(608) 247-9229 abundantlifehousecalls@gmail.com

Pediatric New Patient Paperwork (Under 12 years)

Child's Name: ____ Date of Birth: ______/______/______
Mother's Name: _____________________________ Father's Name: ______________________________
Address: ____
Home Phone: ______________ Mother Cell Phone: ____________ Father Cell Phone: ______________
Fathers Email: ______________________________ Mothers Email: _______________________________
Obstetrician/Midwife Name, Location, and Phone #:

____

Pediatrician/Family MD Name, Location, and Phone #:

____

Health History

Gender: M F Reason for this visit:____
Age: ____ Birth Weight: _____ Current Weight: _______ Birth Length: _______ Current Length: _______
# of Siblings: _______
Childs Congenital Anomalies/Defects: ____
Family History of Congenital Anomalies/Defects:____
Type of Birth (***circle all that apply***): Normal Vaginal Forceps Breech Cesarean
Birthing Location: Home Birth Birthing Center: __________________ Hospital: _____________________
Pregnancy History / Problems During Pregnancy: ____

____

Delivery & Birth History / Problems During Labor & Delivery: ____________________________________

____

APGAR Scores: ____ ____ Was there presence at birth of: ____ Jaundice (yellow) ____ Cyanosis (blue)
Infant Feeding: Breast: ____ # of Months: _______ Bottle: ____ # of Months: _______
Formula: _____ # of Months: _______ Brand(s): ____________________
Number Of Hours of Sleep Per Night: ________ Quality of Sleep (circle): Good Fair Poor
Immunization History:____

Developmental History - At what age did the child:

Respond to Sound ___ mo/yrs Sit Unaided ____mo/yrs Hold Head Up ____mo/yrs
Crawl ____mo/yrs Follow an object with their eyes ___ mo/yrs Stand Unaided ______mo/yrs
Walk Unaided _____mo/yrs

Childhood Diseases (check all that apply):

___ Mumps ___ Whooping Cough __ Diabetes
___ Rubella __ Dizziness __ Arthritis

__ Neuritis
__ Anemia
__ Poor appetite
__ Paralysis
__ Bed wetting
__ Digestive Disorders
__ Colds/Flu
__ Fainting
__ Neck problems
__ Joint problems
__ Backaches
__ Broken bones

__ Stomach Aches
__ Tuberculosis
__ Headaches
__ Hyperactivity
__ Convulsions
__ Rheumatic Fever
__ Arm problems
__Leg problems

__ Colic
__ Ruptures/Hernias
__ Blood Disorders

__ Heart trouble
__ Hypertension
__ Asthma
__ Sinus trouble
__ Walking problems
__ Muscle jerking
Other:___________________
___ Chicken Pox
___ Measles
___ Rubeola

Present History & Allergies:
____
____
Surgeries: ____
Accidents:____
Medications:____
Family History: ____
Anything else the doctor should know: ___________________________________
____
____

AUTHORIZATION FOR CARE OF A MINOR

Chiropractic examination and therapeutic procedures including but not limited to spinal adjustments, heat/ ice application, and manual muscle therapy are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.
I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

I HEREBY AUTHORIZE ABUNDANT LIFE CHIROPRACTIC AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY FOR MY CHILD/WARD.

_____________________________________ _____________________ ____/____/____
PARENT / GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT DATE

_____________________________________ _____________________ ____/____/____
PARENT / GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT DATE

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Informed Consent for Chiropractic Spinal Manipulation and Treatment, Authorization and Release

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed Chiropractic Physician, Dr. Airn Houlahan.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation AKA "adjustments" involve the doctor placing her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment via cash currency, Venmo, Money Order, or by credit card to Dr. Airn Houlahan upon services rendered. I understand and agree to the space of your home approximately 10x10 sq. feet of usage to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Dr. Airn Houlahan to communicate with my medical physician(s) and/or healthcare specialists about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care or others, regardless of satisfaction of treatment. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Due to the nature of this service being outside of conventional therapy, we do not participate with insurance, and any and all patients worked on will be responsible for payment for services rendered.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. I have also read, or have read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its

content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment by this doctor.

Patient Signature: _____________________________________ Date: ____/____/________

Printed Name: ____

CONCIERGE CHIROPRACTIC POLICIES

1. We require a 24-hour cancellation policy for our services. A 50% charge will be added to the bill of the individual if cancellations are made within 24 hours. Situations may vary, so consult with the Doctor prior to treatment if there is an issue regarding payment(s) due.
2. We have the right to not perform any services we do not see appropriate for the presentation of the patient.
3. We reserve the right to refuse service to any and all patients we do not feel comfortable with.
4. If in case of emergency situations such as an acute injury, condition, or illness, please call 9-1-1 instead of our service, or visit your local Emergency Room (ER) or urgent care center for help.
5. We request the patient provide any prior imaging within the last 3 years, especially if it pertains to your chief complaint. We may refer patients out for imaging if we deem it necessary either before or during care.
6. You must complete a phone interview with the clinic prior to the Doctor traveling to your home or residence to provide services listed on our website.
7. You may be asked to participate in filming of techniques or treatments for the purposes of our social media and/or marketing platform. If you do not wish to participate in our filming, you have the right to refuse to take part in it.
8. You must disclose if you have any pets in your home that may in any way interrupt the treatment of the Doctor.
9. You must disclose if you have any young children (age 12 or younger) in the area where the treatment will take place.
10. If the Doctor is running late, she will make sure to contact you either by phone call, text, email notification, or Facebook/Instagram Direct Messages to notify her status.
11. You must provide at least a 10 x 10 (Length by width) space to allow to the Doctor to provide services.
12. Due to the nature of our concierge/house-call business, we do not participate with Medicare, Medicaid, Personal Injury Cases, or any other healthcare insurance agencies.
13. Payment is due upon services rendered either before or after appointments on the same day visit. If there is a discrepancy about a payment, payments or dissatisfaction with services, the Doctor is always willing to have a dialogue with the patient to discuss the issue.
14. If the Doctor has to cancel the appointment at any time, you will receive a full refund or not be required to pay depending on the payment plan discussed. The Doctor will notify you via text message, phone call, email, or Facebook/Instagram Direct Messages regarding a cancellation of an appointment.
15. If participating in a payment plan, payment for the full services are expected up front in full, or as discussed according to the payment plan with the Doctor.
16. Same day appointments may or may not be available depending on schedule availability.

17. Please advise the Doctor who gave the referral, for the patient to seek services at Abundant Life Chiropractic.
18. As a chiropractic physician, we do not "heal" or "cure" any condition or illness. We merely analyze and correct vertebral or extremity subluxations, which are misalignments in the body to restore proper nervous system flow.

Appropriate referrals will be made according to the individual needs of the patient.
I have read and agree to the policies set forth by Dr. Airn Houlahan, DC by my signature below:

____

Signed Name Date

____

Printed Name

HIPAA NOTICE OF PRIVACY PRACTICES

ABUNDANT LIFE CHIROPRACTIC
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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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1.<u>Uses and Disclosures of Protected Health Information</u>

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

<u>Treatment:</u> We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues are required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in the reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in our best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/or before **March 2020.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:________________________________Signature_______________________________________Date_____________