WELCOME TO

Amoskeag Chiropractic, Inc.

SPINAL CORRECTIVE CARE FOR THE ENTIRE FAMILY

Pediatric / Student Form

Today's Date: ____/____/_____

Full Name: _____ What would you prefer to be called? _____

Parent(s)/Guardian(s) Names: _____

Street Address (If P. O. Box, provide street address also.): _____

_____

City: _____ State: _____ Zip Code: _____

Home #: (___) _____ Work #: (___) _____ Cell #: (___) _____

Patient's Date of Birth: _____ Social Security Number: _____

Sex: Male Female

Are you a student? Yes* No *Approximate years remaining: _____

Hobbies: _____

Patient's Employer (if applicable): _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

How did you learn about our office? _____

Any previous Chiropractic Care? Yes* No *Approximate last time seen: _____

Do you have health insurance? Yes* No *If Yes, please complete the back of this page and provide a copy of the insurance card.

REQUIRED INFORMATION SIGNATURE FOR THIRD-PARTY (i.e. INSURANCE) BILLING

Policy Holder/Employee Subscriber: Please circle - Self / Spouse / Parent / Other

Policy Holder Information:

Full Name: First: _____ Middle: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: (___) _____ Work Number: (___) _____

Work Name: _____

Work Address: _____ City: _____ State: _____

Date of Birth of Subscriber: _____ Social Security Number: _____

Patient's or Authorized Person's Signature:
I authorize the release of any medical or other information necessary to process my claim. I understand that some information may go electronically or by fax. I also request payment of government benefits or insurance benefits either to myself or to Amoskeag Chiropractic Inc. that accepts assignment on an individual basis.

Insured's or Authorized Person's Signature:
I authorize payment of medical benefits to Amoskeag Chiropractic Inc. for services rendered.

Disclosure of Insurance benefits:
I agree to present all my eligible insurance or Medicare beneficiary cards to Amoskeag Chiropractic Inc. – Edward J. Rusher, D.C. upon request, to verify coverage and benefits. In the event of personal injury cases or Worker's Compensation, I will supply all information at the time of visit for prompt benefit payment.

Denial of Insurance payments:
If payment is denied by my approved payment source, I agree to pay for services in full within 30 days.

Sign: _____ Date: _____

Print name of patient: _____

AMOSKEAG CHIROPRACTIC, INC.

SPINAL CORRECTIVE CARE FOR THE ENTIRE FAMILY

CONFIDENTIAL PEDIATRIC/STUDENT HEALTH ENTRANCE FORM

Patient's Full Name: _____ **Today's Date:** _____

PLEASE LIST REASON(S) BELOW FOR PURSUING CHIROPRACTIC CARE TODAY:

Primary Reason:

Secondary Reason:

Other:

The vast majority of our patients have experienced literally dozens of impacts that could cause subluxated vertebra.

Were you induced? Yes No Epidural? Yes No C-Section? Yes No

Was the head pulled during birth? Yes No Forceps or vacuum extraction used? Yes No

How long was the entire labor? _____ How long did you actually push? _____

47% of all children fall on their head by the age of one and they have at least 200 more falls by the age of 5 years old.

When was your child's most recent fall? _____ Was any care given? _____

If yes, what: _____

And the fall before that? _____ Was any care given? Yes No

If yes, what: _____

Was s/he checked by a chiropractor? _____

What sports or recreational activities does s/he participate in? _____

When was the most recent, if any, stress, strain, or injury while engaging in these activities? _____

Was any care given? Yes No

If yes, what: _____

Has your child been in a motor vehicle accident as a passenger or driver? Yes No

If yes, briefly describe: _____

Any treatment given? Yes No
If yes, please list treatment. _____

Any chiropractic treatment? Yes No

Subluxated vertebra can cause irritation to different fibers within nerves that can affect any organ or tissue, causing conditions now or in the future.

Are there any other conditions s/he is or was experiencing? Yes No

If yes, what: _____

Depending on the type and degree of the subluxated vertebra, the nerve pressure can be constant or occasional. Does s/he have this condition? Yes No

If yes, how often: _____

Does s/he have any health concerns? Yes No

If yes, please explain: _____

Is your child currently taking any over-the counter or prescription medications? Yes No

If yes, what: _____

Known allergies: _____

This information is very important. Thank you for explaining your child's history of accidents and traumas.

Parent/Guardian Signature: _____ **Date:** _____

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 as a patient at **Amoskeag Chiropractic, Inc.,** we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of 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.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, inform you of health related meetings, workshops or products or and other information that may be 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 provide 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.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

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

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

If you would like further information about our privacy policies and practices please contact: Edward J. Rusher, DC

This office utilizes an **"open-adjusting"** environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

It is our desire for our staff to use your name, signature, photograph and/or radiograph on our Patient of the Week and Month, Referral Boards, S-Ray view boxes, family picture wall, Newsletter and In-Office promotions.

It is our desire for our staff to use your name and/or signature on our sign-in sheets in order to verify your office or workshop visit.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality Chiropractic care.

This notice is effective as of April 1, 2003. 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 (Please Print) Signature Date

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

_____ _____ _____

Personal Representative (Print) Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient.