Practice Member Application for a Minor (Under 18 years)

Name:_________________________________ Age: __________ Today's Date: ______________

Address: ____

Residence and Mailing City State Postal Code/Zip

Home # ________________ Work # ________________Ext.____ Mobile #________________

Email: ________________________ Birth date: ____________________ Male: ___ Female: ___

Mother's Name: _______________ Mother's Occupation: _____________________

Father's Name:____________________ Father's Occupation: ______________________________

Insurance Info: ___________________________ Parents Married: ____ Divorced/Separated: ___

Number of siblings:____ Names & ages of siblings: ____

Has the minor been under previous chiropractic care? Yes ☐ No ☐ Were X-rays Taken? Yes ☐ No ☐

Chiropractic Office/Doctor name: ______________________ When was your last adjustment? __________

Medical Doctor's name and phone number: ____

Who may we thank for referring you to our office? ____

Why This Form Is Important

At New Leaf, we focus on your body's innate design to be healthy. Our goals are to address the issues that brought you here and offer you and your family the opportunity to experience your own maximized expression of optimal health. Please take a moment now to fill out these few questions so that we might better understand your overall health picture and develop an appreciation of the layers of damage that may exist in your body which are currently blocking your innate ability to be 100% healthy.

If you have no symptoms or complaints, and are here for wellness services, please check (√) here _____ and skip to "**Family Health Profile**"

For those who have symptoms or complaints please describe the **chief area of complaint**, including the effects it currently has on your life, when you **first noticed it,** and **how it originally occurred**.

____

____

____

____

Since the problem started, it is: ☐ About the Same ☐ Getting Better ☐ Getting Worse

What makes it worse? ____

____

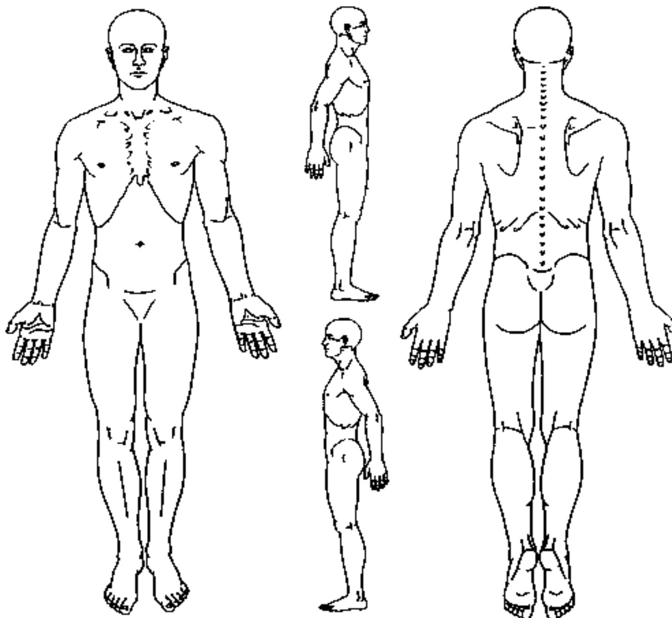
How frequent is the complaint? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only
How long does it last? ☐ All day ☐ A Few Hours ☐ Minutes
Is there anything you can do to relieve the problem? ☐ Yes ☐ No If yes describe: _______________
It Interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

(no pain) 1 2 3 4 5 6 7 8 9 10

Please mark an X on the line above to indicate your problem level

On the diagram below, label ALL areas you are experience using the appropriate letter below.

A=Aching C=Cramping R=Throbbing Pain N=Numbness O=Other ______________
B=Burning D=Dull Pain S=Stiffness T=Tingling



Please list any major accidents or surgeries the patient has had:________________________________

____

Please list any medications: ____

____

In the boxes below please check **(X) for all current symptoms** and **(P) for all past symptoms** you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins & Needles Legs/Arms	☐ Fainting	☐ Neck Pain
☐ Loss of Smell	☐ Sinus Problem	☐ Low Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Numbness in Fingers/Toes	☐ Bed Wetting	☐ Nervousness
☐ Buzzing in Ears	☐ TMJ Pain	☐ Loss of Taste	☐ Upset Stomach
☐ Fatigue	☐ Broken Bone(s)	☐ Irritability	☐ Tension
☐ Sleeping Problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Sensitive Eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers
☐ Depression	☐ Eating Disorder	☐ Difficulty Concentrating	☐ Asthma
☐ Pain with Cough/Sneeze	☐ Ear Infections	☐ Shoulder Pain	☐ Allergies
☐ Dizziness	☐ Mid back Pain	☐ Hip Pain	☐ Cancer
☐ Other______________	☐ Migraines	☐ Kidney Problems	☐ Diabetes

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any CURRENT health conditions or concerns you may have about your family.

