For Children under 12 years of age

Palmer Chiropractic

Date _____ Case No._____

Name _____ Address _____

Phone _____ Date of Birth _____ Age _____ Male/Female

Parent or Guardian's Name _____

Parent or Guardian's Social Security # _____

Address (if different from child's) _____

Chief complaint or problem _____

What type of birth:

_____ Vaginal _____ C-Section _____ Forceps _____ Suction Cup

Presentation: _____ Normal _____ Breach _____ Frontal

With anesthesia (pain killer)? _____ Yes _____ No

Type used: _____ Oral _____ Hypo _____ Spinal Block _____ Subdural Injection _____ General Anesthesia

Child Presently Has _____X or Has Had _____ ✓

_____ Cholic _____ Chicken Pox _____ Measles _____ Mumps Right/Left _____ Colds

_____ Constipation _____ Diarrhea _____ Difficult Sleeping _____ Overactive _____ Asthma

_____ Difficult Breathing _____ Skin Eruptions _____ Vomiting _____ Frequent Crying

_____ Feet Turn Out Right Left Both _____ Feet Turn In Right Left Both

Falls: (details) _____

_____

Injuries: (details) _____

_____

Is she/he taking any medication? Prescription or patent? _____

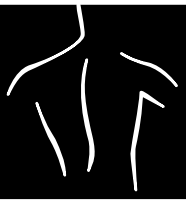
If so, what drugs? _____

Operations: _____ Ear Tubes _____ Tonsillectomy _____ Heart Other _____

I hereby authorize Dr. Palmer and/or whomever he may designate as his assistant to administer Chiropractic care as he deems necessary to my child. It is understood and agreed the amount paid to Palmer Chiropractic Center for X-Ray is for examination only, and the X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I understand that if my insurance company covers services and the check(s) is sent to the patient, it is the patients responsibility to bring the check and explanation of benefits to this office. I understand and agree that if my insurance or medicare fails to provide payment for services rendered that it is my responsibility to pay for these services. Co-pays and/or deductibles that are left unpaid for more than 30 days will incur an 18% interest rate, per month of deliquency.

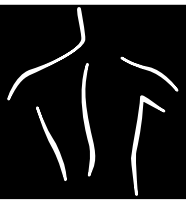
_____ _____

Parent/Guardian Name (Print) Parent/Guardian Signature



Palmer Chiropractic

Your health is our concern

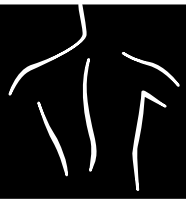


I, (print your name) _____, as the parent or legal guardian of minor child _____ give to Dr. Trace Palmer and his staff my permission to do the following listed and initialed procedures on the above named child.

- ☐ Perform a chiropractic examination. (Your initials please) _____
- ☐ Perform x-rays needed on this patient. (Your initials please) _____
- ☐ Initiate chiropractic care as deemed necessary. (Your initials please) _____

I understand that I am responsible for any portion of the bill not paid for by any health care coverage, including: private or group insurance, accident coverage, and any State or Federal health care program,
etc.

Parent or Legal Guardian Signature _____



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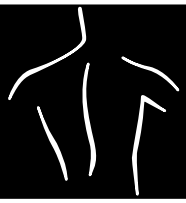


********** PERMISSION SLIP FOR PHOTOGRAPHING YOUR CHILD **********

From time to time we take pictures of our well-adjusted children. We would like your permission to use these pictures in a collage photo frame. We will never reference your child by name or provide any specific information regarding your child. We also will never sell these pictures; we will use them exclusively for our photo wall. Please take a moment to let us know your preferences regarding our use ofphotos of your children:

_____YES. I grant you permission to use photos of my child on Palmer Chiropractic's photo wall.

Or

_____ NO. Please do NOT take or use any photos of my child.

Child(ren)'s Name(s) (PLEASE PRINT):_____

Parent/Guardian's Name (PLEASE PRINT): _____

Parent/Guardian's Signature:_____ Date: _____

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive.

By signing this form, I understand that:

- **Protected health information may be disclosed or used for treatment, payment, or healthcare operation**
- **The practice reserves the right to change the privacy policy as allowed by law**
- **The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions**
- **The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease**
- **The practice may condition receipt of treatment upon execution of this consent**

May we phone you to confirm appointments? **YES** **NO**

May we leave a message on your answering machine at home or on your cell? **YES** **NO**

May we leave a message at your employment? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

If YES, please name the members allowed:_____

_____

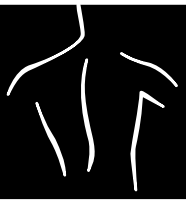
Child's Name: _____

This consent was signed by:_____
PRINT NAME PLEASE

Parent's Signature:_____

Date:_____

Witness:_____**Date:**_____



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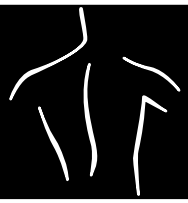

Childs Name _____

Parents Name_____

CONSENT FOR TREATMENT FOR A MINOR CHILD

I hereby give my consent to the performance of diagnostic tests including x-ray, examination procedures, chiropractic adjustments and management of my condition(s). Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **Following are the known risks**: **-Temporary soreness or increased symptoms or pain**. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. **-Dizziness, nausea, flushing,** these symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care. **-Fractures**, when patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. **-Disc herniation or prolapsed**, spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen. **-Stroke**, a certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke. I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care. **INITIALS**_____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to ***Palmer Chiropractic*** professional services rendered. NO OTHER THIRD PARTY, including attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office. **INITIALS**_____

RELEASE OF INFORMATION

I hereby authorize ***Palmer Chiropractic*** to release medical and financial data to my childs insurance carriers.
INITIALS_____

Permission can always be revoked, but this must be done in writing

Parents Signature _____ **Date** _____