**Atlanta Natural Health**

**Child Intake Form**

First Name:_____MI:_____Last Name:_____
Date of Birth:_____Prefers to be called:_____
Address:_____City/State/Zip_____
Primary Phone:_____Other Phone:_____
E-mail:_____SS#:_____
Gender: ( )male ( )female ( )_____ ( )prefer not to disclose Preferred language:_____
Parent(s)/Guardian(s) Name(s)_____
Has he/she ever received a Chiropractic Adjustment? ( )Yes ( )No How long ago?_____
By whom? Where?_____
Please tell us who referred you to our office:_____

_____

**HEALTH PROFILE**

The focus in our office is your child's health. Our goals are, first, to address the issues that brought your child to our office, and second, to offer your child the opportunity of improved health potential and wellness service in the future. On a daily basis, we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual; not even felt until they have become serious. Answering the following questions will give us a profile of the specific stresses your child has already faced, allowing us to better assess the changes that have occurred and ultimately challenge your child's health potential as he/she continues to grow; please answer them to the best of your ability.

**CHILDHOOD YEARS**

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth.

| Yes | No | Not Sure | (Please check the appropriate box and circle to indicate present/previous where appropriate) | Please Explain: |
|---|---|---|---|---|
| | | | Did Mom have any illness or difficulty during pregnancy? | |
| | | | Did Mom take any drugs during pregnancy (prescription or non-prescription)? | |
| | | | Did Mom or Dad smoke during pregnancy? | |
| | | | Was the birth difficult? (forceps, cesarean, breech, epidural, etc.) | |
| | | | Does/did child have trouble with feeding? | |
| | | | Does/did child cry excessively? | |

| | | | | |
|---|---|---|---|---|
| | | | Was child breast fed more than 6 months? | |
| | | | Did child have major childhood illness? | |
| | | | Has child had any serious falls or injuries (including fractures or car accidents)? | |
| | | | Did/does child play sports? | |
| | | | Was/is there prolonged use of medicine such as antibiotics or an inhaler? | |
| | | | Did/does child take/use any drugs? | |
| | | | Has child had any surgeries? Any side effects? | |
| | | | Does he/she have any known allergies? | |
| | | | Was he/she vaccinated? | |
| | | | Has he/she seen a chiropractor regularly? | |

_____If your child has no symptoms or complaints, and is here for wellness services, please check here

**Addressing Your Child's Current Condition (Why are you here?)**
Please briefly describe the chief area of complaint and the effect it is having on your child's life:
_____
_____
_____

**If he/she is experiencing pain**, is it: (please mark all that apply)
___Sharp ___Dull ___Achy ___Stabbing ___Gnawing ___Burning ___Numb ___Tingling
___Comes & goes ___Constant ___Constant
**Since the problem started**, is it: ( )getting worse ( )getting better ( )about the same
When did it start?_____What makes it worse?_____
What makes it better?_____What other doctors have you seen for this?_____
Current medications:_____
Please mark "1" for current issues, "2" for recent issues, and "3" if your child has ever experienced:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Headache | | Depression | | Anxiety | | Heart condition |
| | Facial pain | | Meningitis | | Trouble breathing | | Scoliosis |
| | Jaw pain | | Fatigue/low energy | | Irritability | | Cancer |
| | Heartburn/acid | | Buzzing or ringing | | Menstrual | | Diabetes (specify type I |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | reflux | | in ears | | irregularity | | or II) |
| | Behavioral issues | | Dyslexia or learning disability | | Frequent urination or strong urge | | High blood pressure/hypertension |
| | Autism | | Trouble sleeping | | Loss of balance | | Spine, Leg, or Arm Pain |
| | Earaches | | Emotional trauma | | Hyperactivity | | |
| | Chest pain | | Fainting | | Upset stomach | | |
| | Menstrual pain | | Bed wetting | | Dizziness | | |

Is there any other information you think is relevant to your child's health or could be helpful?

_____

_____

_____

_____

(Please check) How would you rate your child's:

| Poor | Good | Excellent | | Poor | Good | Excellent | |
|---|---|---|---|---|---|---|---|
| | | | Diet | | | | General Health |
| | | | Exercise | | | | Personal stress |
| | | | Sleep | | | | School stress |

**Consent to evaluate and adjust a minor / child**

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.

_____ _____

Signature Date

If am unable to attend an appointment with my child, I consent to my child being treated at the Atlanta Natural Health Clinic in the presence of:

_____ _____

Name Relationship to child

_____ _____

Name Relationship to child

_____ _____

Parent/Guardian's Signature Date

# Atlanta Natural Health

4633 Buford Highway, Atlanta GA 30341
www.AtlantaNaturalHealth.com
770-455-6767

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights *concerning* those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and *agree* with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent .

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patent may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3**.** A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to *privacy,* all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. In this office, we have a semi-open adjustment setting, so there is a possibility of another individual hearing private health information. Patients have the right to request a private consultation and/or adjustment in a closed office if they object to this.

7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

**8.** If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

signature date

# Atlanta Natural Health

4633 Buford Highway, Atlanta GA 30341 770-455-6767 www.AtlantaNaturalHealth.com

**Every type of health care is associated with some risks**, including chiropractic care. We want you to be informed about potential problems associated with chiropractic care before consenting to treatment. This is called informed consent.

**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 33 vertebrae 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.

ADJUSTMENT: Chiropractic adjustments are the specific application of forces to facilitate the body's correction of vertebral subluxation.This is accomplished by use of the doctor's hands or use of an adjusting instrument. Often, those movements result in a "pop" or "click" sound and/or sensation in the area being adjusted.

In this office we may use trained staff personnel to assist the doctor with portions of your consultation, examination, x-rays, exercise instruction, or other services. Occasionally, when your doctor is unavailable, another doctor will adjust you on that day.

