Name of Parent ______________________________

Address ______________________________

City/State/Zip ______________________________

Phone # (Work) ____________________ (Hours ___ to ___)

Home # _________________Cell # __________________

E-mail ______________________________

Insurance Company ______________________________

Policy ID# _____________________ Group # ____________

Name of Child _________________________Date________

Address/Phone (if different from parent)

____

____

Phone # ______________________ Sex □ M □ F

Date of Birth _______________________ Age ___________

Medical Doctor ______________________________

Date of Last Visit ______________________________

During pregnancy, were you on medication? Did you smoke or consume any alcoholic beverages? □ Yes □ No

If so, what? ______________________________

Was there back pain? □ Yes □ No ______________________________

Approximately how long was labor? ______________________________

____

Were you physically ill? (Colds, flu, allergies, German measles, anything like that?) □ Yes □ No

If so, what? ______________________________

Regarding Labor:

Was it chemically induced? □ Yes □ No

Doctor assisted? □ Yes □ No

Was a C-Section performed? □ Yes □ No

Were forceps used? □ Yes □ No

Did doctor have hands on the infant? □ Yes □ No

Were you lying down? □ Yes □ No

Was family member present? □ Yes □ No

If so, who? ______________________________

(95% of all infants were born with hands on or forceps)

Was the baby premature? □ Yes □ No

If so, what was his/her age and weight? ______________________________

Has your child been vaccinated? □ Yes □ No

Was your child breastfed? □ Yes □ No If yes, for how long? ______________________________

Did your child suffer any health problems, such as:

Headaches	□ Yes	□ No	Meningitis	□ Yes	□ No
Allergies	□ Yes	□ No	Diarrhea	□ Yes	□ No
Ear Problems	□ Yes	□ No	Constipation	□ Yes	□ No
Sleeping Disorders	□ Yes	□ No	Colic	□ Yes	□ No
Breathing Problems	□ Yes	□ No	Rashes	□ Yes	□ No
Fatigue	□ Yes	□ No	Milk or Lactose Intolerance	□ Yes	□ No
Irritability	□ Yes	□ No	Bed Wetting	□ Yes	□ No
Hyperactivity	□ Yes	□ No	Digestive Problems	□ Yes	□ No
Frequent Colds	□ Yes	□ No	Latching Difficulty	□ Yes	□ No
Flu	□ Yes	□ No	Other: ____________________		
Bloody Noses	□ Yes	□ No	____________________		

Regarding your child today:

Is your child accident prone: □ Yes □ No

Has the child had any falls down steps?
□ Yes □ No

Has your child ever fallen from heights over 2 feet?
□ Yes □ No

Has your child ever been involved in a motor vehicle accident?
□ Yes □ No

Has your child ever been hospitalized or had surgery?
□ Yes □ No

Does your child suffer from:

Allergies □ Yes □ No

Asthma □ Yes □ No

Headaches □ Yes □ No

Has your child ever had any broken bones or sprain injuries?
□ Yes □ No

Is your child on any medication? □ Yes □ No
If so, what? ____________________

Has your child had a scoliosis examination by an approved Scoliosis determination procedures clinic? □ Yes □ No

Is your child hyperactive? □ Yes □ No

Have learning disorders? □ Yes □ No

Sleeping difficulty? □ Yes □ No

Poor posture? □ Yes □ No

Does your child have any problem associating with friends? □ Yes □ No

Is your child nervous, or has anyone suggested that your child was nervous? □ Yes □ No

Does your child show any signs of nervousness, twitching or excessive talking to themselves? □ Yes □ No

If you could improve one aspect of your child's health or behavior, what would it be? ____________________
____
____

AUTHORIZATION

I, ______________________________, certify that Dr. Teresa Melton does not claim to cure any illness or disease. I understand that I am to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.

I hereby give permission to Dr. Teresa Melton to release any private health information necessary in treatment, payment or health care operations. I authorize the use of my signature on all insurance claim submissions. I understand I may revoke this release only in writing. I understand that this office does leave voicemail messages if they are unable to contact patients, unless instructed in writing not to do so.

I hereby understand that payment is expected when services are rendered unless other arrangements are made in advance. I also understand that I am responsible for all bills and any collection expenses incurred at this office.

I, the undersigned, assign directly to Dr. Teresa Melton all insurance benefits, if any, otherwise payable to me for services rendered.

I fully understand and agree that the insurance policies are an arrangement between an insurance carrier and myself. I understand I am financially responsible for all charges whether or not they are paid by insurance, and I may be billed if necessary for additional costs incurred in the collection of these accounts. I understand that it is ultimately my responsibility to know and understand my insurance plan.

I also understand that insurance benefits are not a guarantee of insurance coverage.

I hereby give permission to the doctor to administer treatment and perform such general procedures as she deem necessary in the treatment of my condition.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I certify that I have read and understand the above information and that it is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's/Guardian's Signature ____Date_______________

PLEASE PRESENT YOUR INSURANCE CARD AND A PHOTO ID
A copy will become part of your medical record.

FINANCIAL POLICY

Communication with our clients regarding our financial policy assists us in providing the best possible service to you. Please read the following. Your initials and signature are required. Thank you.

