

PEDIATRIC HEALTH HISTORY FORM



Name: _____ Date: _____

Sex: _____ Birth Date: _____ Age: _____ Social Security #: _____

Address: _____

Residence and Mailing

City

State

Zip Code

Parent/Guardian Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

How did you hear about us? Billboard Referral (Please Name) _____

Radio Magazine Ad (Please List) _____

Internet Other (Please List) _____

Primary Complaint and Location

Purpose for Contacting Us? _____

Other Doctors Seen for this Condition?: Y N Doctors' Names and Treatments: _____

Other Health Problems? _____

Check any of the following conditions your child has suffered from during the past six months:

- | | | | | |
|---|------------------------------------|---|---|---|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Growing/Back pains | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring fevers | <input type="checkbox"/> Chronic colds | <input type="checkbox"/> Asthma/Allergies |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Car accident | <input type="checkbox"/> Temper tantrums | |

Other _____

Health History

Family History: _____

Previous Chiropractor: _____

Date of last visit: ___ / ___ / ___ Reason: _____

Name of Pediatrician: _____

Date of last visit: ___ / ___ / ___ Reason: _____

Are you satisfied with the care your child receives there? Y N

Number of doses of antibiotics your child has taken: During the past six (6) months: _____ Lifetime: _____

List the antibiotics taken: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician / Midwife: _____

Complications during pregnancy? Y N, _____

Ultrasounds during pregnancy? Y N, Number: _____

Medications during pregnancy / delivery? Y N, List: _____

Cigarette / Alcohol use during pregnancy? Y N, Amount: _____

Location of birth: Hospital Birthing Center Home

Birth intervention: Forceps Vacuum extraction Caesarian section Emergency or Planned

Complications during delivery? Y N, List: _____

Genetic disorders or disabilities? Y N, List: _____

Birth weight: _____ Birth length: _____ APGAR scores: _____, _____

Feeding History

Breast fed: Y N, How long: _____

Formula fed: Y N, How long: _____ Type: _____

Introduced to solid foods at: _____ Months, Cows milk at: _____ Months

Food / Juice allergies or intolerances: Y N, List: _____

Developmental History

At what age was your child able to:

_____ Respond to stimuli (sounds and touching) _____ Respond to visual stimuli _____ Hold head up

_____ Sit up _____ Cross Crawl _____ Stand alone _____ Walk alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.)

Was this the case with your child? Y N

Is / Has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y N, List: _____

Has your child ever been in a car accident? Y N, List: _____

Has your child been seen on an emergency basis? Y N, List: _____

Other traumas not described above? Y N, List: _____

Childhood Diseases:

Chicken Pox Y N Age: _____ Rubella Y N Age: _____ Rubeola Y N Age: _____

Mumps Y N Age: _____ Whooping Cough Y N Age: _____ Other Y N Age: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Signature (Patient or Guardian)

Date

*****Do Not Write Below This Line*****

Infant Reflexes – Under 1	RT	LT	Palpation Exam								
Rooting	P A	P A	OCC	C1	C2	C3	C4	C5	C6	C7	
Sucking	P A	P A									
Nasopharyngeal	P A	P A									
Blink	P A	P A	T1	T2	T3	T4	T5	T6	T7	T8	T9
Pupillary	P A	P A									
Head Control	P A	P A									
Tonic Neck	P A	P A	T10	T11	T12		L1	L2	L3	L4	L5
Neck Righting	P A	P A									
Otolith Righting	P A	P A									
Palmar Grasp	P A	P A	SAC	LI	RI	Doctor's Notes:					
P = Present A = Absent											

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR/FACILITY
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name: _____

Employer: _____

Claim Group #: _____

SS or ID#: _____

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

Greg Crocker, DC
Sandstone Chiropractic Harmony, PLLC
3466 Discovery Creek Blvd., Suite 300
Spring, TX 77386

OR

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

C/O

3466 Discovery Creek Blvd., Suite 300
Spring, TX 77386

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy has payment toward the total charges for professional services rendered. **This is a direct assignment of my rights and benefits under this policy.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

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

I also authorized to release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this claim.

