GRIMSLEY CHIROPRACTIC SERVICES, P.C.
22780 Three Notch Road, Lexington Park, MD 20653
Phone: 301-737-0662 Fax: 301-737-0675

PEDIATRIC HISTORY FORM (Age 5 and Under)

Patient Name: _____
Birth Date: _____ / _____ / _____
Age: _____ Sex: _____ Weight: _____ Height: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Phone: _____
Names of Parents / Guardians: _____
Parent's Work Phone: _____
Referred By: _____
Purpose for today's visit? _____
Other Doctors Seen for this Condition: _____
Prior Treatments: _____
Check any of conditions your child has suffered from during the past 6 months:

- ☐ Ear Infections
- ☐ Asthma / Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ ADHD
- ☐ Car Accident
- ☐ Chronic Colds
- ☐ Recurring Fevers
- ☐ Temper Tantrums
- ☐ Headaches / Neck Pain
- ☐ Back Pain
- ☐ Growing Pain / Leg Pains

Other Symptoms, conditions or diagnoses:
_____
_____
_____

Family History:

Previous Chiropractor: _____ Last Visit: ___ / ___ / ___
Reason: _____
Name of Pediatrician: _____ Last Visit: ___ / ___ / ____
Reason: _____
Number of doses of Antibiotics your child has taken during:
The past 6 months: _____ Lifetime: _____

Prenatal History:

Name of Obstetrician / Midwife: _____
During pregnancy did you:

- Have Complications? ☐ N ☐ Y
- Take Medications? ☐ N ☐ Y
- Smoke Cigarette? ☐ N ☐ Y
- Consume Alcohol? ☐ N ☐ Y

If yes to any answer, please explain:
_____
_____
_____

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Location of Birth:
☐ Hospital ☐ Birthing Center ☐ Home
Birth Intervention:
☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section: ☐ Emergency ☐ Planned
Complications During Delivery? ☐ N ☐ Y List _____
Genetic Disorders or Disabilities? ☐ N ☐ Y List _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____
Vaccination History: ☐ Uneventful ☐ Complications
List: _____

Feeding History:

Breast Fed: ☐ N ☐ Y… How Long? _____
Formula Fed: ☐ N ☐ Y… How Long? _____ Type _____
Introduced to:
Solids at _____
Cow's Milk at _____
Food / Environmental Allergies or Intolerances: ☐ N ☐ Y
List _____
Childhood Diseases:

☐ Chicken Pox : Age _____
☐ Rubella: Age _____
☐ Mumps : Age _____
☐ Whooping Cough : Age _____
☐ RSV
☐ Other
_____
_____

Developmental History:

At what age was your child able to:

Hold Head Up _____
Sit Up _____
Cross Crawl _____
Stand Alone _____
Walk Alone _____

During their first year of life did they fall from a high location? ☐ N ☐ Y
If yes, describe:

_____

Is or has your child been involved in:

Sports? ☐ N ☐ Y
Traumas? ☐ N ☐ Y
Prior Surgery: ☐ N ☐ Y
Medication Usage: ☐ N ☐ Y

If yes, please list:
_____
_____
_____
_____

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize Grimsley Chiropractic Services and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on Grimsley Chiropractic doctors to make those decisions about my care, based on the facts then known that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

By signing below I acknowledge my consent to be examined:

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

Based on current findings, Grimsley Chiropractic doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, Grimsley Chiropractic Services has provided me with the information and Grimsley Chiropractic doctors have answered my questions regarding the planned treatments and course of care that I will receive. The doctors of Grimsley Chiropractic Services have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor the medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice.

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

Doctor's Notes:

_____ _____
Signature of Doctor Date

Notice of Privacy Practices
Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record:

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination and test results, diagnosis, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record", and serves as a basis for planning our care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure accuracy and enable you to relate to who, what, when, where, and why others may be allowed to access your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others. Use or disclosure of your health information will follow the more stringent of State or Federal laws.

Understanding Your Health Information Rights:

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health record be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our Responsibilities:

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.

This office reserves the right to changes it practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. If applicable, this office will post changes on our website that provides information about our customer service and/or benefits. Other than the reason described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or to report a problem:

For further explanation of this notice you may contact our Privacy Officer at (301) 737-0662. If you believe your privacy rights have been violated, you have the right to file a complaint with this office by contacting the individual above, or by contacting the Secretary of Health and Human Services, with no fear of retaliation by this office.

Your Health Information Will Be Used For Treatment, Payment, and Health Care Operations:

Treatment---Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those others involved in providing your care such as his/her physician assistant, nurse, or medical assistant. The sharing of your health information may progress to others involved in your care, such as specialty physicians or lab technicians.

Payment---Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed, and supplies used.

Health Care Operations---The medical staff in this office will use your health information to assess the care provided and the outcome of your care compare to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

(continued over)

Business Associates---Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. For example, it may be necessary to obtain specialized assistance to process certain laboratory tests or radiology images. To protect our health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

Notification---Your health care record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or whereabouts.

Communications with Family---Using best judgment, a family member, or a close personal friend, identified by you, may be given information relevant to your care and/or recovery.

Upon Your Death--- Your health information may be disclosed consistent with laws governing estate and post-mortem personal matters. Generally, your health information may be disclosed to your personal representative as designated by you and certified by the State and to Funeral Directors with laws governing mortician services.

Organ Procurement Organization---Your health information may be disclosed consistent governing entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.

Marketing---This office reserves the right to contact you with information about treatment alternatives and other health related benefits that may be appropriate to you.

Appointment Reminders---This office reserves the right to contact you with appointment reminders through an automated system, by our staff, or via U.S. Postal Service.

Phone Contact---This office reserves the right to contact you via the telephone for such things as test result notification. We may leave a generic message on your answering machine, or with the person answering the phone concerning the nature of the call along with a request that you call us for more specific details.

Research---Your information will be disclosed to researchers upon institutional Review Board approval and upon the assurance that established protocol to ensure the privacy of your health information has been obtained.

Food and Drug Administration (FDA)--- This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable products recalls, repairs, or replacements.

Workers Compensation---This office will release information to the extent authorized by law in matters of Workers' Compensation.

Public Health---This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports or birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.

Correction Facilities---This office will release medical information on incarcerated individuals to Correctional Agents or Institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.

Law Enforcement--- (1) Your health information will be disclosed for law enforcement purposes as required under State Law or in response to a valid subpoena. (2) Provisions of Federal Law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more parties, workers, or the general public.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posed where registration occurs. All individuals receiving care will be given a hard copy

Patient's Comments:

_____

_____

_____ _____

Signature of Patient or Legal Representative **Date**

_____ **(Description of Legal Representative's Attorney)**

AUTHORIZATION TO PAY CHIROPRACTOR

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to:

Henry Chiropractic of St. Mary's
22780 Three Notch Road
Lexington Park, MD 20653

the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check to me and mail it as follows:

Henry Chiropractic of St. Mary's
22780 Three Notch Road
Lexington Park, MD 20653

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date _____

_____ (Signature of Policyholder)

_____ (Witness)

Missed Appointments

Effective November 1st, 2016, we will allow 2 missed appointments per year before charging $40.00 to your account. In other words, you get 2 "free" no show appointments per calendar year. The appointment will not be charged if you call to cancel or reschedule at least 4 hours prior to the appointment time or left a message on our voicemail.

Thank you for your consideration to our other patients who can fill in during these missed slots.

*Print Name:*_____

*Signature:*_____ *Date:*_____