- **______ Private Pay/Cash Patient – (clients without BC/BS insurance) Full payment is required when services are rendered to continue treatment OR payment arrangements need to be agreed upon.**
- **______ Insurance Reimbursement – Clients are required to contact their insurance company to verify their deductible status and the amount of coverage for chiropractic, acupuncture and massage therapy available to them. We will also be contacting your insurance company to verify your coverage. <u>It is important to remember that what the insurance tells us is not a GUARANTEE of payment from them.</u>**
- **______ Deductible and Co-payment - If you have not met your deductible, you will be required to pay the full amount of each visit until you have met it. We require your co-payment or co-insurance at the time of service. If you do not know what your co-insurance is, a minimum of 20% is due at the time of service. Any charges that your insurance company does not pay for or denies will be the patient's responsibility.**
- **_______ Purchasing Products – Payment for all products is the patient's responsibility. Payment for products is due at the time of purchase. As a courtesy to you, we will bill your insurance company. If your insurance company does pay for the product, we will credit/refund your account.**

AGREEMENT TO PAY

I understand that the agreement with my health insurance is an agreement between them and me. I take full responsibility for payment of all charges for professional services rendered. I understand the financial policy detailed herein. I understand that I am responsible for all charges regardless of my existing medical coverage.

Checks, which are declared non-sufficient funds, will be charged a $25.00 service fee. Also, there is a $5 monthly late charge assessed on all balances after 30 days past due. The undersign agrees to pay a collection fee of 33% of the total owed when sent to collection, all attorney fees and court costs incurred by the creditor. All the information provided is correct.

Consent for Treatment/Release of Insurance Assignment Medical Information.

YES____ NO____ I authorize any and all therapy services that the provider feels necessary.

YES____ NO ____ I assign payment of medical benefits directly to Allergies, Aches & Pains.

YES____ NO_____I authorize Allergies, Aches & Pains to leave voicemail messages regarding my appointments. Should I decide that I no longer wish to have messages left, I understand that a written request must be made.

YES ____NO____ I hereby authorize Allergies, Aches & Pains to release to my insurance company, health plan, or insurance group, any medical records or information concerning the treatment to obtain reimbursement on my behalf for the treatment or service provided by Allergies, Aches & Pains. I understand that I may revoke the consent to release information to third parties at any time and that the provision of services is not conditional on my agreement to disclose information to the parties. If I revoke my consent, I will be responsible for paying for all services rendered by Allergies, Aches, & Pains.

I have read , understand and agree to this financial agreement in its entirety.

SIGNATURE **DATE**

Patient Missed Appointment Policy

It is our wish that each and every one of our patients receive the very best care and service possible. Your Treatment Program consists of a recommended series of treatments. If you do not follow this plan, then you will not receive the desired results.

If we did not request that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few guidelines that we ask you follow:

1. Meet all of your scheduled appointments.

2. If you become ill, we still want you to come in, because Chiropractic and/or Acupuncture will help you recover.

3. If you are unable to keep your appointment, please call us and let us know so that we may fill your appointment time with someone on the waiting list.

4. With the exceptions of unexpected emergencies, we request that you notify us 24 hours in advance as to any appointment changes. Appointment confirmation calls will be made 24-48 hours in advance of your scheduled appointment.

5. In order to achieve/maintain the desired results, canceled or missed appointments should be rescheduled within one week. However, the frequency of your visits is your decision.

6. There is a $25.00 service charge for missing an appointment. This charge will be added to your account at the time of your missed appointment.

I have read, understand and agree to follow the above policy.

Patient’s Name: ____

Signature: ____

Staff Witness: ____

HIPAA Notice of Privacy Practices

Allergies, Aches, & Pains Chiropractic & Acupuncture Center

Teresa K. Melton D.C.

130 N. Fair St.

Sycamore, IL 60178

(815)895-2059

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.

Allergies, Aches, and Pains is dedicated to protecting your medical information. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses & Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage you health care and any related services. This includes the coordination or management of your health care with a third party.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example: obtaining approval for a procedure may require that your relevant personal health information be disclosed to the health plan to obtain approval for the procedure.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Servces to investigate or determine our compliance with the requirements of Section 164.500.

Authorizations

We will not use or disclose your medical information for any other purpose without your written authorization. To request a Revocation of Authorization form, you may contact:

Allergies, Aches, and Pains

130 N. Fair St.

Sycamore, IL 60178

Your Rights Regarding Your Medical Information:

You have the following rights with respect to your medical information:

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.

- You may ask us to amend your medical information. We may deny your request for specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by AAP during the last six years, except for disclosure for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You may request a paper copy of this Notice of Privacy Practices for personal health information.
- You have the right to complain to us and/or the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

Allergies, Aches, and Pains

130 N. Fair St.

Sycamore, IL 60178

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact the above address.

THIS NOTICE IS EFFECTIVE AS OF JANUARY 1, 2011

Revision of Notice of Privacy Practices:

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at AAP and will make paper copies of the revised Notice of Privacy Practices available upon request.

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that protected health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your protected medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose protected health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your protected health information, but this MUST be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your protected health information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your protected health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_______________________Signature__________________________Date________

Compliance Assurance Notification For Our Patients

To Our Valued Patients:

The misuse of protected health information has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of protected health information in accordance with the government rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of protected health information. As part of this plan, we have implemented a compliance program that we believe will help us prevent any inappropriate use of protected health information.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients!