ARCHETYPE

Children's Packet

Whom may we thank for referring you to this office?

_____

Today's Date: _____-_____-_____

Please fill out these forms in their entirety so the doctors can deliver the highest level of care and get you functioning at your highest level of health.

ABOUT THE CHILD

Name:_____

Birth Date: _____-_____-_____ Age: _____

☐ Male ☐ Female Weight: _____

Address: _____

City: _____

State: _____ Zip: _____

ABOUT THE PARENT

Name: _____

Phone: _____

Employer: _____

Work Phone: _____

Type of Work: _____

Marital Status: _____

Social Security No.: _____

Driver's License No.: _____

Email: _____

Payment Method: ☐ Cash ☐ Check ☐ Credit Card

VACCINATIONS

Have you chosen to vaccinate your child? ☐ Yes ☐ No

If yes, check all that your child has received:

☐ DPT ☐ MMR ☐ Chicken Pox ☐ Hepatitis ☐ Other

Describe any and all reactions to vaccine(s):

_____

_____

_____

_____

_____

Describe the purpose of this visit: _____

_____

Is the purpose of this appointment related to:

☐ Sports ☐ Auto ☐ Fall ☐ Home Injury ☐ Other

Please explain: _____

When did this condition begin?_____

Has this condition:

☐ Gotten Worse ☐ Stayed Constant ☐ Come & Gone

Does this condition interfere with:

☐ Sleep ☐ Daily routine ☐ Other activities

Please explain: _____

_____

Has this condition occurred before? ☐ Yes ☐ No

Please explain: _____

_____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Doctor's Name(s): _____

Type of Treatment: _____

Results: _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that:	Yes	No
• Doctors of Chiropractic work with the nervous system?	☐	☐
• The nervous system controls all bodily functions and systems?	☐	☐
• Chiropractic is the largest natural healing profession in the world?	☐	☐
• If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	☐	☐

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EXPERIENCE WITH CHIROPRACTIC

Have you been adjusted by a Chiropractor before?

☐ Yes ☐ No

Reason for those visits? _____

Doctor's name: _____

Approximate date of last visit: _____

Has any adult in your family seen a Chiropractor? ☐ Yes ☐ No

Has any child in your family seen a Chiropractor? ☐ Yes ☐ No

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

☐ Drugs / Medicine ☐ Tobacco / Alcohol

Please explain: _____

_____

Any illness during your pregnancy? _____

_____

_____

How was your delivery?

☐ Labor chemically induced

☐ Labor was Dr. assisted

☐ C-section delivery

☐ Forceps/Vacuum extraction?

☐ Did Dr. pull or twist baby?

☐ Premature delivery

Please explain: _____

_____

Did your baby have colic? ☐ Yes ☐ No

Feeding problems? ☐ Yes ☐ No

Vaccinations? ☐ Yes ☐ No

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Allergies
☐ Asthma
☐ Attention problems
☐ Bed wetting
☐ Breathing problems
☐ Colic
☐ Constipation
☐ Digestive problems
☐ Ear problems
☐ Frequent colds
☐ Headaches
☐ Hyperactivity
☐ Irritability
☐ Skin problems
☐ Sleeping disorders
☐ Tubes in the ears
☐ Vision problems
☐ Other

CHILD'S CURRENT HEALTH STATUS

	Yes	No	If Yes, please explain
Has your child ever:			_____
...taken antibiotics?	☐	☐	_____
...been hospitalized?	☐	☐	_____
...had a severe fall?	☐	☐	_____
...been in a car accident?	☐	☐	_____
...taken antibiotics?	☐	☐	_____
Is your child:			_____
...accident prone?			_____
Had Surgery?			_____
Please Explain...			_____
...currently taking	☐	☐	_____
any medication(s)?			_____
...having difficulty	☐	☐	_____
interacting with others?			_____
			_____

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Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

_____

What changes (if any) in your child's health or behavior would you like accomplished

_____

_____

_____

GOALS FOR MY CHILD'S CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief care – Symptomatic relief of pain or discomfort
☐ Corrective care – Correcting and relieving the cause of the problem as well as the symptoms
☐ Comprehensive care – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
☐ I want the Doctor to select the type of care appropriate for my condition.

_____ _____ — _____ — _____

Patient Signature (Parent or Legal Guardian) Date

_____

Child's Name

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize this office to make an examination of my child, including any necessary X-rays, and proceed with Chiropractic adjustments if the Doctor and I deem appropriate in the future.

_____ _____ — _____ — _____

Patient Signature (Parent or Legal Guardian) Date

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be able to obtain it. It will prevent any confusion or disappointment. 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 adjustments of the spine. Health is a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity. Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health. If during the course of a chiropractic spinal evaluation, 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 a health care provider who specializes in that area. 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 innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

Print Name

I understand the intent of Chiropractic care, based on the above, & consent to an examination, including X-rays if necessary.

_____ _____ / _____ / _____

Signature Date

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FINANCIAL AGREEMENT

We are committed to providing you with the best health care possible. We have established our financial policies to achieve this goal. You will be expected to pay for your health care at the time the service is rendered unless other arrangements are made in advance.

