PEDIATRIC HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy 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: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ / _____ / _____ Work Phone: _____

Sex: _____ Weight: _____ Height: _____ Referred By: _____

Names of Parents / Guardians: _____

Purpose For Contacting Us ? _____

Other Doctors Seen for this Condition: _____ N _____ Y , 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	☐ 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: _____

Are You Satisfied with the Care Your Child has Received There ? _____ N _____ Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications During Pregnancy ? _____ N _____ Y , List: _____

Ultrasounds During Pregnancy ? _____ N _____ Y , Number: _____

Medications During Pregnancy / Delivery ? _____ N _____ Y , List: _____

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction

_____ Ceasarian Section , Emergency or Planned ?

Complications During Delivery ? _____ N _____ Y , List: _____

Genetic Disorders or Disabilities: _____ N _____ Y , List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

Feeding History:

Breast Fed: _____ N _____ Y , How Long: _____

Formula Fed: _____ N _____ Y , How Long: _____ Type: _____

Introduced to Solids at: _____ Months , Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____ Y , 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 Saftey Council, approximately 50% of 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 ? _____ N _____ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _____ N _____ Y , List: _____

_____

Has Your Child Ever Been Involved in a Car Accident ? _____ N _____ Y , List: _____

Has Your Child Been Seen on an Emergency Basis ? _____ N _____ Y , List: _____

Other Traumas Not Described Above ? _____ N _____ Y , List: _____

Prior Surgery: _____ N _____ Y . List: _____

Menarche: _____ N _____ Y , Age: _____

Childhood Diseases:

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Rubeola	N / Y, Age _____	Other	N / Y, 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 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: ____ / ____ / ____

HIPPA FORM

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care a patient at The Health and Wellness Center, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment, including electronic health records (EHR).
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, email, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be used of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.
Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your healthy related information should be provided to us in writing.

We are further required by law to abide by the terms of this notice while it is 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 change 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 privacy rules.

The Health and Wellness Center also utilizes other forms of communication, which you may have the right to refuse including:

- (EHR) Electronic Health Records
- Healthy e-mail topics
- Birthday cards
- Thank you cards
- Front desk sign in sheets
- Treatment in our creating wellness semi-open adjustment area.

This notice is effective as of October 1, 2014. 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 (Printed Please) Signature Date

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

_____ _____

Personal Representative (Printed) Personal Representative (Signature)

_____

Date

_____

Description of the authority to act on behalf of the patient

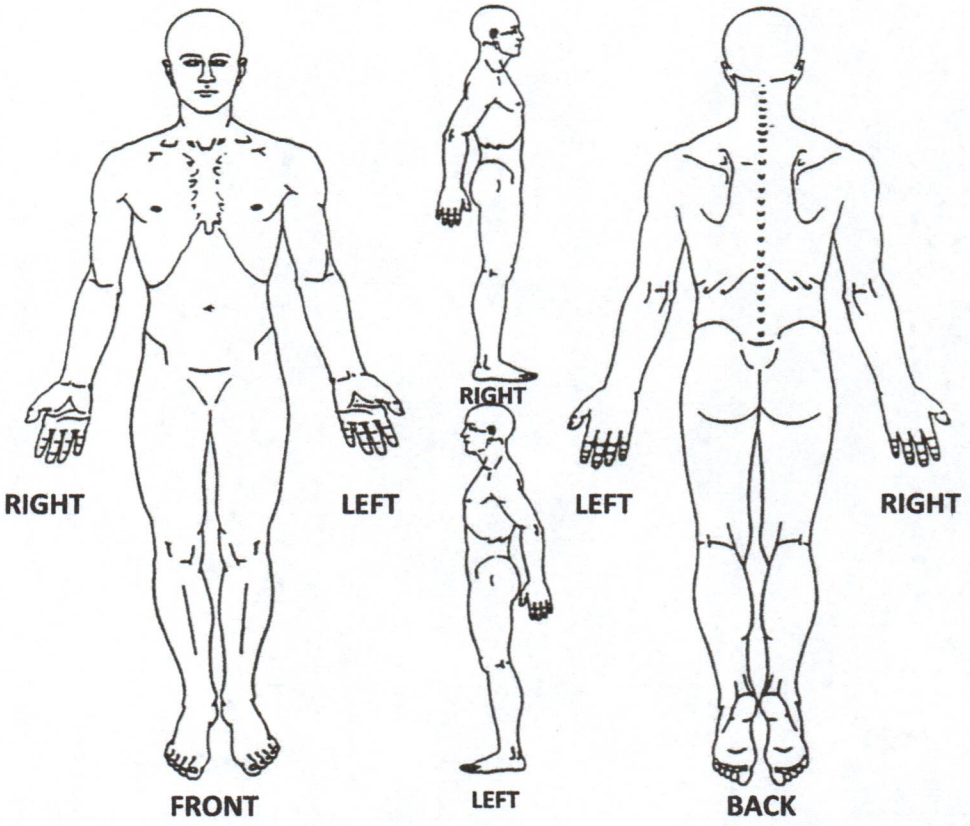
William DeMio, DC
1037 Preakness Ave.
Wayne, NJ 07470
Phone: (973)-595-8969
www.thehealthandwellnesscenter.net

