New Patient Evaluation

6 - 11 Years

Today's Date: _____

Patient Information

Child's Name: _____ Child's Nickname: _____

Reason for Visit: _____

Child's Home Address: _____ City: _____ ST: _____ Zip: _____

Child's Home Phone: _____

Sex: _____ Age: _____ Date of Birth: _____

Who can we thank for referring you? _____

Family Information

Mother's Name: _____ Father's Name: _____

Home Phone #: _____ Home Phone #: _____

Cell Phone #: _____ Cell Phone #: _____

Parent's Marital Status: _____

List Ages of Other Children in the Family: _____

Predominant Language Used at Home: _____

Consent to Treat

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my _____ named _____ as the examining/treating doctor deem necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name: _____ Parent's Signature: _____

Today's Date: _____

Today's Date: _____

Child's Name: _____ Child's Nickname: _____

Pregnancy History

Mother's Name: _____ How Many Children Do You Have? _____

What Was The Term of Your Pregnancy? _____ weeks

During Your Pregnancy, Did You Have Any of The Following:

Falls?		Motor Vehicle Accident?		Near Miss MVA?	
High Blood Pressure?		Diabetes?		Anemia?	
Morning Sickness?		Indigestion?		Seizures?	
Thyroid Problems?		Swollen Ankles?		Heart Problems?	
Back Pain?		Abnormal Bleeding?		Were You Hospitalized?	
Any Other Illness?		Explain:			

During Your Pregnancy, Did You Use Any of The Following:

Tobacco? _____ Alcohol? _____ Non-Prescription Drugs? _____

Prescription Medication?		Medication:		Reason:	
Over-the-Counter Meds?		Medication:		Reason:	

Birth History

How long was the labor from the first regular contraction to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours

Hospital Birth		Home Birth		Midwife Assisted	
Vaginal Delivery		Planned C-Section		Emergency C-Section	
Was Birth Induced?		Forceps Delivery		Vacuum Extraction	
Anesthesia Given		Fetal Distress		Meconium Staining	
Head Presentation		Face Presentation		Breech Presentation	

Baby's Condition Immediately After Birth:

Apgar Scores: At 1 Minute: ___/10 At 5 Minutes: ___/10

Baby's Crying: Baby Cried Immediately After Birth: _____

Strong Cry _____ Weak Cry _____ Did Not Cry for _____ Minutes

Baby's Color: Pink All Over _____ Blue Face _____ Blue Hands/Feet _____

Baby's Activity Arms and Legs Actively Moving _____ Floppy Baby _____

Intensive Care Was Required _____ Days in Neonatal Intensive Care Unit _____ Days

Medication Given at Birth? _____ Vaccines Administered at Birth? _____

Birth Weight _____ lbs/kgs Birth Length _____ ins/cms Baby Home on Day: _____

Today's Date: _____

Child's Name: _____ Child's Nickname: _____

School-Age Child History

The following questions are designed to help Dr. Lomonaco provide the best possible spinal care for your child.

Reason for Today's Visit: _____

When Did This First Occur: _____

_____ Does Your Child Complain of Pain/Discomfort? Explain: _____

Was the Onset of Pain Sudden _____ Gradual _____ Is the Pain Constant _____ Intermittent _____

