

# Child - New Patient Forms



## ChiroSolutions Center

We Care For **EVERY** Body.

### PATIENT APPLICATION FORM: CHILD

WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. We are a very unique team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. Because of this specialized approach, we may not accept your child as a patient until we are absolutely certain we know the cause of their condition; perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

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**PATIENT NAME**

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**DATE COMPLETED**

## Patient Information

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Name of Mother/Guardian: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Age) \_\_\_\_\_ Marital Status: S M D W Work Phone: ( ) \_\_\_\_\_  
Home Address (if different): \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Father/Guardian: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Age) \_\_\_\_\_ Marital Status: S M D W Work Phone: ( ) \_\_\_\_\_  
Home Address (if different): \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

How were you referred to this office? \_\_\_\_\_

## Purpose For This Visit

Reason for this visit: \_\_\_\_\_

Is this related to an accident or specific injury (other than auto or work-related)\*?  Yes  No If yes, when: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*\*If your child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*

Describe incident or reason for onset of symptoms: \_\_\_\_\_  
\_\_\_\_\_

**Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your child's symptoms.**

When did these symptoms begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ Are they:  Constant  Intermittent  Activity-related  
Are they getting worse?  Yes  No Do they interfere with:  School  Sleep  Hobbies/Play  Daily Routine  
Explain: \_\_\_\_\_  
\_\_\_\_\_

What activities aggravate these symptoms? \_\_\_\_\_

Is there anything that relieves your symptoms?  Yes  No If yes, explain: \_\_\_\_\_

Has your child experienced these symptoms before (if not accident/injury related)?  Yes  No  
If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Has your child been treated for this?  Yes  No When was the last treatment? \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of treating practitioner/facility? \_\_\_\_\_

What treatment(s) was performed? \_\_\_\_\_  
\_\_\_\_\_

How did your child respond? \_\_\_\_\_  
\_\_\_\_\_

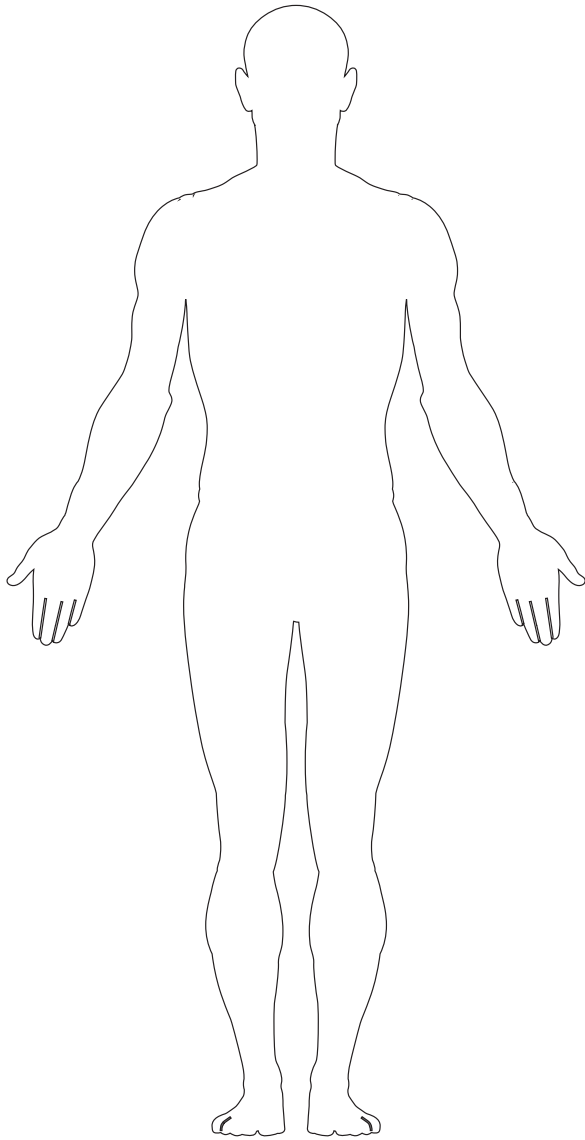
## GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your child's symptoms, as it relates to the purpose of your visit today.

