ELITE WELLNESS **PEDIATRIC HISTORY FORM**

PATIENT DEMOGRAPHICS

Child's Name_____ Today's Date _____/_____/____ PTID#:_____

Date of Birth _____/_____/_____ Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____ Fathers mobile: _____

Mother_____ DOB_____/_____/_____Father _____DOB_____/_____/_____

Pediatrician/Family MD _____City & State _____ Last Visit: ____/____/____

Who is responsible for this bill? ❑ Father Social Security # _____-_____-_____ ❑ Mother Social Security # _____-_____-_____

❑ 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. **Ever had** this problem **before**? ❑ No ❑ Yes If yes when? _____
3. Any **bowel or bladder** problems since this problem began? No Yes *(Describe)*_____
4. Have you seen any **other doctors** for this problem? No Yes If yes, who? _____
5. How long ago? _____Days _____ Weeks _____ Months _____Years
6. What were the results of past treatment? _____
7. How is this problem **NOW:** ❑ Rapidly Improving ❑ Slowly Improving ❑ About the Same ❑ Gradually Worsening ❑ On & Off
8. Please list any **medication taken** for this problem: _____
9. Has your child ever sustained an injury playing sports? _____ If yes, please explain_____

_____

10. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain_____

_____

HAS YOUR CHILD EVER SUFFERED FROM: mark a **Y** for YES OR **N** for NO

___Headaches	___Orthopedic Problems	___Digestive Disorders	___Behavioral Problems	___Fall From Changing Table
___Neck Problems	___Poor Appetite	___ADD/ADHD	___Fainting	___Fall Off Skateboard/Skates
___Stomach Aches	___Ruptures/Hernia	___Seizures/Convulsions	___Leg Problems	___Fall From Bed or Couch
___Muscle Pain	___Heart Trouble	___Joint Problems	___Constipation	___Fall Off Monkey Bars
___Chronic Earaches	___Backaches	___Diarrhea	___Sinus Trouble	___Fall From High Chair
___Hypertension	___Asthma	___Scoliosis	___Anemia	___Arm Problems
___Walking Trouble	___Bed Wetting	___Colic	___Broken Bones	___Dizziness
___Fall In Baby Walker	___Fall From Crib	___Fall Off Swing	___Fall Off Bicycle	___Growing Pains
___Fall Downstairs	___Fall Off Slide	___Sleeping Problems	___Colds/Flu	___Poor Posture
___Reflux	___Allergies to_____		___Other: _____	

I understand that I am directly and fully responsible to Elite Wellness for all fees associated with chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that the actual films are **the sole legal property** of Elite Wellness and that by law; the doctor must retain these films for a period of no less than 7 years.

The risks associated with exposure to ionization, and 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 imaging studies(when applicable), and 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.

_____ _____

Parent or Legal Guardian's Signature Date

Elite Wellness Chiropractic

INFORMED CONSENT

When a patient seeks chiropractic health care and we agree to provide this care, it is essential for the patient and Elite Wellness to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents 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 by specific adjustment 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 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This misalignment results in a lessening of the body's God-given, innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases 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 another health care provider.

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 God-given, innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____, have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____

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 of parent/legal guardian: _____ Date: _____

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____
Signature: _____ Date: _____

Elite Wellness
12101 Bee Cave Rd #5b Bee Cave, TX 78738

Patient Name: _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Elite Wellness of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Elite Wellness.

Authorization to Release Medical Record Information

Elite Wellness is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Elite Wellness This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Elite Wellness Chiropractic.

The undersigned certifies that he / she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of Witness: _____

Signature of Patient or Responsible Party: _____ Date: _____

Elite Wellness Chiropractic & Acupuncture NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information (PHI). In addition, we must provide you with written notice concerning your rights to gain access to your health information and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception area. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Purpose for care - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - an open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public Health and Safety - in order to prevent or to lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government Agencies or Law Enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or notify you of changes in practice hours or up coming events.
11. Change of ownership - in the event this practice is sold the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information; however, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call Dr. Cash Lewis at (512)297 - 2288. If Dr. Lewis is unavailable, you may make an appointment with our Front Desk to see him within 2 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington D.C. 20201

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

Elite Wellness's NOTICE OF YOUR RIGHT TO PRIVACY continued…

I have received a copy of Elite Wellness's Patient Privacy Notice. I understand my rights, as well as the practices 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 their "Notice of Privacy Practice" 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 that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	____/____/_____	_____
Patient's Name	DOB	PTID#:

_____	____/____/_____
Legal Guardian	Date

_____	____/____/_____
Witness	Date