Condition	Patient	Father	Mother	Children (Names)	Child #2	Child #3
Anxiety						
Arthritis						
Asthma or Allergies						
Back Pain						
Constipation						
Difficulty Sleeping						
Disc Problems						
Ear Problems/Infections						
Fatigue						
Fibromyalgia						
Headaches/Migraines						
High Blood Pressure						
Neck Pain						
Numbness						
Pinched Nerves						
Scoliosis						
Stomach/Digestive						
Sinus Congestion/Pain						

Pregnancy Release (Females Only)

I certify to the best of my knowledge that I am not pregnant and the doctors have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period (if applicable) : ______________________

Signature of Parent or Guardian: _______________________ Date: ____________________

Signature of minor: _________________________________ Date: ___________________

New Leaf
Chiropractic & Family Wellness

FINANCIAL POLICY

At **New Leaf Chiropractic & Family Wellness**, we understand that the cost of healthcare is a key concern for our patients. Your care is our main priority, but we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy a member of our staff will be glad to assist you. We are happy to check your chiropractic benefits for you and inform you if there are any additional financial/insurance options. In the event there is no coverage, high deductibles or we are an out of network provider, we are able to provide you with a written summary statement of your charges so that you may submit directly to your insurance company (aka the Superbill). You are expected to pay in-full at the time of your visit and to assist this we accept cash, HAS accounts, credit cards (MasterCard, Visa, Debit) and personal checks.

When you pay by check you expressly authorize this office (Breitlow Chiropractic LLC), if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a processing fee of $35 and any applicable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and it's terms.

Accepting assignment and/or liens is done so under a pre-qualified understanding between the patient, this office and the third party payor(s). Establishing an honest ethical working relationship allows this office to continue accepting liens and assisting patients in their goals for better health. Any and all changes of the original party's agreement, independent of this office's knowledge or consideration, immediately disqualifies the terms of that agreement and demands immediate payment on the outstanding balance.

Financial arrangements are valid under your present condition. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify this office prior to your care. Should you discontinue care or be released from further service, at this office, all outstanding balances are due upon notification. Any past due balance not paid **within 90 days** will be reported to the credit bureau and turned over to an attorney or agency for collections. You will be held liable for up to 50% of the balance owed for the collection fees associated with past due accounts. Please keep your account current to avoid any action or blemish on your credit history. We are happy to put xrays on loan, however any x-rays checked out from the office and not returned within 30 days will be subject to a $250 collection fee as these are part of your permanent record at Breitlow Chiropractic LLC.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions.

I have read, understand and agree to this Financial Policy in its entirety.

Printed Name:____

Signature: ______________________________ Date: ______________

Signature of Parent or Guardian (if patient is under 18) ______________________________

PATIENT PRIVACY

This practice is committed to maintaining the privacy of your **P**rotected **H**ealth **I**nformation (**PHI**), which includes information about your health condition and the care you receive from the practice. This notice details how this information may be used in this office. With consent from you, it is the policy of this office to use the your PHI in the following manners:

1. Treatment: Your PHI will be given to those professionals that require it to provide care.
2. Appointment reminders: Our staff may call/text/email from time to time to remind you of appointments
3. Sign-in Log: We maintain a log of incoming patients for our own statistical use
4. Referral board: We keep a board to thank member of our practice who have referred others
5. Medical Doctors: It is the policy of this office to share our findings with your regular medical doctor. This helps build a better understanding of how we may work together to improve your health.
6. Email: We have compiled a database of "all things health" and we will add you immediately to this list for you and your family's convenience. We never "Spam" in fact we dislike it as much as you. You have the right to easily unsubscribe from future emails with a "one-click" option from any previous email

In special circumstances, your PHI may be disclosed as in the following:

1. Personal Representative: In accordance with applicable law that may represent you.
2. Emergency situations
3. Abuse, Neglect, or Domestic Violence
4. Law Enforcement issues
5. Worker's Compensation claim
6. Avert a health threat

Your rights regarding your health information:

1. Right to inspect and copy your records: A written request must be submitted and cost of copying may be applied to such a request
2. Amend your PHI by submitting a written request with an explicit reason.
3. Request restrictions on your PHI. However, this practice is not obligated to agree to any such restrictions.
4. Revoke consent at any time
5. Complain to the practice

Printed Name of Practice Member/Patient: ____

Signature: ____ Date: ________________

Signature of Parent or Guardian (if patient is under 18) _________________________________

INFORMED CONSENT

The primary treatment used by a Doctor of Chiropractic is a specific spinal adjustment.
Based on the findings from an examination, x-rays, nervous system scan, and history. – we will determine if an adjustment is appropriate to facilitate your health goals. Each person is different and each adjustment is delivered based on the specific nature of the individual. Chiropractic has only one goal: to remove vertebral subluxation.

The nature of the chiropractic adjustment.
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. We will use our hands and/or a mechanical device (called an *Activator*), which removes subluxations and allows your body to heal and fully express itself fully.

The material risks inherent in chiropractic adjustment.
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during your health history, examination and Xray. Stroke has been the subject of tremendous disagreement within and outside of the profession with one prominent authority/researcher (Haldeman, Scott, D.C. M.D.) saying that there is **at most** a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

The availability and nature of other treatment options.
Other treatment options for your condition include, but are not limited to: Self-administered, over-the-counter analgesics; rest; Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers; Hospitalization with traction; Surgery.

The material risks inherent in such options and the probability of such risks occurring include:
• Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

• Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health,

severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks — some with rather high probabilities.

• Hospitalization in conjunction with other care, bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon variables.

• The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies to many factors.

The risks and dangers attendant to remaining untreated.
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Jay Breitlow and/or Dr. Christina Hunter and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved and give my consent to accept chiropractic care on this basis.

Printed Name of Practice Member/Patient________________________________

Signature: ____________________________ Date: __________________

Signature of Parent or Guardian (if patient is under 18) ________________________________

__________________________ _________________________ ____________
Signature of witness Printed Name of Witness Date