Optimal Wellness Redefined
1100 Town Plaza Court • Suite #1020-D • Winter Springs, FL 32708
(407) 901-7704 • info@OWRchiro.com • www.OptimalWellnessRedefined.com

Child's Name: _____ Date of Birth: _____

Age: _____ Parent/Guardian Name: _____

Address: _____
Street

_____
City State Zip

Home #: _____ Work #: _____ Cell #: _____

Email address: _____

Emergency Contact: _____
Name Relationship Phone #

Appointment Reminder: Email ☐ Text ☐ Appointment Card ☐

Has your child been adjusted by a Chiropractor before? Yes ☐ No ☐

What was the reason for the visit? _____

Doctor's Name/Location: _____ Date of last visit: _____

Who can we thank for sending you to us? _____

CHILD'S COMPLAINT

Describe Reason for Today's Visit: _____

_____

When did you first notice it? _____ What caused it? _____

How is the condition now? ☐Better ☐Worse ☐Same ☐Comes and goes

When does it occur? _____ How often? _____

How long does it last? _____ Does it travel? _____

What makes it worse? _____

What makes it better? _____

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CHILD'S COMPLAINT (cont'd)

The condition interferes with: School ☐ Sleep ☐ Daily Routine ☐ Other Activities ☐

Describe: _____

Have you had this condition before? Yes ☐ No ☐ When? _____

Have you seen another doctor for this? Yes ☐ No ☐ When? _____

Doctor's Name: _____ Phone #: _____

Type of Treatment/ Results: _____

_____

GENERAL HISTORY

Were there any complications during pregnancy or delivery? Yes ☐ No ☐

Describe: _____

_____

How was the child delivered? Home Birth ☐ Hospital ☐ Midwife ☐

Induced ☐ Forceps ☐ Vacuum ☐ C-Section ☐ Doctor twisted/pulled ☐

Are there any genetic diseases or birth defects? Yes ☐ No ☐

_____

Please list your child's accidents, falls, injuries, and illnesses: (include dates) _____

_____

_____

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Has your child had any surgeries or been hospitalized? Yes ☐ No ☐

When and for what? _____

_____

What activities/sports does your child participate in? _____

_____

_____

FEEDING HISTORY

Was your child breast fed? Yes ☐ No ☐ How long? _____

Did your child have a "preferred" side? Yes ☐ No ☐ Which? _____

Was your child formula fed? Yes ☐ No ☐ How long? _____

When did your child start eating solid foods? _____ Drinking milk? _____

Does your child have any food allergies/intolerances? Yes ☐ No ☐

Describe: _____

_____

Does your child have any digestive problems? Yes ☐ No ☐ Describe: _____

_____

VACCINE HISTORY

Has your child been vaccinated? Yes ☐ No ☐ Please list: (include dates) _____

_____

_____

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Please place a check mark beside any milestone that your child was DELAYED in achieving.

GROSS MOTOR SKILLS	
AGE	SKILL
☐ wks	Able to hold head up from table momentarily
☐ nths	Head & shoulder cab be supported by forearms
☐ nths	Can be pulled into sitting position by hands
☐ nths	Sits unsupported in upright position
☐ nths	Head & shoulders can be supported by arms
☐ nths	Rolls from face down to face up
☐ nths	Crawls
☐ nths	Stands holding on to furniture
☐ mths	Walks with someone holding onto one hand
☐ mths	Walks unassisted
☐ yrs	Runs
☐ yrs	Negotiates stairs – 2 feet on each step
☐ yrs	Climbs stairs - one foot on each step
☐ yrs	Walks down stairs – one foot on each step
☐ yrs	Hops on one foot

FINE MOTOR SKILLS	
AGE	SKILL
☐ Birth	Primitive grasp reflex
☐ 4 mths	Holds and shakes rattle placed in hand
☐ 5 mths	Grasps objects independently
☐ 6 mths	Moves an object from one hand to the other
☐ 6 mths	Self-feeding, can hold and eat a cookie
☐ 6 mths	Checks objects by placing in mouth
☐ 2 mths	Picks up object with thumb and index finger
☐ 5 mths	Turns 2-3 pages of a book at a time
☐ 8 mths	Turns pages of a book one at a time
☐ 4 mths	Builds a tower containing at least 5 blocks
☐ 4 years	Builds a tower containing at least 10 blocks

SOCIAL SKILLS	
AGE	SKILL
☐ 2 mths	Smiles
☐ 3 mths	Reaches for familiar objects
☐ 4 mths	Plays with hands
☐ 5 mths	Plays with feet
☐ 9 mths	Clearly shows joy and pleasure
☐ 12 mths	Feeds self with fingers
☐ 15 mths	Plays peek-a-boo
☐ 18 mths	Understands yes and no

COMMUNICATION SKILLS	
AGE	**SKILL**
☐ 7 wks	Makes cooing sounds
☐ mths	Laughs
☐ mths	Uses one syllable words such as “da”
☐ mths	Uses 2 syllable words such as “dada”
☐ 2 mths	Uses 2-3 word vocabulary
☐ 4 mths	Uses 2-3 word phrases

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Informed Consent to Chiropractic Treatment and Medical Photography

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications 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 further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: **I have had the following unusual risks of my case explained to me.**

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Consent for Medical Imaging

I consent for medical imaging (photo, video, and/or audio) to be made of me or my child (or for person whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching at Optimal Wellness Redefined. By consenting to this medical photography I understand that I will not receive payment from any party. Refusal to consent to photographs, video, and/or audio recording will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the staff at Optimal Wellness Redefined.

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Health is affected by your nervous system, but it is also affected by your environment, the foods you eat, and your lifestyle activities and habits. Chiropractic care is an important addition to a healthier lifestyle.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my child's medical status.

Print Patient's Name _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____ Date_____

Office Financial Policy

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed with you during your consultation.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided that we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment each visit.
3. We accept assignment as a courtesy to you. You are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into this office. If any over payment exists after all insurance billing has been done, we will issue you an over payment check. It will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than a discharge by the doctor, the bill is due and payment in full expected immediately regardless of any claims submitted.
8. If you have questions concerning this or any other matter, please speak with the office manager or our insurance department prior to seeing the doctor.

Thank you.

I have read and understand the Office Financial Policy and agree to abide by these terms.

_____ _____

Patient/Guardian Signature | Printed Name of Patient

_____ _____

Date | Guardian Relationship *(if applicable)*

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, 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 health care bills, to support the operation of the organization, and any other use required by law.

Treatment: 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 equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. 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 this organization 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 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 this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

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, e.g., electronically.

You may have the right to have our organization amend your 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.**

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 questions concerning or objections to this form, please ask to speak with our President in person or by phone at 407-901-7704.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.