PEDIATRIC APPLICATION FOR CARE AT INTEGRAL WELLNESS CO.

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

Mother's Name: _____ Mother's DOB: _____-_____-_____

Father's Name: _____ Father's DOB: _____-_____-_____

Mother's Cell: _____ Father's Cell: _____

Who is responsible for this bill? ○ Mother ○ Father ○ Other _____

Mother's Social Security # _____-_____-_____ Father's Social Security # _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Emergency Contact: Name: _____ Number: _____ Relationship: _____

If under 1 year old:
Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Purpose of this visit: ○ Wellness Check-up ○ Injury or Accident ○ Other - Please explain:

_____

_____

_____

_____

_____

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Examiner's Signature **Date Form Reviewed**

HISTORY OF COMPLAINT

Explain any known past or present injury(s): (sports, falls, playing, repetitive, etc.)

_____

_____

If you are experiencing Pain/Discomfort/Symptoms, please identify what, where and for how long:

_____

_____

If you are experiencing Pain/Discomfort/Symptoms **PLEASE LIST** the **TOP FOUR** that you are experiencing:

Primary: _____ Secondary: _____

Third: _____ Fourth: _____

Using a scale of **0** to **10** with **0** being no pain and **10** being the worst pain, now rate the **TOP FOUR** conditions you listed above:

Primary Condition Pain Level 0-10:

Right now: _____ At its worst: _____ At its best: _____ On average: _____

Secondary Condition Pain Level:

Right now: _____ At its worst: _____ At its best: _____ On average: _____

Third Condition Pain Level:

Right now: _____ At its worst: _____ At its best: _____ On average: _____

Fourth Condition Pain Level:

Right now: _____ At its worst: _____ At its best: _____ On average: _____

What relieves your symptom(s)? _____

What makes your symptom(s) feel worse? _____

When did the problem(s) begin? _____

How did the problem(s) begin? _____

_____

List Prescription & Non-Prescription drugs you take: _____

_____

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Examiner's Signature **Date Form Reviewed**

REVIEW OF SYSTEMS

CIRCLE <u>all current</u> health concerns you have.

Headache	Left Hand Joint Pain	Right Knee Pain	Diabetes	Stomach Aches
Migraine	Right Rib Pain	Left Knee Pain	Endometriosis	Constipation
Scoliosis	Left Rib Pain	R. ankle/foot joint pain	PMS/Excessive Cramps	Diarrhea
Jaw Pain / TMJ	Upper Back Pain	L. ankle/foot joint pain	Frequent Ear Infections	Irritable Bowel
Neck Pain	Mid Back Pain	Bed Wetting	ADHD	Sinus Allergies
Right Shoulder Pain	Low Back Pain	Frequent Sickness	ADD	Food Allergies
Left Shoulder Pain	Right Sciatic Pain	Asthma	Anxiety	Eczema
Right Elbow pain	Left Sciatic Pain	Colic	Depression	Psoriasis
Left Elbow Pain	Right Hip Pain	Walking Trouble	Hypothyroidism	
Right Wrist Pain	Left Hip Pain	Sleeping Problems	Hyperthyroidism	
Left Wrist Pain	Right Leg Pain	High Blood Pressure	Trouble concentrating	
Right hand joint Pain	Left Leg Pain	Low Blood Pressure	Epilepsy	

Other: _____

If you have headaches or migraines: Are they controlled by (go away with) medication or other treatment? ○ **No** ○ **Yes**

PAST HISTORY

Please circle any below that you have experienced in the past.

Broken Bone Fracture Heart Attack Cancer Tumors Sports Injury Surgery Stroke

Please describe: _____

FAMILY HISTORY

Any hereditary conditions you are aware of? ○ No ○ Yes: _____

_____

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Examiner's Signature **Date Form Reviewed**

HR#_____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Backpack	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Run	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climb Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Play Sports	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Read/Concentrate	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sit for extended periods	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Stand for extended periods	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Complete school work	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walk	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Bending Movement	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Exercise	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

(An Integral Team Member may help you with the table below.)

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Examiner's Signature **Date Form Reviewed**

INTEGRAL WELLNESS CO.

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Integral Chiropractic Co. have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Examiner's Signature **Date Form Reviewed**

REGARDING: X-rays/Imaging Studies for Females Only

FEMALES ONLY: *Please read carefully, check the box, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Examiner's Signature **Date Form Reviewed**

HR#_____

INTEGRAL WELLNESS CO. 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 **P**ersonal **H**ealth **I**nformation. 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. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean 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 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 apprize you of changes in practice hours or upcoming 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. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Micheal Bryan at (423) 299-1895. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 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 DC 20201

HR#_____

INTEGRAL WELLNESS CO. NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Integral Wellness Co.'s Patient Privacy Notice. I understand my rights as well as the practice's 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 this "Notice of Privacy Practice" at a 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.

_____ _____ - _____ - _____

PRINT Name **DATE OF BIRTH**

_____ _____ - _____ - _____

Patient or Authorized Person's SIGNATURE **Date Completed**

_____ _____ - _____ - _____

Examiner's Signature **Date Form Reviewed**

I hereby authorize payment to be made directly to Integral Wellness Co. for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Integral Wellness Co. for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Examiner's Signature **Date Form Reviewed**

HIPAA Personal Health Information Release Authorization

I, _____, on behalf of *(PATIENT'S NAME)* _____, hereby authorize Integral Wellness Co. to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ○ Spouse Name: _____
- ○ Significant Other Name: _____
- ○ Parent/Legal Guardian Name: _____
- ○ Child(ren) Name(s): _____
- ○ Any Specified Person Name: _____
- ○ Information is not to be discussed with or released to anyone.

Restrictions:

- ○ No Restrictions
- ○ Only discuss my appointment time with the above-named individual(s).
- ○ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ○ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call ○ my home ○ my work ○ my cell phone
Phone Number: _____ - _____ - _____

If unable to reach me:

- ○ you may leave a detailed message
- ○ please leave a message asking me to return your call
- ○ _____

I understand I may terminate this consent at any time by giving written notice to Integral Chiropractic Co. Any changes to this form will require a new consent form to be completed, signed, and dated.

_____ _____ - _____ - _____
PRINT Patient's Name **PATIENT'S DATE OF BIRTH**

_____ _____ - _____ - _____
Patient or Authorized Person's SIGNATURE **Date Completed**

HR#_____