STROKE: Stroke is the most serious potential problem which may be associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen for the bloodstream. The result can be temporary or permanent dysfunction of the brain or even death. Chiropractic adjustments may only be associated with the vertebral artery, and recent research has indicated that first, the vast majority of strokes that occur are from the carotid artery (not the vertebral), and second, that the risk of stroke in a chiropractic office is the same as it would be in a medical office, a yoga class, or a hairdresser. If that still doesn't sit right with you, a major study from 1993 indicated that a vertebral artery stroke occurs in 1 per every 3,00,000 adjustments to the upper neck. This means a chiropractor would have to practice for hundreds of years to be statistically associated with a single patient stroke.

SORENESS: It is possible for chiropractic adjustments or other modalities to result in an increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous and may vary according to your general health. Drinking more water after your adjustment may help prevent soreness.

<u>The statements below this sentence generally incur problems so rarely that there are no available statistics to quantify their probability.</u>

SOFT TISSUE INJURY: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, an adjustment, traction, massage therapy, therapeutic exercise or other procedure may damage some muscle or ligament fibers. The result is a temporary increase in pain which may necessitate extra visits for resolution, but there are no long-term effects for the patient.

RIB FRACTURES: The ribs extend from the base of your neck to the start of your lower back and from the spine to the center of your chest. Rarely, a chiropractic adjustment may "crack" or fracture a rib bone. This occurs only in patients who have weakened bones from conditions such as osteoporosis or cancer. We adjust all patients very carefully, especially those with known osteoporosis or who are over the age of 65 or under the age of 18.

There may be other problems or complications that may arise from chiropractic care other than those noted above. These occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

CHIROPRACTIC CARE AND DIAGNOSIS: We do not offer to diagnose or treat any disease, regardless of what the disease is called. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of our examination or care we encounter non-chiropractic or unusual findings, we will notify you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another health care provider. We will not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expressions of the body's innate wisdom.

CHOICE: I understand that if I am wary of having any part of my spine adjusted by hand, the doctor may (at my request) use an instrument to adjust the area in question, minimizing any potential risk of injury. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who may be better able to fulfill your health needs.

I, the undersigned, have read and fully understand the above statements. All of my questions regarding my care and the doctor's objectives for my health have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____ _____

Printed Name Signature of patient/guardian Date

# FINANCIAL AGREEMENT

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you to get the best results in the shortest amount of time. The following are the most common services we provide:

| PROCEDURE | PURPOSE | WHEN PERFORMED | FEE |
|---|---|---|---|
| **CONSULTATION** | Meet with the doctor, discuss your reasons for being here, and review your case history | First visit, new injuries, or new condition | No charge |
| **EVALUATION / EXAM** | Ascertain the nature and severity of your health problem. Assess and evaluate your new or current health status and determine and appropriate course of action | First visits, new conditions, exacerbations, and progress examinations | $90.—$220 |
| **DIAGNOSTIC IMAGING** (X-RAYS and scans) | Visualize the location of spinal problems and confirm other exam findings. | As necessary for 1st visit, re-injuries and progress examinations | $25. -.$150. |
| **CHIROPRACTIC ADJUSTMENTS** | Reduce and remove the Vertebral Subluxation | As indicated by examination | $39. - $65. |
| **NUTRITIONAL RESPONSE TESTING** | Access any nutritional imbalances or toxins that may be contributing to or compromising your body's ability to heal and function at its optimal state | As indicated by examination and evaluation and interest of patient | $140. Initial<br>$39 Follow Up |
| **BEMER** | Improvement of micro vascular function | Interest of patient | $15 - $20<br>(packages available) |
| **NSRT / BAX** | Stress reduction using Low Level Light Laser Therapy and homeopathic support. | Interest of patient | $120<br>(packages available) |
| **DETOX FOOTBATH** | Stimulate detoxification processes and pull toxins from the body | Interest of patient | $35 (1st only $30)<br>(packages available) |
| **HEALTH COACHING** | Create a vision and plan for attaining the ideal expression of your authentic expression of potential. | Interest of patient | $120<br>(packages available) |

**Forms of Payment**

We accept cash, personal checks, Visa, Mastercard, Discover, Tradebank, and Equitrade. Payment is expected at time of service unless other arrangements have been made**. <u>Billing is taken care of at the front desk</u> unless other arrangements need to be made.**
For the convenience of our patients, services may be paid for in advance.

**Special Arrangements**

We have never denied anyone the benefit of care due to their inability to pay our published fees. Individual contracts can be designed to help specific financial needs. **The most important thing to us is that people are given what they need.**

**Preferred Chiropractic Doctor (PCD)**

ANHC is a participating provider with a national organization that legally allows us to reduce our fees for participating members. PCD membership is available to all patients. **Reduced PCD rates are only applicable when insurance reimbursement is not going to be used**. Annual membership fee is $37.00. You can join here or online at www.bewell2.com. Under the "PCD umbrella", d**iscounted prepayment plans are available to PCD members,** details available at the front desk.

**Product Returns**

Unopened supplements may be returned for a full refund within 90 days of purchase. There is no refund on opened products.

I certify that all information provided is true and complete. I agree to pay the amount invoiced in full. I further agree to pay all costs of collection, including costs of a collection agency if the account is turned over to a collection agency, and including 15% attorney's fees and court costs in the event this balance is turned over to an attorney. It is agreed that this agreement will be governed under the law of the State of Georgia. The Atlanta Natural Health Clinic has the option of pursuing an action under this agreement in any court of competent jurisdiction in the State of Georgia and I consent to jurisdiction in the State of Georgia.

**Signature of patient:** _____ **Date:** _____