

MAXWELL FAMILY CHIROPRACTIC CENTER, P.C.

KAREN MAXWELL, BS, DC, FICPA

1298 Roanoke Road, Daleville, VA 24083

(540) 992-3354 Fax: (540) 992-5067

www.maxwellchiropractic.com

Welcome to our **Family Chiropractic Office**

Thank you for choosing our office for chiropractic care. We are committed to providing you and your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an active, healthy, life. We will be working together to help you and your family reach your health and wellness goals.

If you ever have any questions about your chiropractic care, please do not hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report and your Human Potential Program.

We look forward to a long, healthy relationship with you and your family.

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CHILD HISTORY FORM

Date _____ Patient # _____

Name _____ Nickname _____

Parent's/Guardian's Name _____ S.S.# _____

Home Address _____

Parent's Phone: Home _____ Cell _____ Work _____

Parent's Email: _____

Birth Date _____ Age _____ Height _____ Weight _____ Number of Siblings _____

Referred To This Office By _____

Reason for contacting us? _____

Other Doctors Seen for This Condition _____ Result _____

Pediatrician/Family M.D. _____

Name _____ Location _____

Has this child had previous Chiropractic care? Yes ___ No ___ If, yes, where? _____

Is your child currently taking any prescription or over-the-counter medications or herbs?

Prenatal History

Name of Obstetrician/Midwife _____

Problems During Pregnancy _____

Y N Experience any physical trauma (falls or injuries)? _____

Y N Have any ultrasound studies or Doppler-tones? If so, how many? _____

Y N Eat a well-balanced diet? **Y N** Smoke tobacco? **Y N** Drink alcohol? _____

Y N Take any drugs or medications? _____

Y N Have any emotional trauma or difficulty? _____

Birth Information

Hospital Birth _____ Home Delivery _____ Birthing Center _____

Birth Intervention: Labor Induced ___ Forceps ___ Vacuum Extraction ___

Cesarean ___ Planned **Y N** Breech ___ Position _____ Medication during labor **Y N** _____

Was there any 'pulling' by the doctor or midwife? _____

Problems During Labor/Delivery _____

Birth Weight _____ Birth Length _____ Apgar Scores _____

After birth, was there a presence of: Jaundice (Yellow) _____ Cyanosis (Blue) _____

Congenital Anomalies/Defects _____

Feeding History

Infant Feeding and Duration: Breast _____ Formula _____ Introduced to Solid Foods at ___ months Introduced to cow's milk at _____ months Food Allergies _____

Developmental History

During the following times your child’s spine is most vulnerable to stress and should routinely be checked by a Chiropractor for early detection and correction of vertebral subluxations (nerve interference) At what age was your child able to: ___Respond to sound ___Follow object with eyes ___Hold head up ___Sit alone ___Crawl ___Stand ___Walk Alone ___Roll over

This child is: Right handed ___ Left Handed ___ Ambidextrous ___ Not yet known ___

Accidents/Traumas

According to the National Safety Council, approximately 50% of 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? _____

Is/has your child been involved with any high impact or contact type sports (soccer, football, gymnastics, baseball, cheerleading, martial arts)? _____

Has your child ever been involved in a car accident? _____ Dates _____ Type _____

Has your child ever been seen in the emergency room? _____ Reason _____

Other traumas/surgeries not yet described? _____

Childhood Diseases: If any, please indicate at what age:

Chickenpox _____ Mumps _____ Rubella _____ Rubeola _____ Whooping Cough _____

Other _____

Antibiotics prescribed – Number of doses _____

Other prescription or non-prescription Medication (Tylenol/aspirin/etc.)

During past six months: _____ Total during child’s lifetime _____ List them _____

Vaccination History _____

Has your child ever been diagnosed with or suffered from:

- | | | | |
|------------------------|-----------------------|----------------------|-----------------------|
| ___ Ear Infections | ___ Headaches | ___ Growing Pains | ___ Chronic Colds/flu |
| ___ Dizziness | ___ Backaches | ___ Bed Wetting | ___ Scoliosis |
| ___ Fainting | ___ Neck Problems | ___ Seizures | ___ Asthma |
| ___ Allergies | ___ Muscle Jerking | ___ Arm/Leg Problems | ___ Anemia |
| ___ Pneumonia | ___ Cancer | ___ Joint Problems | ___ HIV/AIDS |
| ___ Ruptures/Hernias | ___ Broken Bones | ___ Poor Appetite | ___ Sore Throats |
| ___ Sinus Trouble | ___ Skin Problems | ___ Diabetes | ___ Walking Problems |
| ___ Digestive Problems | ___ Numbness | ___ Rheumatic Fever | ___ Paralysis |
| ___ Colic | ___ Behavior Problems | ___ Appendicitis | ___ Arthritis |
| ___ Constipation | ___ Hyperactivity | ___ Meningitis | |
| ___ Diarrhea | ___ ADHD/ADD | ___ Encephalitis | |
| ___ Other _____ | | | |

Family History Have the child's parents, siblings, or grandparents ever experienced problems with any of the following:

- | | | | |
|--------------------------------|---------------------|------------------|--------------------|
| ___ Diabetes | ___ Thyroid Disease | ___ Tuberculosis | ___ Kidney Disease |
| ___ High blood pressure | ___ Heart disease | ___ Arthritis | ___ Cancer |
| ___ other family history _____ | | | |

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

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CONSENT FOR TREATMENT OF MINOR

Chiropractic care is a mutual undertaking between the patient and the doctor. As a patient, you should be searching for a health care facility that can determine your problem, and care for your health care needs. We take pride in being such an office. We are a Subluxation based facility and determine your level of care based on the removal and management of the Vertebral Subluxation Complex. You are encouraged to participate in our many educational programs that outline the reality of the Subluxation and the benefits of chiropractic care. We welcome your questions and concerns, and hope that a clear channel of communications will always prevail.

