Riverview Family Chiropractic Center

Quality Care for the Entire Family

Todd Jarvis, D.C.
Preston Rogers, D.C.

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

Child's Name_____ Parent's Name_____

Home Address_____

City_____State_____Zip_____

Parental email address:_____

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.

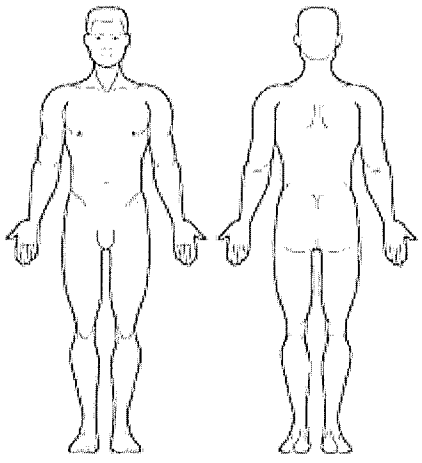
____ I recently had my spine checked and understand the value of getting my child evaluated.

____ 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 healthy. 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 blank if neither apply)

___Asthma	___Frequent Diarrhea	___Failure to Thrive / Slow weight gain	___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 experiencing this? _____
Is it getting better, worse or staying the same? _____
Was this sudden or a gradual onset? _____
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 child 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

Riverview Family Chiropractic Center, PA 10833 Boyette Road, Riverview, Fl. 33569 (813)741-0655

CONSENT

Our goals are to provide a detailed assessment of your child's current health status. Also, to provide you with 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, which is the balance turned over **PLUS 30-50%** of the balance at the time the account is turned over. This is including, but not limited to all 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 cash, checks, MasterCard, Visa, American Express and Discover credit cards and Apple pay.

If paying by credit card, there is a **4%** or less convenience fee added to the charge by our card processing company. A returned check will result in a **$30.00 service charge,** and all future payments must then be made by cash or credit card.

There is a $30.00 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 the balance turned over, **PLUS 30% to 50%**, depending on the balance at the time it is sent to the collection agency, and you 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: _____

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ACKNOWLEDGEMENT AND CONSENT

The federal laws that protect your protected health information ("HIPAA") do not provide you with complete privacy. HIPAA allows your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research.

Our privacy policy. We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, you will be given a copy of our privacy policy, in detail. You have the right to review our privacy policy before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures. You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

Your right to authorize us to disclose your protected health information. You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

Your right to revoke any limitation, authorization, or consent. You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I ACKNOWLEDGE receipt of the PRIVACY POLICY and CONSENT to my personal health information being used in the manner described above. I am also acknowledging that I have been offered a copy of this consent.

Patient Name Printed

Date

Patient (or Personal Representative) Signature

Authorized Provider Representative

Personal Representative's Name Printed

Personal Representative's Authority

I am acknowledging that I have been offered a copy of the PRIVACY POLICY and this consent, but I DECLINE to give my chiropractor and members of the practice staff consent to use my protected health information for any purpose other than treatment and those required by federal law.

Patient Name Printed

Date

Patient (or Personal Representative) Signature

Personal Representative's Authority

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize **Todd Jarvis, DC and/or Preston Rogers, DC** to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____ . This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

_____ _____

Patient's Name (printed) Witness Name (printed)

_____ _____

Parent/Guardian Name (printed) Witness Signature

_____

Signature of Parent or Guardian of minor

_____

Relationship

_____

Doctor's initials

Medical Records Release Form

By signing this form, I authorize _____ to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility listed below:

Patient name: _____ **Date of Birth:** _____

The information you may release subject to this signed release form is as follows:

____ Complete Records ____ Progress Notes ____ Initial and/or Final Report
____ Radiology Reports ____ Other (please specify): _____**x-rays**_____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Facility: **Riverview Family Chiropractic Center**
10833 Boyette Road
Riverview, Fl. 33569
(T) 813-741-0655 (F) 813-741-0945 email: chirorfcc@gmail.com

Thank you.

Signature:

_____ _____
Patient Name Signature of Patient or Personal Representative

_____ _____
Patient's Date of Birth Witness Signature

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Quality Care for the Entire Family

Todd Jarvis, D.C.

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Text Messaging Consent Form

Patients in our practice may be contacted via text messaging to remind you of an appointment and general information.

Please check either OPT-IN or OPT-OUT.

__ **OPT-IN** I consent to receiving appointment reminders and general information via text from Riverview Family Chiropractic Center. The cell phone number that I authorize to receive text messages for appointment reminders is: (_____)_____

You can cancel the SMS service at any time. Just text **"STOP"** to the number from which you have received a message. After you send the SMS message **"STOP"** to us, we will send you an SMS message to confirm that you have been unsubscribed. After this, you will no longer receive SMS messages from us. If you want to join again, just sign up as you did the first time and we will start sending SMS messages to you again. You may also text **"START"** to the number to resume receiving SMS communications.
If you are experiencing issues with the messaging program you can reply with the keyword **"HELP"** for more assistance, or you can get help by calling us at **(813) 741-0655**.
Carriers are not liable for delayed or undelivered messages.
As always, message and data rates may apply for any messages sent to you from us and to us from you. You will receive text reminders for each appointment and may receive occasional general messages. If you have any questions about your text plan or data plan, it is best to contact your wireless provider.

___ **OPT-OUT I DO NOT** consent to receive text messages from the practice at my cell phone.
I understand that this request to text messages will apply to all future appointment reminders, unless I request a change in writing.

SMS Privacy Policy

We value your privacy and the information you consent to share in relation to our SMS (text messaging) service. We use this information to send you text notifications/reminders concerning the status of your scheduled appointment. Opt-in data and consent for text messaging will not be shared with any third parties except for messaging partners, for the purpose of enabling and operating our text messaging program.

Patient's Printed Name: _____

Patient Signature: _____ Date:_____