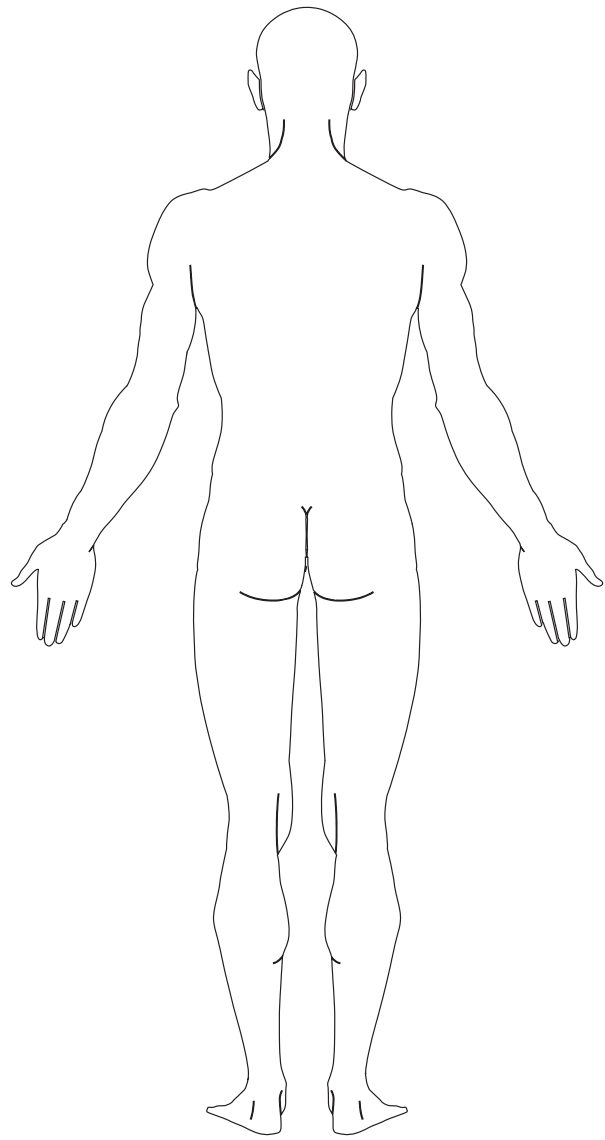
A = ACHE  
B = BURNING  
P = PINS & NEEDLES

G = STABBING  
M = SPASMS  
F = STIFFNESS

N = NUMBNESS  
T = TINGLING  
O = OTHER



**FRONT**



**BACK**

If you marked "O" for Other on any part, please explain below:

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## Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.<sup>1</sup> Please answer the following questions accurately so we may determine the full extent of your child's condition.

### HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

- Fell from a height of two (2) feet or more as an infant
- Experienced a fall that left a bruise or lump on their head or other resulting trauma\*
- Rough shaking as an infant
- Were involved in a car accident (*if you check this item, please ask the front desk person for the corresponding form*)
- Experience broken bones or debilitating injuries\*
- Difficult Birth (see below)

Explanation of (\*) item(s): \_\_\_\_\_

### BIRTH EXPERIENCE:

How long was labor? \_\_\_\_\_

Describe any complications: \_\_\_\_\_

Type of delivery:  Vaginal  C-Section  Vacuum Extraction  Forceps Assistance

### VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. \_\_\_\_\_ Age:  Mos.  Yrs. Where received: \_\_\_\_\_
2. \_\_\_\_\_ Age:  Mos.  Yrs. Where received: \_\_\_\_\_
3. \_\_\_\_\_ Age:  Mos.  Yrs. Where received: \_\_\_\_\_
4. \_\_\_\_\_ Age:  Mos.  Yrs. Where received: \_\_\_\_\_
5. \_\_\_\_\_ Age:  Mos.  Yrs. Where received: \_\_\_\_\_

**Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Swelling, redness, heat/hardness of site   | <input type="checkbox"/> Body rash or hives                     | <input type="checkbox"/> High fever (over 103 degrees) |
| <input type="checkbox"/> High-pitched screaming                     | <input type="checkbox"/> Extreme sleepiness or unresponsiveness | <input type="checkbox"/> Body twitching or paralysis   |
| <input type="checkbox"/> Breathing problems (asthma, etc.)          | <input type="checkbox"/> Excessive bleeding or anemia           | <input type="checkbox"/> Head banging                  |
| <input type="checkbox"/> Excessive diarrhea or chronic constipation | <input type="checkbox"/> Loss of memory/foggy state             | <input type="checkbox"/> Muscle weakness               |
| <input type="checkbox"/> Chronic ear or respiratory Infections      | <input type="checkbox"/> Vision or hearing disturbances         | <input type="checkbox"/> Joint pain                    |
| <input type="checkbox"/> Crossing of eyes                           | <input type="checkbox"/> Seizures                               | <input type="checkbox"/> Other (please explain)        |