Health Insurance: We accept Blue Cross Blue Shield insurance. On your first visit, we will check your benefits and collect payment based on the information given on the Blue Cross Blue Shield portal. Insurance claims are filed on a bi-weekly basis. Once remittance files are received from Blue Cross Blue Shield, your ledger will be updated. If your ledger shows a credit, we will reimburse you the difference between what you paid and the patient responsibility stated in the remittance form. If your ledger has a balance, you will be responsible for it and required to pay for it without dispute. If during your care your insurance information changes, it is your responsibility to update your records with our office.

If you are not a BCBS insured, it is your responsibility to collect these benefits. We will provide you with a statement or "Superbill" at your request, which contains all the information necessary for your insurance company to reimburse you.

Cash Patients: All fees are payable at the time services are rendered.

Methods of Payment: For your convenience we accept Cash or Credit Cards (Visa, MasterCard, AMEX, Discover) for your initial visit. If a payment plan is chosen for future care, this is handled by auto collection through your card on file with our office. We do not accept checks for your initial first two visits. All checks returned as insufficient funds will incur a $45 returned check fee.

We make the payment process as simple and smooth as possible, so you will have an enjoyable visit in our office.

I have read and understand the above policies.

_____ _____ / _____ / _____

Patient Signature (Parent or Legal Guardian) Date

_____

Print Name

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PATIENT ATTENDANCE AGREEMENT

Archetype Health strives to provide each patient with the highest quality of care while attempting to accommodate your schedule. Therefore, we provide reserved time slots for each patient in order to minimize waiting times and assure continuity of your personal treatment. Appointments can be scheduled by phone, email, or in person at the office. We ask that all patients arrive 5 minutes before your scheduled time to empty your pockets and warm up your spine. Your consistent attendance of the planned treatment care plan is paramount to your health.

Cancellations, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. We ask for your full cooperation with the following policy:

- If you are unable to keep a scheduled appointment, we request that you notify our office 24 hours in advance of your scheduled appointment time. If someone is not available to take your call, please leave a voicemail or email info@archetype.health.

- All chiropractic no call, no shows will be documented in our records. If you accumulate 2 no call no shows for chiropractic adjustments, an office visit will be deducted from your careplan on each no call, no show thereafter.

- All muscular therapy no call, no shows will be charged a fee of half the price of the scheduled muscular therapy session.

- All nutrition, movement and neuroscience consultation no call, no shows will be assessed a $150 fee.

- All movement class no call, no shows will still count as one of your visits for that week.

We believe that this policy is necessary for the benefits of all patients, so that we can continue to provide the highest quality treatment and service to every patient.

All Archetype Health staff and patients appreciate your cooperation with this policy.

_____ _____/_____/_____

Patient Acknowledgement/Signature Date

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the uses and limitation of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I, _____ acknowledge that I have received a copy of Archetype Health's Notice of Privacy Practices for Protected Health Information.

_____ _____ / _____ / _____

Patient Signature (Parent or Legal Guardian) Date

_____ _____

Personal Representative Printed Personal Representative Signature

Description of personal representative's authority to act for the patient:

_____

_____

_____

_____

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AUTHORIZATION TO DISCUSS OR RELEASE MEDICAL INFORMATION

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to someone, you must sign this form. Signing this form will only give information to family members indicated below.

Patient Name: _____ Date of Birth: _____

I authorize Archetype Health to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

_____ _____/_____/_____

Patient Signature Date

If you are 18 years of age or younger, please list your parent(s) and/or guardian(s) name below so that we are clear who to discuss your care with.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____

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NOTICE OF PRIVACY FOR PROTECTED HEALTH INFORMATION

This notice Describes how Chiropractic and Medical information about you may be used and disclosed and how you can get access to this information. Please review carefully. Archetype Health is hereafter abbreviated AH.

Use and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. An ***AH*** staff member may have to disclose your health information, including all of your clinical records, to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health.

2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.

3. An AH staff member may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.

4. An AH staff member may need to use your name, address, phone number, and your clinical records to contact you to provide phone call, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(l)(iii)(A). If you are not at home to receive the appointment reminder, a message will be left on your machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

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Permitted Uses and Disclosures Without Your Consent or Authorization

Under Federal Law, we are also permitted or required to disclose your health information without your consent or authorization in the following circumstances:
1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you as an inmate.
3. If we provide health care services to you in an emergency.
4. If we are required by law to treat you and were unable to obtain your consent after attempting to do so.
5. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples and noted in the uses and disclosures section above, other use or disclosure of your health information will only be made with your written authorization.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:
1. If we have already released your health information before we receive request to revoke your authorization 164.508(b)(5)(i).

2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at our office address, c/o Billing Department.

Your Right to Limit Uses or Disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know in writing to what individuals or organizations you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your Right to Inspect and Copy Your Health Information

You have the right to request that we give you an account of the disclosures we have made of your health information for the last six years before the date of your request.

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The accounting will include all disclosures except these disclosures:

- Required for your treatment, to obtain payment for your services, or to run our practice
- Made to you or to individuals involved in your care
- Necessary to maintain a director of the individuals in our facility
- For national security or intelligence purposes, as required by law
- Made to correction officers or law enforcement officers, as required by law
- That were made prior to the effective date of the HIPAA privacy law

We will provide the first accounting within a 12 month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request, we will tell you the amount of the fee, and you will have the opportunity to withdraw or modify your request.

Your Right to Obtain a Paper Copy of This Notice

If you have agreed to the privacy notices by email, you may request a paper copy of this notice at any time.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your 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 our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all your health information in our files.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal privacy rules.

Your Right To Complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint, and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to the administration at our office address.