. I further authorize this office to compromise, settle and otherwise resolve said claim or cause of action as they see fit.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this assignment, lien, and authorization. I agree that the above-mentioned office be given authorization to endorse/sign my name in any and all checks for payment of my doctor bill. I understand that health and accident insurance policies are an arrangement between myself and the insurance company.

I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of, and will reimburse this office for all costs of such collection efforts. This is including, but not limited to al court costs, interest occurred, collection fees and all attorney fees.

Patient Signature: _____

Spouse / Guardian Signature: _____

Date: _____

FOR OFFICE USE ONLY

Co-Pay is $_____ per visit, while under active care toward services rendered. Balance will be billed at the end of care.

FINANCIAL POLICY

The Doctors and Staff at ***Riverview Family Chiropractic Center*** would like to welcome you to our practice!

We strive to provide you with excellent medical care.

BY SIGNING BELOW, YOU CONFIRM THAT YOU HAVE READ AND UNDERSTAND OUR OFFICE POLICY.

It is **your** responsibility to inform our office of any address and telephone number changes.

Your account is to be kept current; accordingly, all self-pay or insurance co-payments and deductibles will be collected **at the time of service,** unless prior arrangements have been made. We take checks, MasterCard, Visa, American Express and Discover credit cards.

A returned check will result in a **$25.00 service charge** and all future payments must then be made by cash or credit card.

You will be sent a statement each month if your balance exceeds $10.00.

There is a $25.00 NO SHOW fee for anyone not giving the office a 24-HOUR CANCELLATION NOTICE for appointments (doctor, massage, or laser).

If your account is turned over to a collection agency, you will be responsible for any cost incurred in collection of said balance and must work with the collection agency to pay balance, not our office.

We submit your claims, however, we must emphasize that as a medical provider, our relationship is with you and not your insurance company.

It is your responsibility to inform us of any changes in your insurance coverage.

It is your responsibility for non-covered charges not payable by your insurance company. Although filing your insurance claim is a courtesy extended to you, all charges are always **your** responsibility.

We realize that temporary financial problems may affect payment of your account. If such problems do arise, we urge you to contact our billing department at **(813) 741-0655** for assistance in management of your account. If you have any questions, please do not hesitate to ask us.

Print Name: _____

Signature: _____

Date: _____

RIVERVIEW FAMILY CHIROPRACTIC CENTER, P.A.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, *Riverview Family Chiropractic Center, P.A.,* may use my disclosed protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Riverview Family Chiropractic Center, P.A.'s Notice of Privacy Practices for a more complete description.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I am acknowledging that I have been provided a copy of the Notice of Privacy Practices and that I have, will, or decline to read them, and understand the Notice of Privacy Practices. I understand this form will be placed in my patient chart and maintained for seven years. *Riverview Family Chiropractic Center, P. A.* reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to ***Riverview Family Chiropractic Center, P. A., Privacy Office at 10833 Boyette Rd., Riverview, Fl. 33569.***

With my consent, *Riverview Family Chiropractic Center, P. A.* may mail to my home or other designated location, any item that assists the practice in carrying out TPO; such as appointment reminder cards and patient statements as long as they are marked *Personal and Confidential.*

I have the right to request that *Riverview Family Chiropractic Center, P. A.* restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested patient statements, as long as they are marked *Personal and Confidential.*

By signing this form, I am consenting to *Riverview Family Chiropractic Center, P. A.'s* use of my disclosed PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, *Riverview Family Chiropractic Center, P. A.* may decline to provide treatment to me.

_____	_____
Print Name of Patient	Print Name of Legal Guardian
_____	_____
Signature of Patient or Legal Guardian	Date

___ By initialing here, I am stating that I was provided with a copy of the Notice of Privacy Practices and have chosen not to keep the copy. I have been made aware of an office copy that is available for review.