Explanation(s): \_\_\_\_\_

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

## Health Conditions *continued...*

### CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Neck Pain                       | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Sinusitis             |
| <input type="checkbox"/> Pain in shoulders/arms/hands    | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Allergies/Hay fever   |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances    | <input type="checkbox"/> Recurrent colds/Flu   |
| <input type="checkbox"/> Hearing disturbances            | <input type="checkbox"/> Coldness in hands      | <input type="checkbox"/> Low Energy/Fatigue    |
| <input type="checkbox"/> Weakness in grip                | <input type="checkbox"/> Thyroid conditions     | <input type="checkbox"/> TMJ/Pain/Clicking     |
| <input type="checkbox"/> Colic                           | <input type="checkbox"/> Ear Infections         | <input type="checkbox"/> Flu/Stomach disorders |
| <input type="checkbox"/> Sore throats                    | <input type="checkbox"/> Learning disabilities  | <input type="checkbox"/> Hyperactivity/ADD     |
| <input type="checkbox"/> Auto-Immune Diseases            | <input type="checkbox"/> Other (please explain) |  |

Explanation(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Palpitations                             | <input type="checkbox"/> Heart Murmurs                       | <input type="checkbox"/> Asthma/Wheezing               |
| <input type="checkbox"/> Shingles                                       | <input type="checkbox"/> Shortness Of Breath                 | <input type="checkbox"/> Tachycardia (fast heart beat) |
| <input type="checkbox"/> Upper Back Pain                                | <input type="checkbox"/> Pain On Deep Inspiration/Expiration | <input type="checkbox"/> Other (please explain)        |
| <input type="checkbox"/> Recurrent Lung Infections/Bronchitis/Pneumonia |  |  |

Explanation(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Mid Back Pain   | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Pain in Ribs/Chest  | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Hypoglycemia           |
| <input type="checkbox"/> Indigestion/Heartburn   | <input type="checkbox"/> Reflux           | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Liver problems  | <input type="checkbox"/> Spleen problems  | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Tired/Irritable after eating or when not having eaten for a while |   |   |

Explanation(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Health Conditions *continued...*

### LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Pain in hips/legs/feet                      | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles | <input type="checkbox"/> Low back pain         |
| <input type="checkbox"/> Numbness/tingling in your legs/feet         | <input type="checkbox"/> Recurrent bladder infections           | <input type="checkbox"/> Coldness in legs/feet |
| <input type="checkbox"/> Frequent/difficulty urinating               | <input type="checkbox"/> Muscle cramps in legs/feet             | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Menstrual irregularities/cramping (females) | <input type="checkbox"/> Other (please explain)                 |  |

Explanation(s): \_\_\_\_\_

### OTHER

Please list any health conditions not mentioned: \_\_\_\_\_

Please list any medications (include name, dose, for what condition, and how long your child has been taking it): \_\_\_\_\_

Please list any surgeries (include type of surgery and date it was performed): \_\_\_\_\_

## Family Health History

Have any of your family members ever been diagnosed with the following? **If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation):**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> ADD                    | <input type="checkbox"/> Allergies/Hay fever* | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Appendectomy         |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Bed wetting        | <input type="checkbox"/> Blood sugar problems |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Chicken pox/shingles |
| <input type="checkbox"/> Circulatory problems   | <input type="checkbox"/> Crohn's/Colitis      | <input type="checkbox"/> Depression         | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Ear Infections         | <input type="checkbox"/> Eczema               | <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Epilepsy/seizures    |
| <input type="checkbox"/> Fetal drug exposure    | <input type="checkbox"/> Food allergies*      | <input type="checkbox"/> Gall bladder       | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Heart murmur         | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Hernia               |
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Influenza            |
| <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Liver disease        | <input type="checkbox"/> Lumbago            | <input type="checkbox"/> Lung disease         |
| <input type="checkbox"/> Measles                | <input type="checkbox"/> Metal implants       | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Mumps                |
| <input type="checkbox"/> Neurological problems  | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Paralysis          | <input type="checkbox"/> Pleurisy             |
| <input type="checkbox"/> Pneumonia/Bronchitis   | <input type="checkbox"/> Polio                | <input type="checkbox"/> Rash               | <input type="checkbox"/> Rheumatic fever      |
| <input type="checkbox"/> Scoliosis              | <input type="checkbox"/> Seizure disorder     | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Small Pox            |
| <input type="checkbox"/> Spinal Bifida          | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Thyroid problems   | <input type="checkbox"/> Tonsillectomy        |
| <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Varicose veins       | <input type="checkbox"/> Whooping cough     | <input type="checkbox"/> Other*               |