Dated at Montgomery County, this _____ day of _____ 2020

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder



Authorization to Consent to Treatment of Minor

I, _____ [name], am the
[parent/grandparent/guardian/managing conservator] of _____
a minor child, and have the power to consent to healthcare treatments for him.

Include if applicable:

If I am not present, please allow _____ to be my agent to consent to medical/chiropractic treatment of the minor when I cannot be contacted. Please allow my agent listed to provide consent for such treatment to include, without limitation, x-ray, examination; chiropractic adjustments or physical medicine treatment. No prior determination of life-threatening emergency or danger of serious or permanent injury resulting from delay of treatment need be made under this authorization.

I will indemnify and hold harmless from any expense or claim of any nature any entity that provides or causes to be provided examination, treatment, or care under this authorization (except to the extent such entity is negligent therein) and conditionally agree to make or cause to be made, by assignment of third-party benefits or otherwise, full and complete payment for such examination, treatment, or care.

Name

Date

Witness

Date



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 takes effect on the date received and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

This Notice explains how our office may collect, use and disclose your protected health information. It also explains your rights regarding your protected health information and the steps we take to keep your protected health information secure. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health condition, the provision of care to you or the payment for that care.

Our office is required to provide you with this Notice by state and federal law. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards. Our office is legally required to maintain the privacy of protected health information and to follow the privacy practices that are described in this Notice. However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to all of the protected health information that we maintain, including any information we have created or received prior to issuing any new Notice. When we make an important change to our privacy policies, we will promptly change this Notice and post a new Notice in the office. You may also obtain any new Notice by asking for one at any time. This Notice goes into effect April 14, 2003.

2. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

Our office uses and discloses your protected health information for different reasons. We may collect and disclose protected health information from you and your other healthcare providers for the purposes of coordinating treatment, payment, or operating your health care plan. Any uses or disclosures other than those described herein will be made only with your prior written authorization, unless otherwise permitted or required by law. In the event you authorize us to use or disclose your protected health information in ways other than those described above, you have the right to revoke that authorization at any time by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

FOR TREATMENT: We may use and disclose your protected health information to assist in your diagnosis and treatment. For example, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

FOR PAYMENT: We may use and disclose your protected health information in order to bill and collect payment for the treatment and services provided to you. For example, we may provide your protected health information to our billing department and your health plan to get reimbursed for health care services. We may also provide your protected health information to our business associates, such as billing companies, claims processing companies, and others that participate in claims payment process.

FOR HEALTH CARE OPERATIONS: We may use and disclose your protected health information for activities necessary to operate your health care plan including quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, underwriting or determining premiums. We may also collect and disclose your protected health information as required by industry or government regulators such as the state licensing boards and insurance regulatory agencies. Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

ADDITIONAL USES AND DISCLOSURES: As required, we may also disclose protected health information to the sponsor of your health plan (usually your employer). Our office must disclose protected health information about you when required by law. Examples of such disclosures include the following:

Avoid Threat to Health or Safety: We may disclose protected health information to law enforcement personnel or persons able to prevent or lessen a serious threat to the health or safety of a person or the public.

Coroners, Funeral Directors, Organ Donation: We may disclose protected health information to coroners, medical examiners, and funeral directors as is necessary for such persons to carry out their duties. Additionally, we may disclose protected health information relating to organ, eye, or tissue donations and transplants.

Health Oversight Activities: We may disclose protected health information to assist the government agencies for activities allowed or required by law such as when it conducts an investigation or inspection of a health care organization.

Health-Related Benefits or Services: We may disclose protected health information to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits that may be of interest to you.

