GEORGIA
CHIROPRACTIC & MASSAGE

Pediatric New Patient

Patient First Name: _____ Date of Birth:_____

Patient Last Name: _____ Age: _____ Gender: _____

Parent / Guardian First Name: _____ Last Name: _____ Date of Birth:_____

Address:_____ City:_____ State: _____ Zip:_____

Email:_____ Consent to email appointment reminders & office updates : □ Yes □ No

Home Phone:_____

Cell Phone:_____

How did you hear about us?

□ Friend who is a patient _____

□ Internet Search □ Event □ Social Media □ Drive By □ Other

1. **Reason for Chiropractic Care**:_____

Other Doctors Seen for this Condition: □ No □ Yes, Name of Doctor: _____

Check any of the following conditions **your child** has suffered from during the past six months: □ N/A

□ Ear Infections	□ Reflux/ Excessive Spit Up	□ Chronic Colds	□ Constipation
□ Scoliosis	□ Asthma/Allergies	□ Stomach Pain/Gassy	□ Headaches
□ Seizures	□ Food Sensitivities	□ Hyperactivity	□ Growing / Back Pains
□ Temper Tantrums	□ Sensory Processing Issues	□ Colic	□ Bed Wetting

□ Other: _____

Has child been evaluated for tongue and lip tie? □ No □ Yes, has it been revised? □ Yes □ No

2. Birth History (only required if under 5years old)

Did you deliver in a hospital? □ No □ Yes;

Name of Hospital: _____

Were there any problems/complications during labor? □ No □ Yes;

If yes, explain: _____

Name of Midwife or Obstetrician: _____

Infant's gestational age:

□ Preterm ; _____ wks

□ Full Term

□ Post-term; _____wks

Initial feeding of baby:

□ Breast; any pain with latching or difficulty feeding on one side

□ Yes □ No

□ Bottle; was breast feeding attempted □ Yes □ No

Birth Weight;

_____

Birth Length;

_____

Any use of instrument assisted tools during delivery?

□ No

□ Yes; □ Forceps □ Vacuum

Type of Delivery:

□ Vaginal

□ C-section

□ VBAC

AUTHORIZATION AND ASSIGNMENT
AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his/ her staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/ her of any consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

I authorize the following health care professional, medical facility, medical records service, employer, family member, etc. to receive information regarding my entire medical record, treatment records, and diagnostic records:

Person/Organization to Release Information:_____ Relationship: _____

Person/Organization to Release Information:_____ Relationship: _____

Person/Organization to Release Information:_____ Relationship: _____

TERMS OF ACCEPTANCE

I have read, or have had read to me the Terms of Acceptance, Patient Informed Consent, Healthcare Authorization Form, Right to Revoke Authorization Form, Insurance Disclaimer, Beneficiary Agreement, and the Notice of Privacy Practices for Protected Health Information. I have also had the opportunity to ask questions about its content and my signing this authorization I agree to the named procedures. 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.

Georgia Chiropractic & Massage, PC

Authorization

The person signing below must be over the age of 18 and a parent or legal guardian

with authority to act on behalf of named applicant

Signature: _____ Date _____

First Name (OF SIGNER): _____ Last Name (OF SIGNER): _____ Date of Birth (OF SIGNER): _____

Description of Authority to act on patient behalf: _____ Social Security (last 4 only) -_____

Space Reserved for Doctor Notes:

Terms of Acceptance

When a patient seeks chiropractic health 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 detect and correct/reduce the vertebral subluxation complex. It is important to each patient to understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express maximum health potential.

Patient Inform Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modalities of physical therapies and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/ or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, included but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/ her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing the authorization on the application 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 any future conditions for which I seek treatment.

Healthcare Authorization and Privacy Policy

The Notice of Privacy Practices for Protected Health Information has been made available to me, and an additional copy will be provided at my request. The Notice of Privacy Practices describes the types of uses and disclosures of this chiropractic office.

This notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Georgia Chiropractic and Massage to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Georgia Chiropractic and Massage to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications , birthday cards, holiday related cards, newsletters, information about treatment alternatives, or other health related information.
- If Georgia Chiropractic and Massage contacts me by phone, I give them permission to leave a phone message.
- I give permission to Georgia Chiropractic and Massage to use my testimonial written by me for marketing purposes, such as sharing with other patients or potential patients, in their brochures, on their website, or in ads in print media.
- I give Georgia Chiropractic and Massage permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some on my protected health information during the course of care. Should I need to speak with my doctor at any time in private the doctor will provide a room for these conversations.
- By signing the authorization I am giving Georgia Chiropractic and Massage permission to use and disclose my protected health information in accordance with the directives listed above.

The use of this format is intended to make my experience with Georgia Chiropractic and Massage's office more efficient and productive, as well as to enhance my access to quality health care and health information. This authorization will remain in effect for the duration of my care at Georgia Chiropractic and Massage, plus 7 years or until revoked by me.

Disability and Worker's Compensation Claim Notification Form

We at Georgia Chiropractic and Massage (GACM) understand that you have your choice of medical providers, and are grateful that you have chosen us. As a patient of GACM, it is our mission to provide you treatments that will assist you in getting back to a better quality of life. It is our position that while receiving treatments at the office, the ability to maintain your daily routine as much as possible can be beneficial to your overall health and recovery. However, depending on the individual circumstances, we understand that this might not be possible for everyone despite the quality of treatment you are receiving.

At some point you may feel the need to apply for temporary or permanent disability benefits, or file a worker's compensation claim. By signing you understand and agree to the following:

1. GACM will not get involved in any disability or worker's compensation claims that you may file as a result of your condition in which you are receiving treatment.
2. GACM will provide copies of your records to any third-party, after receiving a HIPAA authorization, signed by you, providing the necessary information on where to send the records.
3. GACM, including any of its Doctors and staff, will not complete any disability or worker's compensation packets and/or information on your behalf, outside of providing copies of your records.

You or your legal representative agree to these terms with the knowledge that you have the right to file a worker's compensation claim or apply for and obtain disability benefits on your behalf; and that there are other practitioners and practices who provide similar services and will assist with such claims, and you voluntarily choose not to seek treatment from those other practitioners or practices.

Right to Revoke Authorization

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official at Georgia Chiropractic and Massage. The written notice must contain the following information: Your name, Social Security Number, a date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature. The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Georgia Chiropractic and Massage for its own use/disclosure of PHI. (*Minimum necessary standards apply*)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION it will not be possible for Georgia Chiropractic and Massage to file third party billing on my behalf and I will be responsible for:

- payment in full at the time services are provided to me

- scheduling my own appointments since Georgia Chiropractic and Massage will be unable to contact me

- all contact with Georgia Chiropractic and Massage regarding my care.

Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form, the Right to Revoke Authorization Form, and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature on the application represents agreement with these practices.

Insurance Disclaimer

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service.

Beneficiary Agreement

I understand that my health insurance company may deny or revoke payment for the services received. If my health insurance company denies or revokes payment, I agree to be personally and fully responsible for payment. I also understand if my health insurance company does not make payment for services, I will be responsible for any co-payment, deductible, or co-insurance that applies.