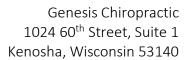




Is this visit due to an auto or workman's comp accident? NO / YES

(If yes, please inform the front desk of this if you haven't already.)

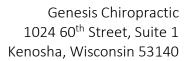
Parent/Guardian Name:	e	
Address: City:State:Zip:	e	
City: State: Zip:	e	
Date of Birth: Gender: Male / Female Social Security #:	e	
Race: American Indian / Asian / Black or African American / Native Islander / White / Decline Ethnicity: Hispanic-Latino / Non-Hispanic-Latino / Decline Preferred Language:	е	
Ethnicity: Hispanic-Latino / Non-Hispanic-Latino / Decline		
Primary Care Physician Name: Clinic Name/Location: Who may we thank for referring you to our office? Have you had x-rays, MRI, or CT scans completed? (if yes) When/Where/Area of body: CURRENT HEALTH CONDITIONS: Current Height and Weight: Is your child receiving care from any other health please name them and their specialty: What health condition(s) bring your child to be evaluated by a chiropractor? When did the condition(s) begin? How did the condition start? (I.E. Suddenly, Gradually, Posts this condition getting: Worse, Improving, Intermittent, Constant, Unsure:		
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Is this condition getting: Worse, Improving, Intermittent, Constant, Unsure:	 t-Iniurv):	
	, , , <u> </u>	
What makes the problem better? What makes the problem wo		
What makes the problem better:	t makes the problem better?:What makes the problem worse?:	
What are your health goals for your child?:		
Has your child seen a Chiropractor before?:		
Please tell us about your pregnancy:		
Any fertility issues? No/Yes:		
Did you consume alcohol? No/Yes Casual Drinker Moderate Drinker	Heavy Drinker	
Did you smoke? No/Yes Current Smoke (Since :) Former S	•	
Did you have health issues/concerns during your pregnancy No/Yes:	-	
Did you exercise? No/Yes Daily Weekly Walks Run:		





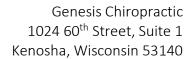
<u>Labor & Delivery History:</u>

Childs birth was: Natural vaginal Birth, Scheduled C-Section, Emergency C-Section,							
At how may weeks was your child born?: Childs Birth Weight/Height:							
Where was your child born?: Who delivered your baby?:							
Please indicate any applicable interventions or complications: Breech, Induction, Pain Meds, Epidural, Episiotomy,							
Vacuum Extraction, Forceps, Other: Please describe any other concerns or notable							
remarks about your child's labor / delivery / conception:							
Growth & Development History:							
Is/was your child breastfed? Yes/No If Yes, how long? Was there difficulty?:							
Did they ever use formula? If yes, at what age? What type?:							
Did/does your child suffer from colic, reflux, or constipation as an infant?: No / Yes: If yes, please explain:							
Did/does your child frequently arch their neck/back, feel stiff, or bang their head?:							
At what age did your child; Respond to sound:, Follow an object:, Hold their head up:,							
Vocalize:, Teethe:, Crawl:, Walk:, Begin Cows Milk:, Begin Solid foods:							
Does your child consume caffeine? No/Yes, If Yes: < 3 Drinks/day, 3-6 Drinks/day, >6 Drinks/day							
Does your child exercise: Yes/No How many hours a day is your child interacting with an electronic device/tv?							
Have you chosen to vaccinate your child? No/Yes If Yes: On a delayed schedule OR On schedule.							
Has/had your child experienced night terrors or difficulty sleeping? Yes/No If Yes explain:							
Does your child have behavioral, social, or emotional issues: No/Yes, If yes explain:							
List ALL Allergies & Date they started:							
List ALL Surgeries (dates included):							
List ALL Medical History conditions:							
List ALL Medications/Vitamins they are taking (DATE STARTED as well as dosage):							
Has your child received any antibiotics? No/Yes If yes, how many times and for what reasons:							