_____ Has Your Child Ever Had This Problem Before?

_____ Has Your Child Been Treated For This Problem? By Whom: _____

Date: _____

_____ Has Your Child Ever Had Chiropractic Care? By Whom: _____

Date: _____

Health History - *In the Past Year, Has Your Child Had Any of the Following:*

_____ Does Your Child Ever Complain of Back/Neck Pain? Comments: _____

_____ Does Your Child Ever Complain of Arm/Leg Pain? Comments: _____

_____ Does Your Child Ever Complain of Headaches? Comments: _____

_____ Has Your Child Had Any Recent Falls/Trauma? Explain: _____

_____ Has Your Child Been in a Car Accident or Near-Miss? Explain: _____

_____ Has Your Child Fallen From a Bike/Skateboard/Similar? Explain: _____

_____ Has Your Child Ever Had Bone Fracture/Joint Dislocation? Explain: _____

_____ Has Your Child Had Any Other Trauma or Injuries? Explain: _____

_____ Has Your Child Had Asthma? Comments: _____

_____ Has Your Child Had a Problem with Bedwetting? Comments: _____

_____ Has Your Child Had Any Surgeries? If Yes, Please List Each Procedure and Its Approximate Date:

Surgery: _____ Approx. Date: _____

Surgery: _____ Approx. Date: _____

_____ Is Your Child Taking Any Prescribed Medication? Medications: _____

Medications: _____

Medications: _____

_____ Do You Have Any Other Concerns About Your Child's Health?

Explain: _____

Nutrition

_____ Do You Have Any Concerns About Your Child's Diet? Explain: _____

_____ Does Your Child Have Any Food Allergies? Explain: _____

_____ Does Your Child Have Any Skin Rashes? Explain: _____

_____ Does Your Child Take Vitamin Supplements? Explain: _____

What Does Your Child Usually Eat for Breakfast? _____

What Does Your Child Usually Eat for Lunch? _____

What Does Your Child Usually Eat for Dinner? _____

What Does Your Child Usually Eat for Snacks? _____

How Many Sodas Does Your Child Drink Per Day? _____

What is Your Child's Favorite Food? _____

How Much Water Does Your Child Drink Per Day? _____

How Often Does Your Child Eat Fast Food? _____

About Your Child's LifeStyle

What Are Your Child's Grades in School? _____

How Do They Carry Their School Books? _____

How Heavy is Their School Book Bag? _____

What Sports Does Your Child Play? _____

What Hobbies Does Your Child Have? _____

How Many Hours of TV is Watched Per Day? _____

How Many Hours Are Spent on a Computer Per Day? _____

How Often Does Your Child Play Video Games? _____

How Many Hours of Sleep Does Your Child Get Per Night? _____

Are There Any Smokers in The Child's Home? _____

Does Your Child Feel Stressed? _____

Does Your Child Have Trouble Reading the Board in Class? _____

Does Your Child Ever Get Blurred Vision? _____

Does Your Child Wear Contacts or Glasses? _____

Does Your Child Get Headaches When Reading? _____

INFORMED CONSENT TO EXAMINATION AND CHIROPRACTIC TREATMENT

Today's Date: _____

Patient Name _____

I, _____ understand that this office does not file my insurance and that any fees incurred for treatments are charged directly to me and are my sole responsibility. I hereby authorize the Doctor to perform upon me examination and diagnostic procedures arising from any current or presently unforeseen conditions, which the Doctor considers necessary or advisable in the course of my health care.

The Doctor will be treating his/her patients through any or all of the following: the adjustment of the spine through both low and high force techniques, nutritional counseling, and exercise. The Doctor will utilize various Chiropractic techniques in order to best serve each individual patient. These techniques may include adjustment of the cranial bones, the vertebral column, the pelvis, and the upper and/or lower extremities. The techniques focus on maintaining healthy spinal alignment and motion thereby influencing nervous system function. The Doctor will not directly treat any specific medical conditions.

The material risks inherent in the Chiropractic adjustment:

- As with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring:

- Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history, examinations, and possible x-rays. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

It is important that you understand other treatment options outside of Chiropractic care are available to you.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest.
- Medical care with prescription drugs.
- Hospitalization.
- Surgery.

The material risks inherent in such options and the probability of such risks include:

- Overuse of over-the-counter medications produces undesirable side effects. Premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self-discipline in not abusing the medication. Professional literature describes highly undesirable effects from long term use of over-the-counter medications

- Prescription medications can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's illness, his/her pain tolerance, self-discipline in not abusing the medication, and proper professional supervision. Such medications generally entail very significant risks, some with rather high probabilities.
- Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable diseases is likely with adverse result from such exposure dependent upon unknown variables.
- The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The risks and dangers attendant to remaining untreated:

- Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I,_____, UNDERSTAND THE RISKS INVOLVED IN CHIROPRACTIC TREATMENT, THE OTHER OPTIONS AVAILABLE AND THEIR RISKS, AND THE RISKS OF REMAINING UNTREATED. BY SIGNING BELOW I STATE THAT I HAVE WEIGHED THE RISKS INVOLVED IN UNDERGOING TREATMENT AND HAVE MYSELF DECIDED THAT IT IS IN MY BEST INTEREST (OR SAID MINOR'S INTEREST) TO UNDERGO THE TREATMENT RECOMMENDED. HAVING BEEN INFORMED OF THE RISKS, I HEREBY GIVE MY CONSENT TO THE DOCTORS OF THIS CLINIC TO TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF MANIPULATION OF MY SPINE AND EXTREMITIES, NUTRITIONAL CHANGES, AND RECOMMENDED EXERCISES AND ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE AS TO THE RESULTS THAT MAY BE OBTAINED FROM THIS TREATMENT HAS BEEN GIVEN TO ME.

_____
DATE

_____
PATIENTS PRINTED NAME

_____
PARENT OR GUARDIAN SIGNATURE (FOR MINORS)

Authorization to Leave Messages and Convey Information

Today's Date: _____

Patient Name _____

It is sometimes necessary for representatives of Lomonaco Family Chiropractic to contact patients for various notification purposes. The purposes of these communications can range from reminders of appointments, to notify patients that supplements or products they requested are ready for pickup or to ask a patient to call Lomonaco Family Chiropractic regarding an issue or concern.

At no time will a representative of Lomonaco Family Chiropractic discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave a message with members of your household, on your answering machine or voicemail service or through email with your consent below.

You have the right to revoke this consent, in writing, effective the day following your instruction.

_____ I authorize Lomonaco Family Chiropractic to LEAVE A MESSAGE ON MY ANSWERING MACHINE AND/OR VOICEMAIL USING THE CONTACT NUMBERS I HAVE PROVIDED.