Prior to our accepting you as a patient, we want you to be satisfied that you understand your problem; what can and cannot be done to assist you and outline to you a schedule of corrective care. Chiropractic has only one 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.

We do **not** offer to diagnose or treat any disease or conditions other than the vertebral subluxation. Nor do we offer advice regarding treatment prescribed by others. We will be detecting and correcting your Subluxation using a very specific adjustment to the spinal column. This is our only practice objective. If you realize that health comes from within your body and that chiropractic removes interference to the healing force, you've got the big idea!!!

Being the parent/guardian of _____, a minor, I authorize, request, and direct Dr. Karen Maxwell to perform in her judgment any necessary examination, X-ray(s), and chiropractic adjustments necessary for their care. I have also read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature

File #

Date

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Office Fee Schedule and Financial Policy

Chiropractic Consultation	\$50.00 to \$100.00
Comprehensive Exam and Case History	\$65.00 to \$85.00
Comprehensive Progressive Exam	\$55.00
X-Rays (per view)	\$35.00
Chiropractic Office Visits, Brief Exams and Spinal Adjustments	
One or Two Areas of the Spine	\$45.00
Three or Four Areas of the Spine	\$45.00
Five Areas of the Spine	\$50.00
Extremity Adjustment	\$50.00
BEST or Cranial Adjustment	\$55.00
Spinal Mechanical Traction	\$20 Per Unit
PH Testing	\$10.00
Supplies and Nutritional Supplements	Vary according to supply

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time service is rendered unless you arrange an Active Life Plan in advance. We expect you to honor the financial agreements you make with our office. If you find you cannot do so, please advise our staff immediately so new arrangements can be made. These Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report. Please understand that all responsibility for payment for services provided in this office for yourself or for your dependents is yours. In the event that payments are not received by the agreed upon dates, a 5% monthly finance charge will be added to your account until the balance is paid. Account balances greater than 90 days will be turned over to collections. In the event that you default on your payments, all legal interest, collection costs and legal fees will be your responsibility.

- ❑ **Health Insurance:** If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed quickly. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. If your insurance company requires documentation to substantiate your claim we will provide a copy of your records at a cost of \$20.00 up to 40 copies and \$0.25 each additional page. We have found it is easier for your record keeping, and ours, if we give you receipts and /or forms at the end of your initial visit and then once a month after that. Just send in your receipts with a copy of your claim form and your insurance company will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.
- ❑ **No Health Insurance:** You will be given a receipt for tax purposes or medical savings accounts (MSA) indicating the total amount you have paid for chiropractic care during the year. There are no insurance codes given with these receipts.
- ❑ **Medicare:** We will be submitting your Medicare claims for you. We are non-participating providers and fees are due as service is rendered.

I have read and I understand the above policies. I have initialed the one that applies to me.

Patient 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.

I. In the course of your care as a patient at Maxwell Family Chiropractic Center, P.C., we may use or disclose personal and health related information about you in the following ways:

A. Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

B. Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

We are permitted and may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

- If we provide services to you in an emergency treatment situation.
- If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.
- If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition, or death.
- If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.
- If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse, neglect, or domestic violence
- If we are required to disclose your health information to the Food and Drug Administration.
- If we are required to disclose your health information in response to a court order or a subpoena or a law enforcement official.
- If we are required to disclose your health information to a coroner, medical examiner or funeral director.
- If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.
- I understand Maxwell Family Chiropractic Center, P.C. may use my name, address, phone number, and email to contact me with birthday cards, holiday related cards and announcements regarding patient appreciation days and/or other special occasions, and information about treatment alternatives or other health related information. I am also aware that on specific occasions photographs may be taken and posted within the office or placed in a photo album for others to see.
- If I have given, or will give in the future, a written testimony as to my health care with Maxwell Family Chiropractic Center, PC, I give permission to share this information in whatever manner they deem appropriate

II. Your Rights

A. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official, Dr. Karen Maxwell.

B. Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request must be made in writing to our Privacy Official, Dr. Karen Maxwell. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

C. Right to Receive Notice. You have the right to receive a paper copy of this notice, upon request.

III. Our Duties

We are required by state and federal law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this notice, we will notify you in writing and provide you with a paper copy of the new notice, upon request. 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 privacy rules.

IV. Complaints

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. Karen Maxwell. You also have the right to lodge a complaint with the Secretary of Health and Human Services. You may file a complaint with us by writing to our Privacy Official, Dr. Karen Maxwell, at the address that follows. We will not take any action against you for filing a complaint.

V. How to Contact Us

If you would like further information about our privacy practices, please contact Dr. Karen Maxwell 1298 Roanoke Road, Daleville, VA 24083. Effective Date of Notice: April 14, 2003. This notice will expire seven (7) years after the date upon which the record was created. This is to certify that I have been informed of the above.

Signature _____ Relationship to Patient _____
Patient or Personal Representative/Guardian

Print Name _____ Date _____
Patient Name