



# Healing Hands Chiropractic Family Wellness Center

An Integrative Approach To Optimal Health

## *Policies for Patient, Client, & Student Conduct*

### **Late appointments**

When you schedule an appointment, that time is reserved for you and, therefore, not available to others who are waiting for services.

**If you will be late to an appointment, we request that you notify us by calling the office at (603)434-3456.**

If you will be more than 5 minutes late for your appointment, we will make every effort to accommodate you. However, you may be asked to reschedule your appointment.

### **Missed appointments**

**If you do not arrive for a scheduled chiropractic appointment, and do not contact the office more than 24 hours prior to your scheduled appointment time, you will be charged a fee for the missed appointment for each person scheduled.**

In the unlikely event that a patient misses or cancels three or more consecutive appointments/classes, this could result in dismissal from our practice. Please contact the office and we will supply you with information on obtaining your medical records and refer you to another care provider.

### **Cancelling appointments**

Email confirmations are considered a courtesy. If you need to cancel/reschedule your appointment you may do so more than 24 hours of your scheduled appointment time by calling our office at 603-434-3456.

**Cancellations via email will not be considered cancellations and will be subject to a fee for the missed appointment.**

### **Payment**

Insurance information, if applicable, must be received prior to your scheduled appointment. **It is the patient's responsibility to verify insurance coverage at this office prior to the start of care.**

**Payment is required at the time of service for appointments.** Co-pays and referrals (if required by your insurance) must be received at each visit, or you may be asked to reschedule your appointment. Co-pays are due at the time of service, as per your insurance guidelines.

### **Discount Plans**

Plans for multiple visits for chiropractic care and body-mind wellness classes may be purchased at a discounted rate. Payment for all health investment plans is non-refundable with few exceptions. If your situation does warrant a refund, any and all used appointments/classes on the discount plan are rated at the per diem price.

**Please note that all discount plans have expiration dates. It is the patient's/student's responsibility to note when the expiration date is for their particular discount plan.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

# CHIROPRACTIC HEALING HANDS

## PEDIATRIC CONSULTATION FORM

Today's Date \_\_\_\_\_  
Child's Name \_\_\_\_\_ D. O.B. \_\_\_\_\_  
Parent's Name(s) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

**Please circle the answers to the following questions regarding your child's birth:**

Were you induced? Y N      Nerve Block? Y N      C- Section? Y N  
Was there any pulling on the head? Y N      Forceps or vacuum extraction used? Y N  
How long was the entire labor? \_\_\_\_\_ How long did you actually push? \_\_\_\_\_

**47% of all children fall on their head by the age of one and they have at least 200 more falls by the age of 5 years old.**

When was your child's most recent fall? \_\_\_\_\_  
Was any care given? \_\_\_\_\_ Was s/he checked by a chiropractor? \_\_\_\_\_  
And the fall before that? \_\_\_\_\_ Any care given? \_\_\_\_\_  
What sports/recreational activities is your child involved in? \_\_\_\_\_  
When was his/her most recent stress, strain or injury while doing these activities?  
\_\_\_\_\_

Any care given? \_\_\_\_\_  
Has your child been involved in a motor vehicle accident as a passenger? \_\_\_\_\_  
Please describe briefly \_\_\_\_\_  
Any treatment received? \_\_\_\_\_ Chiropractic? \_\_\_\_\_

**Subluxated (misaligned) vertebrae can cause irritation to different fibers within nerves. These can affect any organ or tissue, causing health conditions now or in the future.**

Do you believe your child experiences any health conditions due to misaligned vertebrae? (Please keep in mind that conditions caused by subluxated vertebrae are *not* limited to the spine itself.) Y N

If yes, please explain \_\_\_\_\_

Does your child have any past health complaints? \_\_\_\_\_

Is your child taking any medications? \_\_\_\_\_ If yes, please list \_\_\_\_\_

**Symptoms caused by nerve pressure can be constant or occasional. Depending on the type and degree of the subluxated (misaligned) vertebrae, your child may show signs of experiencing nerve pressure.** Does your child show symptoms of nerve pressure? \_\_\_\_\_ If so, how often does this happen? \_\_\_\_\_

Parent/Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

# CHIROPRACTIC HEALING HANDS

## Notice of Privacy Practices

The Health Insurance Portability and Accountability Act concerns the security of your personal and medical information. We respect your privacy and rights, so we follow these guidelines as applicable to our practice.

A partial list of your rights includes but is not limited to allowing (or prohibiting) health care providers from revealing information with your permission, as necessary, to others involved in your health care, such as insurance carriers, physicians, home care aides, and family members, friends, or other health care proxies who share responsibility for your well-being or billing services rendered.

Information includes but is not limited to medical records, diagnostic reports, treatments, tests and results, billing, and referrals, as well as personal data such as birth date, etc.

We will coordinate with all parties necessary for prompt, accurate and effective treatment and proper billing. We will gladly explain all aspects of your care to you or assigned persons as you wish.

**Please sign and return lower portion.**

### Privacy Policies of Healing Hands Chiropractic, LLC

The health Insurance Portability and Accountability Act (HIPAA) is in effect. HIPAA has certain requirements with which health care providers are required to comply.

We are required to give each patient a notice of Privacy Practices (see above) listing in which we might use your Protected Health Information. Please sign below, hereby stating that you received the notice, and return the lower portion to us.

Thank you for helping us comply with these regulations.

Patient Name (printed): \_\_\_\_\_

Patients Signature: \_\_\_\_\_

### Release of Information

I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above other health care professionals to whom I am referred and to the insurance carrier or other entity responsible for payment, utilization and/or quality review for all or a portion of my care and treatments.

Today's date: \_\_\_\_\_ Signature of Patient: \_\_\_\_\_

If patient required assistance to complete information forms, please sign below and state your relationship to the patient.

Today's date: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_

# Terms of Acceptance

When a patient seeks chiropractic care, and when a chiropractor accepts a patient for such care, it is essential that they both be seeking the same goals.

It is not the goal in this office to treat, nor cure physical, mental, or emotional ailments; nor to diagnose or give advice about such ailments.

Our only goal and intention is to keep the body as free from vertebral subluxations as we can. We do this because of our absolute conviction that every human being functions better on all levels when no subluxations are present.

I \_\_\_\_\_ undertake chiropractic care at Healing Hands Chiropractic on the understanding of and agreement with the above explanation.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_