Law Enforcement, Judicial and Administrative Proceedings: We may disclose protected health information when ordered to do so in a judicial or administrative hearing. We may disclose protected health information in response to a subpoena, discovery request or other lawful process. Finally, we may disclose protected health information in response to a warrant, to identify or locate a suspect, or to provide information about the victim of a crime.

National Security and Intelligence: We may disclose protected health information as required by military officials for national security and military intelligence purposes.

Public Health Activities: We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.

Research: In certain circumstances, we may disclose protected health information in order to conduct medical research. Such circumstances include taking steps to protect your privacy.

Victims of Abuse, Neglect or Domestic Violence: We may disclose protected health information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence.

Workers' Compensation: We may provide protected health information in order to comply with workers' compensation laws.

3. YOUR INDIVIDUAL RIGHTS

Right To Request Restrictions On Uses And Disclosures of Protected Health Information: You have the right to request restrictions on the use and disclosure of your protected health information. To request a restriction please speak to our privacy officer. Please note that while you may request a restriction, we have a right to refuse that request. If we accept your request, we will put the limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right To Receive Confidential Communications: You have the right to receive confidential communications, including the right to direct where communications containing protected health information are sent. For example, you may request that information be sent to your work address rather than your home address or via alternative means such as email rather than regular mail. To verify or modify where or how you would like such communications sent, contact our privacy officer. We will accommodate all reasonable requests. Unless requested otherwise, we will direct mailings and telephone messages containing protected health information to the address and telephone number we have on record for the subscriber of the health plan.

Right To Inspect And Copy Protected Health Information: In most cases, you have the right to see and get copies of your protected health information that we maintain. If you want to see or get copies of your protected health information you must submit your request in writing to our privacy officer. If we do not have your protected health information but knows who does, we will tell you where you can get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do deny your request, we will tell you, in writing, the reasons for the denial and explain your right to have the denial reviewed. If you request copies of your protected health information, we will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance. Instead of providing the protected health information you requested, we may provide you with a summary or explanation of the protected health information as long as you agree to the summary and any applicable charges in advance.

Right To Amend Protected Health Information: If you believe that there is a mistake in your protected health

information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reasons for the request in writing to our privacy officer. We will respond within 60 days of receiving your request. We may deny your request in writing if the protected health information is (1) correct and complete, (2) not created by us, (3) not allowed to be disclosed or (4) not part of our records. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a rebuttal, you have the right to request that copies of your initial request and our denial be attached to all future disclosures of your protected health information. If we approve your request, we will make the change to your protected health information, inform you when the change is completed, and inform others that need to know about the change to your protected health information.

Right To Receive An Accounting Of Disclosures Of Protected Health Information: You have a right to receive an accounting of any disclosures of your protected health information that were made for purposes other than coordinating treatment, payment or other health care services plan operations. The accounting will not include uses or disclosures made for treatment, payment, or health care operations, disclosures made directly to you or your family, or disclosures that you have already authorized. Additionally, the accounting will not include uses and disclosures made for national security purposes, or to corrections or law enforcement that has lawful custody over you. We will respond within 60 days of receiving your written request. The accounting will include the date of the disclosure, to whom protected health information was disclosed (including their address, if known), a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting you request within a 12-month period at no charge. For additional accountings within the same time period, we may charge you a fee for each additional request but will inform you of that fee in advance. To request an accounting of any such disclosures submit your request in writing to our privacy officer stating the time period for which you want the accounting. This time period may not be longer than six years and may not include dates before April 14, 2003.

Right To Get A Paper Copy Of This Notice: You have the right to get a paper copy of this Notice at any time even if you previously agreed to receive an electronic copy.

4. DISCLOSURE OF PHYSICIAN OWNERSHIP – NOTICE TO PATIENTS

Disclosure of Physician Ownership: Sandstone Chiropractic has partial ownership of Essential Imaging. You have the right to choose the provider of your health care services. Therefore, you have the option to use an imaging facility other than Essential Imaging.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Sandstone Chiropractic, P.A. or Essential Imaging. By signing this form, you understand the forgoing notice and understand that your physician has an ownership interest in Essential Imaging.