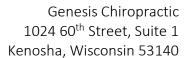


Family Health History: Please write down any/all medical histories below that apply to the following family members					
		Mother: Sisters:			
				Son:	
	<u>Development</u>	al Accomplishments			
	Gross Motor Skills: ☐ Holds head up from table momentarily	Fine Motor Skills: ☐ Grabs your finger when placed in palm			
	□Pushes up with hands and forearms □Can be pulled into a sitting position by hands	☐ Holds and shakes a rattle placed in the left hand☐ Grabs objects by him/her self			
	□Sits unsupported in the upright position □Rolls from back to belly	☐Moves an object from one hand to the other☐Self feeding — can hold and eat food			
	□Crawls □Stands holding onto something	□Checks objects by placing them in mouth □Picks up objects with thumb and pointer finger			
	□Walks with someone holding onto one hand□Walks unassisted	☐Turns 2 to 3 pages of a book at the same time ☐Turns 1 page of a book at a time			
	□Negotiates stairs placing 2 feet on each step □Negotiates stairs placing 1 foot on each step □Hops on 1 foot	☐Builds a tower containing at least 5 blocks ☐Builds a tower containing at least 10 blocks			
	Social Skills:	Communication Skills:			
	□Smiles	□Makes cooing sounds			
	□Reaches for familiar objects □Plays with hands	□Uses 1 syllable words such as "ma" □Uses 2 syllable words such as "mama"			
	□Plays with feet	Uses multiple words together to make a sentence			
	□Clearly shows joy and pleasure	a seemand to be the make a semente			
	□Plays peak-a-boo				
	□Understands yes and no				
	□Laughs				
	Adaptive Skills:				
	□Holds his/her own bottle				
	□Drinks from a cup unassisted				
	□Feeds self with fingers				
	□Feeds self with spoon and fork				
	□Able to identify and match some colors				
	□Copies a circle or a cross				





Printed name of patient or patient's representative/parent	 Date
Genesis Chiropractic Clinic Inc communicates with its patient point information the patient or the patient's representative/parent phone, text messaging, email, fax and U.S. mail. By providing your registration process, you: 1. Consent and agree to receive teleptommunications. These calls may be in regard to services receive your financial obligations related to those services. I understant future medical service accounts for which I am the Guarantor. such calls, messages, or other communications by your wireless responsibility to inform Genesis Chiropractic Clinic Inc if I choose withdraw this consent at any time by contacting Genesis Chiropractand, and agree to the above:	opulation in a variety of ways. We use provides, including landline phone, cell our cell phone number during the phone calls, text messages and other ived at Genesis Chiropractic Clinic Inc and and this consent applies to all current and 2. Understand you may be charged for as carrier. 3. I understand it is my se to withdraw this permission. I can
Payment in full is due at the time services are rendered. We their chiropractic insurance benefits prior to appointment insurance benefits if you need to be informed. Co pays an or your appointment may be rescheduled. If payment arrangement speak with our office staff to make payment arrangement not ensure payment, in cases of partial payment OR deniating insurance carrier) you are responsible for the remaining be our office of any changes to your insurance policy prior to can result in timely filing, in which the unpaid claim will be	We urge patients to be familiar with t. Our office staff calls and verifies your nd deductibles are due at time of service angements need to be made, please ts. Billing your insurance company does al (unless stated otherwise by your palance. You are responsible to inform by your visit at our facility, not doing so
Signature of patient or patient's representative/parent	
Printed name of patient or patient's representative/parent	Date
We at Genesis Chiropractic Wellness and Rehabilitation Center privacy of and provide individuals with the attached Notice of crespect to protected health information. If you have any object with our HIPPA Compliance Officer in person or by our main phthe Notice, please ask. I hereby acknowledge that I have review document.	our legal duties and privacy practices with tions to the Notice, please ask to speak none number. If you would like a copy of





INFORMED CONSENT

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal; to identify and correct subluxations. 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.

