Ron Engler, DC, PTA, LDHS

Redlands Chiropractic & Wellness Center, LLC

Helping you take charge of your health

Child & Adolescent Patient Introduction

Name: ____Date:____________
First Middle Last

Address: ____
Street City State Zip

Phone: (_____)______________________________(_____)_____________________________
Home Cell

Date of Birth: Mo: _______ Day: _______Yr:_______ Age:________ Sex:_________

Parent's/Guardian's Names: ____

Address: ____
Street City State Zip

Phone: (_____)________________(_____) ________________(______)____________________
Home Cell Work

Insurance:____
(Please bring card to front desk.)

Parent's/Guardian's Occupations: ____

Previous Chiropractor(s):__________________________________City ________________

When & reason for care: ____

____

Reason(s) for leaving: ____

____

Present Pediatrician: _________________________________City:____________________

Referred to us by: __________________________________Relationship: ______________

Parent or Guardian Signature ____

Printed Name_______________________________________Date____________________

2148 Broadway, C3, Grand Junction CO 81507 **(970)-243-5164** www.redlandschiropracticgj.com

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Our Services & Fee Structure

Please note that fees for your child's initial visit include an exam and adjustment.

Consultation:	Complimentary
Examination:	$ 75.00 (adult, teen age 15-17) $ 44.00 (child age 0-9) $ 50.00 (child age 10-14)
Spinal Adjustment/Treatment:	$ 52.00 (adult, teen age 15-17) $ 26.00 (child age 0-9) $ 32.00 (child age 10-14) $ 45.00 (Medicare & senior rate, 65+ for non-Medicare)
Pre-pay package of 10 adjustments/treatments:	$ 450.00 (adult, teen age 15-17) $ 300.00 (child, age 10-14)

If needed and applicable, ask about our Medicaid rates for exams & adjustments.

Comprehensive Nutritional Evaluation:	$ 550.00
Includes urinalysis lab workup, interpretation and 5 exams	
24-Hour Urinalysis lab workup and interpretation:	$140.00 plus overnight shipping cost
Two Nutritional Exams:	$100.00 (Adult) $ 75.00 (Child)
HealthLight Therapy:	$ 25.00/session $ 240.00/package of 10 *(for established patients only)*
Sunlighten Sauna:	$ 25/30 minutes individual session $ 200/package of 10 thirty minute sessions $ 49/month for unlimited visits; appointments recommended *(established patients only)*
Orthotics (FootLevelers & Fastech):	Prices vary, starting at $299

Emergency Chiropractic after hours will be billed at 1 ½ times the above applicable rates.

Please note that if your child has been involved in a motor vehicle accident, our fee structure may differ due to the complexity of the needs in such cases.

I clearly understand and agree that I am personally responsible for payment of all fees charged by Redlands Chiropractic & Wellness Center, LLC for my child's care.

Parent or Guardian Signature ____

Printed Name____Date________________________

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Pediatric & Adolescent Consultation History

Child's Name: ____________________________DOB:______________________Age:___________

Primary purpose for visit: ____

Condition onset: _________________________ Cause, if known:_____________________________

When it is at its worst, how does it make your child feel? ___________________________________

____

What effect does it have on your child's body functions? ____________________________________

____

What makes it worse?____

____

What makes it better?____

____

What have you tried to do to get rid of this problem that **DID NOT** work? ____________________

____

Other doctors seen for this condition:____

Treatment: ____

Check any of the following that pertains to your child:

- ☐ ADHD
- ☐ Allergies
- ☐ Asthma
- ☐ Adverse vaccine reaction
- ☐ Bedwetting
- ☐ Chronic colds
- ☐ Colic
- ☐ Congenital torticollis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Digestive problems
- ☐ Dizziness
- ☐ Ear infections
- ☐ Fatigue
- ☐ Growing pains
- ☐ Headaches
- ☐ Headaches
- ☐ Pain in:
  - ☐ Arm/shoulder/wrist
  - ☐ Back/neck
  - ☐ Foot/ankle/knee
- ☐ Recurring fevers
- ☐ Scoliosis
- ☐ Seizures
- ☐ Temper tantrums
- ☐ Tingling and/or numbness in arms, hands, legs
- ☐ Traumatic birth
- ☐ Ringing in ears
- ☐ Sleep issues
- ☐ Weight gain/loss
- ☐ Other____

Please provide further explanation for any of the above: _______________________________________

____

Has your child ever fallen? ☐ No ☐ Yes, list:____

____

Has your child ever been in a car accident? ☐ No ☐ Yes, list:_________________________________

____

Has your child had prior surgery? ☐ No ☐ Yes, list:____

____

If your child is currently on any medications, please list: ____________________________________

____

Other medications your child has taken in past:____

____

Parent or Guardian Signature ____

Printed Name____Date______________________

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CHILD'S NAME: ______________________________ DOB: ______________________________

Vaccination history:____

Name of Pediatrician: ______________________________Date of last visit:______________________

Reason:____Treatment:___________________________

Family History:____

____

Feeding History:
☐ Breast-fed, how long?______________________ ☐ Formula, how long?______________________

Introduced solids at ___________ months. Cow's milk at _________________ months.

Prenatal History:
☐ Complications during pregnancy? Explain: :____

____

☐ Ultrasounds during pregnancy? How many?:____

☐ Rx during pregnancy/delivery? List them: ____

____

☐ Tobacco/alcohol use during pregnancy? Frequency ____

Birth History:
Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home ☐ Other________________________
Birth intervention:☐ Forceps ☐ Vacuum Extraction ☐ C-section
Delivery complications: ☐ No ☐ Yes, explain:____

____

Birth Weight:________________ Birth Length___________________ APGAR Scores:________________

Childhood Diseases:
☐ Chicken Pox Age:_________ ☐ Rubeola Age:__________ ☐ Whopping Cough Age: ________
☐ Rubella Age:_________ ☐ Mumps Age:__________ ☐ Other:______________________

Developmental History:
At what age was your child able to:
Respond to sound __________________________ Crawl _______________________________

Respond to visual stimuli ____________________ Stand Alone ___________________________

Hold head up ______________________________ Walk _________________________________

Sit ____

Is there any other information, or other symptoms you would like us to know about?________________

____

____

____

Parent or Guardian Signature ____

Printed Name____Date_______________________

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

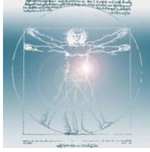
_________________________________ ____ _________________

Print Name 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 Informed Consent and hereby grant permission for my child to receive chiropractic care.

_________________________________ ____ _________________

Print Name Signature Date



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HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you with appointment and/or missed appointment reminders, including leaving voice mail or answering machine messages. We treat in an open room where other patients may be present and may overhear some of your protected health information during the course of care. Should you need to speak with your physician at any time privately, the physician will provide a room for these conversations

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient or Guardian Signature ____ Date_________________________

Printed Name____