_____ I authorize Lomonaco Family Chiropractic to LEAVE MESSAGES WITH HOUSEHOLD MEMBERS.

_____ I authorize Lomonaco Family Chiropractic to contact me at the following email address:

Email Address: _____

Parent Signature: _____ Date: _____

Financial Policy

Today's Date: _____

Patient Name _____

Our first concern in this office is to provide you, the patient, with excellent chiropractic care and wellness education.

- Payment for the Initial New Patient Visit with our doctors is required at the time of your first visit to our office. All other payments, including adjustments, cranial sacral therapy, allergy clearing, and vitamin/ supplements are due at the time that the services are performed. For your convenience we accept cash, checks, MasterCard, Visa, Discover and American Express credit cards.

- Because we run a cash practice, we DO NOT file any insurance claims including Medicare. We are currently not providers for Medicare which means you WILL NOT and CANNOT be reimbursed by Medicare for your visits to our office. Upon request we will print a statement that will provide you and your private insurance carrier with the information necessary to make a claim. If you wish to file a claim you are responsible for contacting your insurance carrier and submitting your claim. **Please note that this does not guarantee payment for any part of services rendered. It has been our experience that insurance companies will often deny reimbursement for procedures. It is not uncommon for some insurance companies to deny a claim either at the onset of the patient's acute care or when a patient seeks reimbursement for wellness care. Most insurance companies do not understand wellness care and true holistic prevention. They are allopathic in nature and reimburse accordingly. Please, take the opportunity to educate your insurance providers as to the value of a wellness lifestyle.**

- **Missed Appointment Policy** – In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. Please realize how important it is to keep your reserved time. Thank you for your consideration of our policies.

- **Automobile Accident Policy** – Our office will be happy to file your Personal Injury case if the insurance company that will be handling your case has approved you. After treatment is finished you then become responsible for your balance whether paid with the insurance check received for treatment or from your own personal account. If the insurance company did not cover all of your treatment you become responsible for the remaining balance.

All questions regarding other financial matters should be addressed to our Office Manager/Chiropractic Assistant, Michelle Ashley. We want you to be comfortable dealing with these matters, and we believe open communication will enhance the positive outcome we all desire.

Parent Signature: _____ Date: _____

Section 7: Notice of Privacy Practices

Lomonaco Family Chiropractic

Effective April 14, 2003

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your health information. Lomonaco Family Chiropractic is required by law to maintain the confidentiality of your health information. Lomonaco Family Chiropractic realizes that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances:

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your health insurance coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the best service available. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about your health and health-related products we have available to you.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.

- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

Your rights regarding your health information:

1. Communications. You can request that Lomonaco Family Chiropractic communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that Lomonaco Family Chiropractic contact you at home, rather than work. Lomonaco Family Chiropractic will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that Lomonaco Family Chiropractic restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. Lomonaco Family Chiropractic is not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our Privacy Official: Michelle Ashley.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Official: Michelle Ashley. You must provide us with a reason that supports your request for the amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our Privacy Official: Michelle Ashley.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Regional Office for Civil Rights, US Department of Health and Human Services. Regional Office information may be found online at **http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html** or ask the Privacy Official for the information. To file a complaint with our practice, contact our Privacy Official: Michelle Ashley. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

In accordance with the standards of implementation specifications of 45 C.F.R. § 164.524, Provider may grant an individual access to inspect and obtain a copy of protected health information about the individual in a designated record set.

Lomonaco Family Chiropractic's policy:

1. The designated record set that is subject to access by an individual is as follows:
    a. Medical Records
    b. Billing Records
    c. List of all those requesting copies of designated record set

2. The titles of the persons or offices responsible for receiving and processing requests for access by individuals are as follows:

Privacy Official: Michelle Ashley

Lomonaco Family Chiropractic also uses protected health information for the following reasons: (you may opt out of this authorization). Special initial authorization is required and attached.

Marketing; internal referral board, testimonials, pictures on bulletin board, sending newsletters or information unrelated to healthcare and other marketing materials.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Michelle Ashley

You can reach the Privacy Official at:

Lomonaco Family Chiropractic
2016 Justin Rd., Suite 310
Highland Village, TX 75077
Phone number: 972-966-1600
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form

Lomonaco Family Chiropractic

Effective: April 14, 2003

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Lomonaco Family Chiropractic. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Michelle Ashley.

Lomonaco Family Chiropractic also uses protected health information for the following reasons: (you may opt out of this authorization). Special initial authorization is required and attached.

Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (please initial)

If you have any questions regarding this notice or our health information privacy policies, please contact:

Michelle Ashley, you can reach her at: Lomonaco Family Chiropractic, 2016 Justin Rd., Suite 310, Highland Village, TX 75077, 972-966-1600

Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: _____ (you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

Staff complete only if NO signature is obtained, If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices

☐ Other: _____

Staff Signature: _____ Date:_____