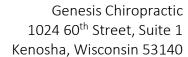
- **1. Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral/extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities
- 2. Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.
- **3. Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
- **4. Extremity Subluxation:** A misalignment of an extremity causing edema, fixation and or joint irregularity. The aim of extremity adjusting is to assess the extremity, do an analysis, and then develop a treatment for the extremity.

We may diagnose any condition or disease that comes into our office in addition to the vertebral and extremity subluxations. It is our goal to refer a patient to their health care practitioner, or in urgent matters, to the closest emergency room if we feel their health, or our diagnosis, warrants the referral. We do not treat diseases or conditions in our office beyond the spine or extremities, however, other diseases may improve with chiropractic care. In doing so, it's important to work with you, the patient, on reaching your optimal health. Our only practice objective is to serve you the patient. We are here for your health! Chiropractic care, while rare and unlikely, has risk factors. Most are self-limiting but rare serious risk factors include fracture, exacerbation of a disc herniation, and stroke.

Privacy and Sharing of Information

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we require you to read and sign this consent form stating that you understand and agree with how your records will be used.

- 1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
- 2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- **3.** A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- **4.** The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.





- **5.** For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
- **6.** Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- **7.** If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-Ray Release

This is to certify that **practitioners at Genesis Chiropractic have my permission to perform an X-ray evaluation**. I have been advised that x-ray can be hazardous to an unborn child and, if applicable, will inform Genesis Chiropractic if I am or might be pregnant. If I am pregnant, I consent to receive an x-ray once it is safe to do so.

I hereby authorize any medical facility to release my previous films/images and reports to Genesis Chiropractic for comparative purposes. In addition, I authorize Meier Family Chiropractic to release my films/images to any other facility for comparative purposes or to a radiologist for review of my films/images.

Consent to Care for Minor

If applicable, I authorize providers at Genesis Chiropractic to administer care necessary to my son/daughter.

Insurance & Financial Responsibility

Signature of patient or patient's representative/parent

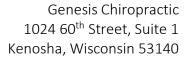
I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Genesis Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Genesis Chiropractic will be credited to my account on receipt. Your insurance company will only pay for services that they determine are medically necessary. I understand that some or all services provided for me might not be covered by my contract benefits.

I understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for services rendered to me will be immediately due and payable.

I understand that cancellations must be communicated prior to my appointment. A no call/no show will result in a fee except in the event of an emergency. I understand that a no call/no show fee will be collected at the time of my missed appointment.

I have read and fully understand the above statements. All questions regarding the doctor's objectives

pertaining to my care in this office have been answered to my c chiropractic care on this basis.	omplete satisfaction. I therefore accept
Printed name of patient or patient's representative/parent	 Date





WELLNESS/MAINTENANCE CARE

Most insurance companies do not pay for maintenance care. Maintenance care is deemed **medically unnecessary** through insurance companies. Some verbiage your insurance company might use to describe medically unnecessary treatment is as follows:

- Treatment for a chronic condition if there is no reasonable expectation of improvement.
- Treatment to prevent a relapse or exacerbation of a condition (maintenance)
- Treatment dates over a 2-4 weeks interval
- Long term treatment for the same or similar condition

This notice is to inform you of possible non-covered services that you may be responsible for payment. Any services deemed not medically necessary or unpaid by your insurance, will be discounted to our cash fees.

Upon signing this notice, I am declaring that I fully understand what has been described above and agree to pay all uncovered services. I fully understand that my insurance company will no longer be billed for treatment received and I cannot appeal to see if my insurance will pay for said treatment.

Printed name of patient or patient's represe	ntative/parent Dat	re
Signature of patient or patient's representa	cive/parent	
AUTHO	RIZED CONSENT FORI	М
l,a any and all chiropractic treatment at Ge INC. This includes any information perta calling and scheduling/canceling appoin	nesis Chiropractic Welln Ining to medical treatme	ess and Rehabilitation Center,
1		atient
2	Relationship to Patient Phone #	
Printed name of patient or patient's represe		<u></u>
Signature of patient or patient's representa	· 	E