JOSHUA SPINE + HEALTH CENTER

CHIROPRACTIC • MASSAGE • WELLNESS

Confidential Patient Information
PEDIATRIC

Date: _____

About Your Child

Name_____
First Last

Who can we thank for the referral?_____

Address _____ City ___-_____ State _____ Zip _____

Guardian Telephone Cell (____)_____ ____ ___ Home (____)_____ Work (____)_____ ____
Is it ok to contact you at work? Yes☐ No☐

Guardian Email _____
Your email will NOT be shared with any 3rd party, and is used for general office communication.

Child's Age _____ Birth Date _____ Sex M☐ F☐ Height _____ Weight _____

Grade: _____ School: _____Activities _____

Family Doctor/Pediatrician _____ Clinic_____ Phone _____

Previous Chiropractic care? Yes☐ No☐ If Yes, where and when? _____

Your Child's Family

Parents/Guardians' Names _____

Cell Phone(s) (_____)_____(_____)_____

Occupation(s): _____ Employer(s) _____

Names and Ages of Siblings_____

Are child's siblings or parents currently under Chiropractic care? Yes☐ No☐ Name of Doctor _____

Your Child's Condition

Purpose of Appointment/Complaint_____

When did it start? _____ Has it happened before? Yes☐ No☐ When? _____

How did it happen? _____

The pain is ☐ constant ☐ comes and goes ☐getting worse Does the pain travel? Where? _____

The pain interferes with ☐school ☐sleep ☐exercise/play ☐daily activities ☐other _____

The pain is aggravated by: ☐moving ☐lifting ☐bending ☐sitting ☐walking ☐lying down ☐other _____

The pain is relieved by: ☐ice ☐heat ☐rest ☐stretching ☐medication_____ ☐other_____

What other professionals have you seen for this condition? _____ Results? _____

Health History

Check any of the symptoms your child has suffered from/been diagnosed with during the past six months:

☐Ear infections
☐Asthma
☐Allergies
☐Colic
☐Headaches
☐Scoliosis
☐Bed Wetting
☐Digestive Problems
☐Temper Tantrums
☐Neck Pain
☐ADHD/Hyperactivity
☐Abnormal weigh loss/gain
☐Chronic colds/sore throat
☐Seizures
☐Back pain
☐Headaches
☐Recurring Fevers
☐Growing pains
☐Serious fall
☐Other. Please explain _____

- OVER -

Childhood Disease	Yes	No	Age
Chicken Pox	☐	☐	_____
Rubeola (Measles)	☐	☐	_____
Rubella (German Measles)	☐	☐	_____
Whooping Cough	☐	☐	_____
Mumps	☐	☐	_____
Other_____	☐	☐	_____

Vaccination history:

☐ My Child's vaccinations are up to date

☐ My child has not received any vaccinations

☐ I don't know if my child was vaccinated

☐ My child had an adverse reaction to the following vaccine:

_____

Number of doses of antibiotics your child has taken:

1) In past six months_____ 2) Total in his/her life _____

List all other medications (prescription and over-the-counter) taken:

1) Currently: _____ 2) In past year: _____

Feeding History:

Breastfed: Yes☐ No☐ If Yes, how long? _____ Formula: Yes☐ No☐ If Yes, how long? _____

Introduced solids at _____ months. What kind? _____ Cow's Milk at _____ months

Food/drink intolerance? _____

Prenatal History:

Name of Obstetrician/Midwife/Doula: _____

Complications during pregnancy? Yes☐ No☐ If Yes, please explain: _____

Medications during pregnancy? Yes☐ No☐ If Yes, please list them: _____

Cigarette/Alcohol use during pregnancy? Yes☐ No☐ Any smokers in the home? Yes☐ No☐

Was the baby carried Full term? Yes☐ No☐ If No, please explain:_____

Location of Birth: ☐Hospital ☐Home ☐Other: _____

Birth Interventions: ☐C-Section. Planned or Emergency?_____ ☐Forceps ☐Vacuum extraction

☐Epidural ☐Induction Complications during delivery? Yes☐ No☐ If Yes, please explain:_____

Genetic Disorders or Disabilities? Yes☐ No☐ If Yes, please explain:_____

Birth Weight: _____ Birth Length _____

Developmental History:

At what age was your child able to: Sit _____ Crawl _____ Stand alone _____ Walk _____