Explanation of (\*) item(s): \_\_\_\_\_

## Experience with Chiropractic

Has your child seen a Chiropractor before?  Yes  No Who? \_\_\_\_\_

Reason for visit(s): \_\_\_\_\_

Did the previous chiropractor take 'before' and 'after' x-rays?  Yes  No What was the diagnosis? \_\_\_\_\_

Did he or she recommend a specific course of treatment?  Yes  No Did they recommend a Home Health Care program?  Yes  No

If yes, what? \_\_\_\_\_

How long was your child treated? \_\_\_\_\_ Last treatment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

How did your child respond? \_\_\_\_\_

Are you aware of any poor posture habits in your child?  Yes  No Is there any history of spinal problems in your family?  Yes  No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Pregnancy Release

This is to certify that to the best of my knowledge that my child is not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my child's spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if my child/charge does not follow the doctors and/or staff's specific recommendations at this clinic that he/she will not receive the full benefit from these programs; and that if I terminate this care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient's Name Printed \_\_\_\_\_

If patient is not your biological child, but a legal charge requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded \_\_\_\_\_ County, State of Guardianship \_\_\_\_\_

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## In Case of Emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

## Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

## DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services?  Yes  No

Signature of Person Authorizing Care:

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ Policy# \_\_\_\_\_

Address Phone # ( ) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Policy# \_\_\_\_\_

Address Phone # ( ) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_



## NOTICE OF PRIVACY POLICIES CHIROSOLUTIONS CENTER

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.

### Understanding Your Health Record/Information

Each time you visit the office, a record is made of your visit. Typically, this record contains any symptoms you may report, our assessment of you on that day, any change to your diagnosis, what procedures we performed, and any change in your care plan. This information serves many purposes:

- it helps us track your care and progress toward your health goals
- it serves as a means of communication to other health professionals involved in your health care
- it is a legal document describing the care you received
- it allows a third-party payer (insurance company) to verify that the services billed were actually provided
- it can be used as a source of data for research
- it helps you track your care and gives you a way to make sure we have accurate records about you

### Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information in it belongs to you. You have the right to:

- request restrictions as to how your information is used or disclosed as provided by 45 CFR 164.522
- obtain a paper copy of this notice upon request
- inspect and obtain a copy of your health record as provided by 45 CFR 164.524
- make amendments to your record as provided by 45 CFR 164.528
- obtain a record of any disclosures we've made as provided by 45 CFR 164.528
- request confidential means of communicating your health information to you from our office

### Our Responsibilities

Our office is required to:

- maintain the privacy of your health information
- provide you with a copy of this notice
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction from you
- accommodate reasonable requests from you regarding communications from our office to you

We reserve the right to change our privacy practices as necessary and to make the new provisions effective for all protected health information we maintain. Should our privacy practices change, we will supply a copy of our revised notice. We will not use or disclose your health information without your authorization, except as described in this notice.

### For More Information or to Report a Problem

If you have questions or need additional information, please contact our health information director, Dr. Samantha Coleman, D.C. at (757) 271-0001. If you believe your privacy rights have been violated, you can file a complaint with our health information director or with the Secretary of the U.S. Department of Health and Human Services. There can be no retaliation for filing any complaints.

## Examples of Disclosures for Treatment, Payment and Health Operations

### 1. How we may use your health information for treatment:

- First, we have chosen to work in an open office environment, meaning that all patient treatment is done in an open treatment area. We have found that this environment is conducive to learning and enables us to provide the highest quality of service to our patients. Of course, all consultations, exams, x-rays and financial discussions will be handled in the privacy of a separate room.
- Our patients' names may appear in a variety of places around the office. For example, all of our patients sign in on our daily sign in sheet. We have a Lifetime Wellness Wall that once patients graduate to maintenance care, their name will be displayed.
- We often display photos of office events like our Patient Luncheon or community events we're involved in.
- On occasion, Dr. Samantha Coleman, D.C. will use a patient's x-rays to help another patient see what can be achieved with corrective chiropractic care. Patient's names do not appear on the X-Rays, however.
- Lastly, patient names may appear on our office mailings, postcards, newsletters, Facebook and website.

### 2. How we may use your health information for payment:

A bill for services may be sent to you or to your insurance company or other third party payer. Information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and any supplies used.

Patient Print/Sign:

**3. How we may use your information for daily clinic operations:**

- Members of the Chiropractic Solution Center, P.C. have access to your health information for the performance of reasonable job-related tasks such as scheduling, appointment reminders, insurance filing, report preparation, data gathering, communications with family members involved in your care, etc.
- Certain business associates of Chiropractic Solution Center P.C. may have access to your health information for the performance of outside services. These include any outside diagnostic services, lab testing services, insurance claims filing, attorneys handling legal aspects of a case and collections matters. To protect your health information, we require our business associates to appropriately safeguard your information through a signed agreement.
- Other disclosures: We may disclose health information about you to Workers Compensation programs, public health officials, the FDA, or law enforcement officials as required by state and federal law.

**PRODUCT RETURN/EXCHANGE NOTICE**

We are unable to accept any return/exchange for any item purchased from our office if it has been used/opened. This includes, (but not limited to) supplements, denerolls, pillows, back supports, seat cushions, Smart Weigh Food, shoe inserts, heel lifts and protein powder.

If an item is unopened/unused, it may be returned for a credit to your account (not a refund of purchase price) within in 1 week of purchase date and verification of purchase here. There is a 25% restocking fee for any unopened/unused item returned.

**Effective Date: August 31, 2013**

**Updated: November 7, 2018**

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I have been presented with a copy of Chiropractic Solution Center, P.C.'s **Notice of Privacy Policies**, detailing how my health information may be used and disclosed as permitted under state and federal law. I understand the contents of the notice and I request the following restrictions concerning the use of my personal health information:

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by the patient, please indicate relationship to patient (ex. mother, father)

Relationship: \_\_\_\_\_ Witnessed By: \_\_\_\_\_

IF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW:

q Patient refused to sign this acknowledgement

Employee Name/Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ChiroSolutions Center

### Policies and Procedures

In order to better serve you and make your time more efficient while you are here, the following policies and procedures are mandatory. Please initial by each one and print, sign and date at the bottom.

\_\_\_ While it's understood that emergencies and interruptions are a part of life, appointments that are not cancelled with at least a 24 hours' notice will be charged \$25. This will be due at the beginning of your next appointment with us or a bill will be mailed to you. In the event a 24-hour notice is not given, you will be responsible for the missed appointment fee unless it is a mutually agreed upon emergency.

\_\_\_ If you are going to be more than 5 minutes late, please call the office. (757-271-0001)

\_\_\_ Talking to friends/family members and on cell phones will not be permitted during traction. Ear phones are ok to use with your cell phone to listen to music. We appreciate your mindfulness of this during your appointment.

#### **All stations are a first come, first serve; which means....**

1. Drop off all personal items in a cubby before proceeding to a station. This will make for a smoother transition from station to station.
2. If you are waiting for an adjustment and a table is free, please go ahead and get ready (take glasses off, empty pockets, etc.) and lay down. This will better prepare your body for your adjustment and give you the appropriate amount of time with Dr. Coleman.
3. If there is a power plate free and you need to complete your posture exercises, etc. please go ahead and get started. Hadley and/or Zoe will be over to check in and answer any questions.
4. If you are waiting for traction and there is a table/chair free, please go ahead and sit down and we will be right over to put you in traction.

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Patient Name

Patient Signature

Date

ChiroSolutions Center  
287 Independence Blvd., Ste 118  
[chiroresolution1@hotmail.com](mailto:chiroresolution1@hotmail.com)  
757-271-0001  
[www.mychiroolutions.com](http://www.mychiroolutions.com)

The Chiropractic Physician has offered to communicate using the following means of electronic communication [check all that apply]:

- Email
- Videoconferencing (including Skype®, FaceTime®)
- Text messaging
- Website/Portal
- Social media (specify): Facebook, Instagram, Twitter, YouTube
- Other (specify): MailChimp

**PATIENT ACKNOWLEDGMENT AND AGREEMENT:** I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Chiropractic Physician and the Chiropractic Physician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Chiropractic Physician may impose on communications with patients using the Services. I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Chiropractic Physician or the Chiropractic Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Chiropractic Physician or the Chiropractic Physician's staff using these Services with a full understanding of the risk. I acknowledge that either I or the Chiropractic Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

Patient Email: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_