Name: _____ Date: _____

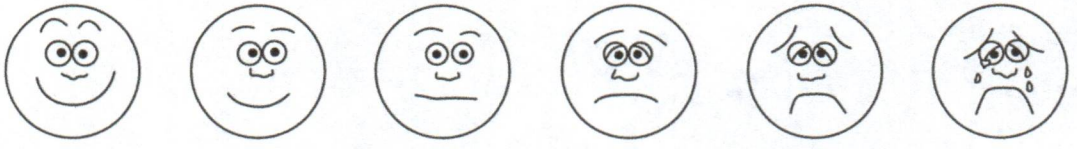
Please indicate the type and area of your pain on the drawings below, by using the abbreviations provided:

D = Dull Pain T = Tingling B = Burning

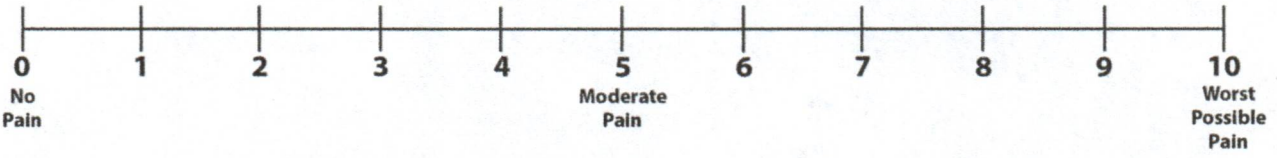
N = Numbness P = Sharp Pain S = Stiffness



Please check the face that most accurately depicts your pain.



Please give a numeric value to your pain on the pain scale below.



The HEALTH AND WELLNESS Center

Consent for Treatment

I, the undersigned, hereby authorize the providers of The Health and Wellness Center, LLC, to provide chiropractic treatment including procedures such as examination, diagnostic x-rays, spinal/extra-spinal adjustments and various ancillary modalities such as electronic muscle stimulation (EMS), cold-laser therapy, ultrasound and spinal traction. As with any other health care procedure, complications are possible following an adjustment, which may include muscular or ligamentous soreness. The risks of complication due to chiropractic treatment have been studied and determined to be rare; less than the complications that are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even future reduced by screening and examination procedures.

The probability of adverse reactions due to ancillary procedures is also described as "rare". Other treatment options which you may consider instead, include, over-the-counter and prescription medications, injections, or surgery, which may all include a multitude of side effects to the stomach, liver and kidney organs. The risks to remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. This may complicate treatment making it less effective the longer it is postponed.

I understand the importance of informing the doctor in writing about any new factors which may change or affect the treatment of my condition. I have had the opportunity to discuss with the doctor the nature of my condition, the intended result of proposed treatment and the risks of chiropractic adjustments and other recommended procedures. I also understand and agree to accept my responsibilities as a patient seeking care, understanding that results are not guaranteed. ***By signing below, I state that I have read the explanation of treatment in and outside of The Health and Wellness Center, LLC.***

I have decided that it is in my best interest to undergo the course of chiropractic care recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment/care. I, the undersigned understand that I am responsible for payment for services received, including any balances not covered if using a medical insurance plan to pay a portion of your care depending on benefits of the policy.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Patient/Guardian(print): _____ Doctor's Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

The HEALTH AND WELLNESS Center

Financial Policy

Please review our financial policy *thoroughly*.
We want you to know what to expect before you receive care, so that we may move comfortably forward and focus on what is most important –YOUR HEALTH.

Horizon Policies

We are a participating provider in the Horizon Traditional and Managed Care networks.
All co-payments and deductibles are payable at time of service.
Computerized re-scans are not covered and are $30.

Medicare

Our office is a participating provider with Medicare.
Chiropractic adjustments are usually covered for acute care, but therapy, x-rays, and exams are not. Medicare will not cover maintenance or preventative services. Medicare requires that all patients sign specific forms (i.e. ABN, NEMB). Medicare requires us to collect annual deductibles if not covered by a secondary policy. Medicare allows 18-30 visits depending on your condition.
Computerized re-scans are not covered and are $30.

Major Medical Policies: Aetna/Cigna/United Healthcare/Oxford/Health Net…

We are an out-of-network provider with these companies. Payment is due at the time of service. Payments from your insurance carrier will be reimbursed to you upon satisfaction of your policy's deductible. Reimbursement on these policies can vary in coverage and cannot be guaranteed. Our office will provide completed forms and the guidance necessary to enable you to receive reimbursement from your insurance company.

All Patients

Should you interrupt or discontinue your care all balances are immediately due. You are financially responsible for any services rendered.
All expenses incurred involving a collection agency is the patient's responsibility, *including an additional 30% fee.*

Missed Appointments

Missed appointments will incur a $20.00 charge.
No charge will be made if 24 hrs. notice is given for missed appointments.

Returned Checks

A handling fee of $20.00 will be charged on any returned checks.

Patient/Parent/Guardian(print): _____

Signature: _____ Date:_____