INNER SUN CHIROPRACTIC

PEDIATRIC PATIENT INTRODUCTION CARD

Date: _____

Childs's Name: _____ Age: _____ Date of Birth: _____ Sex: F M

Street Address: _____ City, State, Zip: _____

Parent's Names: _____

Phone: _____ Email: _____

Whom may we thank for referring you to our office? _____

Reason for coming to our office: _____

Name of Person Responsible for the Account: _____

Relationship to Patient: _____ Preferred Phone: _____

Address if different than above: _____

Insurance Company: _____ Name of Insured: _____

Relationship to Patient: _____ Date of Birth: _____

Present Health Challenge(s)

For what health challenge(s) is your child here for? When did it begin? _____

_____

Has your child seen other health care practitioners for this? What did they recommend? _____

_____

What was the out come of the prior treatment recommendations? _____

_____

Is this condition getting progressively worse? ____Yes ____ No

Health History

Symptoms: Please check any current or past problems your child has on the list below:

___ Anemia	___ Colic	___ Headaches	___ Poor Memory
___ Arthritis	___ Concussions	___ Heart Condition	___ Rashes
___ ADHD	___ Constipation	___ Hernias	___ Reflux/Spitting Up
___ Allergies	___ Convulsions	___ Hyperactive	___ Runny Nose
___ Anxiety	___ Cough Wheeze	___ Hypertension	___ Scoliosis
___ Arm Elbow Pain	___ Diabetes	___ Joint Pain	___ Sinus Trouble
___ Autism	___ Diarrhea	___ Insomnia	___ Sprains/Strains
___ Back Aches	___ Digestive Problems	___ Itchy Eyes	___ Stomach Aches
___ Behavioral Issues	___ Dizziness	___ Knee Foot Pain	___ Unusual Moles
___ Bed Wetting	___ Eczema	___ Leg Hip Pain	Other_____
___ Blood Disorders	___ Fainting	___ Muscle Pain	_____
___ Broken Bones _____	___ Fever/Chills	___ Neck Pain	_____
___ Chest Pain	___ Frequent Colds	___ Nightmares	_____
___ Chronic Earaches	___ Growing Pains	___ Poor Appetite	

Name of Pediatrician: _____ Date of Last Visit: _____

Current Medications & Vitamins: _____

Past Trauma (falls, sports injuries, accidents, etc.) _____

_____

Past Surgeries: _____

_____

Prenatal History

Locations of Birth: ____ Home ____ Birthing Center ____ Hospital

Complications during pregnancy: ____ Yes ____No List: _____

_____

Medications during pregnancy/Delivery: List: _____

Cigarette/Alcohol use during pregnancy: ____ Yes ____ No

Birth intervention: ____ Forceps ____ Vacuum ____Caesarian

Complications during delivery: ____ Yes ____No List: _____

Birth weight _____ Birth length _____

Feeding History

Breast Fed: ____ Yes ____ No How long? _____ Formula fed: ____ Yes ____No How long? _____

Type: _____ Introduced to cereal at ____ months. Solids at ____ months. Cow's Milk at ____ months.

Food/Juice allergies or intolerances ____ Yes ____ No List: _____

Developmental History

Sleep (hours per night) _____ Problems sleeping _____

Medical/Vaccination History

Has your child ever had an adverse reaction to a prescription or over-the-counter medication?

____ Yes ____ No If yes please explain: _____

Has your child been vaccinated? ____ Yes ____No Adverse reactions to any vaccine? _____

Childhood Diseases

____ Chicken Pox: Age ____	____ Meningitis: Age ____	____ Whooping Cough: Age ____
____ Measles: Age ____	____ Rubella: Age ____	____ Other: _____
____ Mumps: Age ____	____Tuberculosis: Age ____	_____ Age ____

_____ _____

Signature of Parent or Guardian **Date**

Inner Sun Chiropractic, P.C.
Dr. Ron Burnett, D.C.
1211 West Sixth Street, Suite 800
Austin, Texas 78703

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

I, _____(print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used within the office for purposes of my care, to those individuals designated by the doctor.

Patient or Parent Signature: X_____ Date: _____

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier.
If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

Assignment of Rights and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request.
To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility.
I instruct checks to be made payable to Inner Sun Chiropractic, and the payment sent to 1211 W Sixth Street, Ste. 800, Austin, Texas 78703.
This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s).

Patient or Parent Signature: X_____ Date: _____

Informed Consent for Treatment

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

• I, the undersigned parent or legal guardian of _____ (minor child), hereby give my permission to the staff of Inner Sun Chiropractic to treat said child.

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case.

Patient or Parent Signature: X_____ Date: _____