Has you child ever fallen from a high place during the first year of life (changing table, stairs, stool, etc.)? Yes☐ No☐

Has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, etc.)? Yes☐ No☐

Has your child ever:	Yes	No	Briefly explain
Broken bones?	☐	☐	_____
Been hospitalized?	☐	☐	_____
Been in a car accident?	☐	☐	_____
Had Sprains/Strains?	☐	☐	_____
Been struck unconscious?	☐	☐	_____
Had Surgery?	☐	☐	_____

(For girls only) Has your daughter had a menstrual cycle yet? Yes☐ No☐ If Yes, age of her first cycle: _____

Lifestyle

Please list any Vitamins and/or Supplements that your child is taking _____

Please list recent Emotional stressors (divorce, death, loss of a pet, school change, etc.) _____

Does your child ☐drink soft drinks? ☐eat pre- packaged meals/snacks? ☐drink more than 2 glasses of milk/day?

☐Eat candy/cookies? ☐eat fast food? ☐eat boxed cereals

Please list any Vitamins and/or Supplements that your child is taking _____

Please list recent Emotional stressors (divorce, death, loss of a pet, school change, etc.) _____

Does your child ☐drink soft drinks? ☐eat pre- packaged meals/snacks? ☐drink more than 2 glasses of milk/day?

☐Eat andy/cookies? ☐eat fast food? ☐eat boxed cereals?

Insurance Information

Insurance Co _____ Policy # _____ Group # _____

Subscriber's Name _____ Birth Date _____ Relation to patient _____

Additional/Secondary Insurance Co _____ Policy # _____ Group # _____

Subscriber's Name _____ Birth Date _____Relation to patient _____

Please give your insurance card to the front desk so they can verify your coverage.

Auto Injury? Yes☐ No☐ If Yes, please ask the front desk for *Automobile Accident Form*

Consent to Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures for my child. This includes examination tests, diagnostic x-rays and physical therapy techniques, which are recommended by the doctor of Chiropractic who now, or in the future, renders treatment to my child, while employed by , working for , associated with, or serving as backup for the doctor of Joshua Health Center. I understand that X-rays will remain property of this office, being on file where they may be seen at any time while a patient of this office.
I have had an opportunity to discuss with the doctor and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and their recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.
By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my child's best interest to undergo Chiropractic treatment recommended. I have also been made aware of the risks associated with refusing treatment. 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 conditions for which I seek treatment for my child. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian Signature _____ Date _____

Assignment of Benefits

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Joshua Spine and Health Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Joshua Spine and Health Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Also, I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Authorization & Release

- ✓ I hereby authorize Dr. Joseph Thomas, D.C. to 1) release any information necessary to insurance carriers regarding my illness and treatments 2) to process insurance claims generated in the course of examination or treatment and 3) to allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.
- ✓ I have requested medical/chiropractic services from Dr. Joseph Thomas, D.C. on behalf of myself and/or my dependants, and understand that by making this request, I become fully responsible for any and all charges incurred in the course of the treatment authorized.
- ✓ I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I also understand that if I suspend or terminate my care or treatment, any fees for professional services, which are rendered to me, will be immediately due and payable, unless agreed otherwise. Should my account become delinquent, I will be responsible for any interest (to accrue at 9% annually, commencing 30 days after the initial bill for services issued), for collection fees, including but not necessarily limited to attorneys fees and court costs incurred in collection attempts on my account. A photocopy of this assignment is to be considered as valid as the original.

Terms of Acceptance

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

Chiropractic has only one goal: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition(s). To remove the vertebral subluxations, a specific process us used which is called a chiropractic adjustment. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advice you. Regardless of what the disease is called, we do not offer to treat it.

When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Please feel free to ask for additional information.

Signature: _____ Date: _____

Printed Name of Patient or Legal Representative _____

Joshua Spine and Health Center, Dr. Joseph J. Thomas, D.C

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy and/or have been given the opportunity to review this office's Notice of Privacy Practices.
As required by the Privacy Regulations, I am aware that this practice reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- ○ I wish to file a "Request for Restriction" of my Protected Health information.
- ○ I wish to fil a "Request for Alternative Communications" of my Protected Information.
- ○ I wish to object to the following in the "Notice of Privacy Practices":

_____

_____

I understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original/previous version(s).

Printed Name:_____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please specify)

_____

_____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE