PEDIATRIC INTAKE at WALK-IN CHIROPRACTIC, LLC

2001 N. Atlantic Ave, Cocoa Beach, FL, 32931

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued …

Please complete the following where indicated and return to our front desk staff.

Patient initials: _____ **- retaining *page 1 of 2***

I hereby acknowledge I have read and received a copy of Walk-In Chiropractic, LLC Privacy Practices Notice.
I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.
I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.
I am aware an extended detail version of this "Notice" is available to me upon request.
At this time, I do not have any questions regarding my rights or any of the information I have received.

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

Name of Patient: _____

Signature: _____ Telephone: _____

HIPAA Personal Health Information Release

I, _____, hereby authorize Walk-In Chiropractic, LLC to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ○ Spouse Name: _____
- ○ Significant Other Name: _____
- ○ Parent/Legal Guardian Name: _____
- ○ Child(ren) Name(s): _____
- ○ Any Specified Person Name: _____
- ○ Information is not to be discussed with or released to anyone.

Restrictions:

- ○ No Restrictions
- ○ Only discuss my appointment time with the above-named individual(s).
- ○ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ○ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call: ○ my home ○ my work ○ my cell phone Number: _____

If unable to reach me:

- ○ you may leave a detailed message
- ○ please leave a message asking me to return your call
- ○ _____

I understand I may terminate this consent at any time by giving written notice to [Insert Practice Name]. Any changes to this form will require a new consent form to be completed, signed, and dated.

Patient or Authorized Person's Signature _____ Date Completed _____

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INFORMED CONSENT REGARDING:
Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at [Insert Practice Name] have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

CONSTENT TO INITIATE CARE

I have one simple goal - I want to render the highest quality Chiropractic care at the lowest possible fee. To accomplish this goal, I have some business procedures to keep my fees reduced. Please read over these procedures below to understand how this office functions and decide if you wish to participate. If you have any questions, please ask.

- You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. We take no responsibility for non-payment by insurance companies for services rendered at our office.
- Our office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may request a copy of their records at no charge.
- No balances can be kept or run by patients at any time.
- All adjustment visits are paid immediately prior to the service being rendered.
- All initial visits are paid for upon completion of these services.
- Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served. You will be given a list of other providers who may serve you better.

I wish to initiate care at this office. I understand that I am directly and fully responsible to WALK-IN CHIROPRACTIC, LLC and or Dr. Bret Glas, D.C. for all fees associated with chiropractic care I receive. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

WORK-RELATED INJURIES, AUTOMOBILE ACCIDENT INJURIES OR PERSONAL INJURIES & PURPOSE OF AN ADJUSTMENT DISCLOSURE

By signing below, I acknowledge that I am aware that Walk-In Chiropractic, LLC and Bret Glas, D.C. reserves the right to not provide care for work related injuries, automobile accident injuries or personal injuries unless agreed upon in writing by the patient and Walk-In Chiropractic, LLC and Bret Glas, D.C. I also acknowledge that I must inform this office if I am in a work-related injury, automobile accident injury or personal injury and must seek care at my medical doctor's office or another healthcare provider for injuries or conditions sustained. I am also completely aware that Walk-In Chiropractic, LLC and Bret Glas, D.C. will not bill, submit claims nor prepare or submit reports for any work-related injury, automobile accident injury or personal injury claim. I also understand that I am responsible to pay each visit myself at the time of service.

Furthermore, I understand that chiropractic care is given to correct spinal misalignments called Subluxations. One of the benefits of a chiropractic adjustment is that you MAY feel better, but this is not the GOAL of an adjustment. The goal of a chiropractic adjustment is to correct SUBLUXATIONS, thereby removing the interference to the nervous system allowing the body to heal itself. As a result, Walk-In Chiropractic, LLC and Bret Glas, D.C. DOES NOT TREAT PAIN OR DISEASE; we remove subluxations, so the body is able to function properly and be better enabled to heal itself.

Patient Name (print)	Patient Signature	Date
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date

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PATIENT DEMOGRAPHICS **Todays date:____-____-____**

Child's Name: _____ Birthdate: ____-_____-_____ Age: _____ ○ Male ○ Female

Birth Height: _____ Birth Weight_____ Current Height: _____ Current Weight: _____

Address: _____City: _____State: _____ Zip: _____

Mother's Name: _____Birthdate: ____-_____-_____

Mother's Phone: Home _____Work_____ Mobile_____

Father's Name: _____Birthdate: ____-_____-_____

Father's Phone: Home _____Work_____ Mobile_____

Pediatrician/Family MD: _____ City/State:_____

Last Visit Date: _____-_____-_____ Reason for visit:_____

○ Other *(please explain)*: _____

CHILD'S CURRENT PROBLEM

Purpose of this visit: ○ Wellness Check-up ○ Injury or Accident ○ Other

Please explain: _____

If your child is experiencing **pain/discomfort, please identify where and for how long:**_____

_____

1. When did the problem first begin? Date: _____-_____-_____ ○ Unknown ○ Gradual ○ Sudden
2. Has this problem occurred before? ○ No ○ Yes If yes, when? _____
3. Any bowel or bladder problems since this problem began? ○ No ○ Yes **If yes,** describe: _____

   _____
4. Have you seen any other doctors for this problem? ○ No ○ Yes **If yes**, whom? _____

   _____
5. How long ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatment? _____
7. How is this problem NOW?

   ○ Rapidly Improving ○ Improving Slowly ○ About the Same ○ Gradually Worsening ○ On and Off
8. Please list any medication(s) taken for this problem: _____

   _____
9. Has your child ever sustained an injury playing organized sports? ○ No ○ Yes **If yes,** please explain:_____

   _____
10. Has your child ever sustained an injury in an auto accident? ○ No ○ Yes **If yes,** please explain:_____

    _____

Dr. Bret Glas Signature: _____ Date Reviewed_____

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HAS YOUR CHILD EVER SUFFERED FROM - *Check all that apply*

○ Headaches	○ Orthopedic Problems	○ Digestive Disorders	○ Behavioral Problems
○ Dizziness	○ Neck Problems	○ Poor Appetite	○ ADD/ADHD
○ Fainting	○ Arm Problems	○ Stomach Aches	○ Ruptures/Hernia
○ Seizures/Convulsions	○ Leg Problems	○ Reflux	○ Muscle Pain
○ Heart Trouble	○ Joint Problems	○ Constipation	○ Growing Pains
○ Chronic Earaches	○ Backaches	○ Diarrhea	○ Asthma
○ Sinus Trouble	○ Poor Posture	○ Hypertension	○ Walking Trouble
○ Scoliosis	○ Anemia	○ Colds/Flu	○ Sleeping Problems
○ Bed Wetting	○ Colic	○ Broken Bones	○ Fall off swing
○ Fall in baby walker	○ Fall from bed or couch	○ Fall from crib	○ Fall down stairs
○ Fall off bicycle	○ Fall from high chair	○ Fall off slide	
○ Fall from changing table	○ Fall off monkey bars	○ Fall off skateboard/skates	

○ Allergies to: _____

_____

○ Other: _____

_____

I understand that I am directly and fully responsible to WALK-IN CHIROPRACTIC, LLC and or Dr. Bret Glas, D.C. for all fees associated with chiropractic care I receive.

The risks associated with spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____

Dr. Bret Glas Signature **Date Form Review**