5. QUESTIONS AND COMPLAINTS

Right To File a Complaint: If you believe that your protected health information has been improperly used or disclosed, or that your privacy rights have been violated you may file a privacy complaint with us. To file such a complaint you should contact our privacy officer. You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services (DHHS). We will take no retaliatory action against you if you file a complaint with us or the DHHS.

Address: Please send all correspondence to:

Compliance Officer
Mallory Southard
Sandstone Chiropractic Harmony, PLLC
3466 Discovery Creek Blvd., Suite 300
Spring, Texas 77386

Patient Signature

Date

OFFICE POLICY

We believe that a clear definition of our office policies will allow you, the patient, and us, the doctor, to concentrate on the big issue - regaining and maintaining your health.

APPOINTMENT POLICY

Multiple appointments will be scheduled, for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts, and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to **make up a missed appointment within 7 days of any cancellation.**

The office reserves the right to charge for those appointments canceled without six hours notice. The cancellation fee is \$25.

When entering the office on any given visit, please go directly to the front desk and "sign-in." We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

The purpose of requiring all new patients to attend a Special Consultation/Spinal Health Orientation is to educate you about your body, especially the spine and nervous system. Since chiropractic is clearly not the practice of medicine, and is probably new to you, it is essential to understand how to help us help you get well faster. We have found that patients attending the class seem to respond better because they understand the cause of their problem and what we are attempting to do to correct it.

Your attendance at the Special Consultation is mandatory! It is part of your program of care. Further, we request that you bring your spouse or another family member, so he/she can understand too, and learn to assist you in your quest to regain your health. Friends and relatives may also attend, as this is a terrific way for them to find out the value of chiropractic care. Just ask at the front desk to reserve a place for your guests.

FINANCIAL POLICY

1. Ultimately, the patient is responsible for all services rendered, including those not reimbursed by third party payers. Insurance verification is a courtesy we provide for the patient. **Sandstone Chiropractic recommends that all patients call their respective insurance companies to verify the benefits we have been quoted.**
2. All payments are expected at the time of service, or at the beginning of each week. Payment plans are available through the written authorization of Sandstone Chiropractic.
3. All insurance patients must pay their deductibles in full and the co-payment at the time of service, or at the beginning of each week.
4. All accounts not paid within 90 days will automatically be transferred to a collection agency.
5. Any changes of insurance companies and/or information needs to be reported immediately. All services rendered will be charged directly to you for failure of notification.

Signature

Printed Name

Witness

Date



3466 Discovery Creek Blvd., Suite 300
Spring, Texas 77386
(281) 367-5020
(281) 466-1019 Fax

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, authorize _____

to have access to the following information indicated below in my patient file at Sandstone Chiropractic.

Records Reports X-Rays MRI Patient Schedule Account Balance

Delivery Method:

Mail Fax Patient Pick-up Phone

(Patient Signature)

(Patient Name)

(Witness Signature)

(Date of Birth)

(Date of Request)

(Daytime Phone Number)



3466 Discovery Creek Blvd., Suite 300
Spring, Texas 77386
(281) 367-5020 Office
(281) 466-1019 Fax

PHONE CONTACT CONSENT AND AUTHORIZATION

I, _____, with respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, for the below listed individual, fully consent to and authorize Sandstone Chiropractic or any of its automated systems to contact me via phone (including to my cellular phone by way of phone call or text message) in relation to any services received from Sandstone Chiropractic or any services planned to be received from Sandstone Chiropractic (including any billing items or appointment reminders).

If this Consent and Authorization applies to someone for whom you are a legal representative, please print their name below, if not please indicate so by populating the blank with N/A.

Patient Name

Patient Signature

Legal Representative Name

Legal Representative Signature

Witness

Date