



TERMS OF ACCEPTANCE

When a person 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 one important goal. It is important that each patient 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 the specific application of forces to facilitate the body’s correction of vertebral subluxation. Our chiropractic method of correction is 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 its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body’s innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO CARE

I do hereby authorize the doctors of HOLLENBACH FAMILY CHIROPRACTIC to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments or any other procedure which is advisable and necessary for my health.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____ have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Signature: _____ Date: _____

Consent to evaluate and adjust a minor child (under 18 yoa):

I, _____, being the parent or legal guardian of _____ Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Parent or Legal Guardian’s Signature

Date

**NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION**

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health providers. An example of this would include a physician examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payments.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointments reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

To have the following rights with respect to your health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information. Including those related to disclosures to family members, other relatives, close personal friends, or any person identified by you. We are however, not required to agree to a request restriction. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquires, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257/Toll Free: 1-877-696-6775

I, _____ have read and understand these guidelines above.

Patient Signature: _____

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 changes 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 policy 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 Dr. Hollenbach.

This notice is effective as of _____. 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 Name

Personal Representative Signature

Date

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



Pediatric History Form

Dear New Patient,

It is a pleasure to welcome you to our family of healthy and happy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ Email: _____

Sex: M F Weight: _____ Height: _____ Date Of Birth: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Referred by: _____

Name of Parents/Guardians: _____ Parent/s Work Ph #: _____

Purpose for contacting us: _____

Have other Doctors been seen for this condition? No Yes If yes, Doctors' Names and Prior Treatments: _____

Other Health Problems?

Check any of the following conditions your child has suffered from during the past six months:

- Ear Infections Scoliosis Seizures Chronic Colds Headaches
 Asthma / Allergies Digestive Problems ADD / ADHD Recurring Fevers Growing/back pains
 Colic Bed Wetting Car Accident Temper Tantrums Other

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason: _____

Number of antibiotics your child has taken in: _____

Past 6 months: _____ Total during his/her lifetime? _____

Number of doses of other prescription medications your child has taken in: _____

Past 6 months: _____ Total during his/her lifetime? _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications during pregnancy: No Yes List: _____

Ultrasounds during pregnancy: No Yes List: _____

Medications during pregnancy / delivery: No Yes List: _____

Cigarette / alcohol use during pregnancy: No Yes List: _____

Location of Birth: _____ Hospital Birthing Center Home

Birth intervention: Forceps Vacuum extraction Caesarian:- Emergency Planned

Complications during delivery: No Yes List: _____

Genetic disorders or disabilities: No Yes List: _____

Birth weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding history:

Breast fed: No Yes How long: _____ Formula fed: No Yes How long: _____

Introduced to solids at: _____ months Cows milk at: _____ months

Food/juice allergies or intolerances: No Yes List: _____

Developmental history:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to sound: _____ Respond to visual stimuli: _____

Hold head up: _____ Sit up: _____

Cross crawl: _____ Stand Alone: _____

Walk alone: _____

According to the National Safety Council, approximately 50% of all children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs etc.). Was this the case with your child? No Yes

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)?

No Yes List: _____

Has your child ever been involved in a car accident? No Yes When? _____

Has your child been seen on an emergency basis? No Yes When/why? _____

Other traumas not described above? No Yes List: _____

Prior surgery? No Yes List: _____

Menarche: No Yes Age: _____

Childhood diseases:

Chicken Pox: No Yes Age: _____ Mumps: No Yes Age: _____

Rubella: No Yes Age: _____ Whooping cough: No Yes Age: _____

Rubeola: No Yes Age: _____ Other: No Yes Age: _____

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results.

Authorization for care of a minor

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____

Date: _____