Child's name:_____

Address:_____

Home Phone #:_____

Child's Birth Date:_____ Child's age:_____

Child's Social security #:_____ Child's Gender: M F

CHILD'S LEGAL GUARDIAN INFORMATION

Mother's full name (or guardian):_____

Employment:_____ Social Security #:_____

Phone #:_____

Is it OK for Keith Clinic to send you text messages and/or voicemails? **Yes** **No**

Father's full name (or guardian):_____

Employment:_____ Social Security #:_____

Phone #:_____

Is it OK for Keith Clinic to send you text messages and/or voicemails? **Yes** **No**

Person responsible for payment at time of services:_____

How did you hear about our office?_____

Has your child ever received Spinal Adjustment by a Doctor of Chiropractic before?
YES NO

If yes when and whom?_____ How long did your child go?_____

What do you hope for your child to receive from Chiropractic care in this office?_____

_____

_____

_____

Medicaid Rulings for Your Chiropractic Care

1. Medicaid limits chiropractic visit to 8 office visits per physical year. If you have already incurred visits with another chiropractor toward the 8-visit limit, or if you have already reach the 8-visit limit, our office must know this information to determine the proper billing procedures.

2. You must present a valid Medicaid Card and ID.

3. You may be subjected to a $2.00 copya per visit and it is due at the time of service.

4. Medicaid ONLY COVERS Spinal Manipulations (ADJUSTMENTS) and (1) x-ray to document the neuromusculoskeletal condition for which manual manipulation of the spine is appropriate. ANY OTHER TREATMENTS MUST BE PAID BY THE PATIENT.

5. Medicaid does not provide for any type of physical therapy such as ultrasound, electrical stimulation, ice/hot packs, or massage therapy. There will be an additional charge for these services. Medicaid does not cover any type of Durable Medical Equipment, supplies or supplements.

6. If you are a Carolina Access/Medicaid patient you must have a referral from your primary doctor that is listed on your card. Your primary care physician will contact this office and provide us with a referral number and the limit visit period.

Should you have any questions regarding your treatment, account or your Medicaid claims, please feel comfortable in requesting assistance.

"I have read and understand the above INFORMATION & FINANCIAL POLICY and will comply with these terms"

_____ _____

PATIENT SIGNATURE **DATE**

_____

PATIENT PRINTED NAME

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ Date: _____

1. Describe Your Symptoms _____

   _____

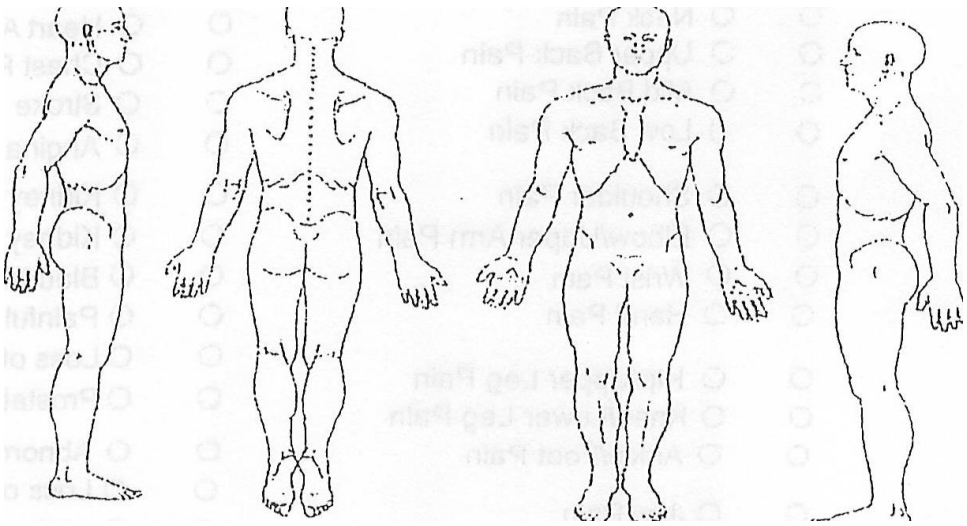
   _____

   a. When did your symptoms start? _____

   b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have the pain

   a. Constantly (75–100 % of the day)
   b. Frequently (51-75 % of the day)
   c. Occasionally (26-50 % of the day)
   d. Intermittently (0-25 % of the day)



3. **What describes the nature of your symptoms?**

___ Sharp ___ Shooting
___Dull Ache ___Burning
___Numb ___Tingling

4. **How are your symptoms changing?**

___Getting Better
___Not Changing
___Getting Worse

5. **During the past 4 Weeks:**

   a. Indicate the average intensity of your symptoms NONE 0 1 2 3 4 5 6 7 8 9 10 Unbearable

   b. How much has pain interfered with your normal work (including both work outside the home and housework)

   ___Not at all ____A Little Bit ____Moderately ___Quite a bit ___Extremely

6. **During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc.)**

   ____All the time ___Most of the time ___Some of the time ___A little time ___No Time

7. **In general would you say your overall health right now is….**

   ____Excellent ____Very Good ____Good ____Fair ____Poor

8. **Who have you seen for your symptoms?** _____

   a. what treatment did you receive and when? _____

   b. what test have you had for your symptoms ___x-rays date_____ ___CT Scans date _____ and when were they performed? ___ MRI date_____ ___ Other date _____

9. **Have you had similar symptoms?** _____

   Who did you see for your symptoms?_____

10. **What is your occupation?** _____

    a. If you are not retired, a home worker, or a student, what is your current work status?_____

Patient Health Questionnaire (PHQ) – Page 2

Patient's Name: _____ **Date**: _____/_____/_____

What type of exercise do you perform? ○ **None** ○ **Light** ○ **Moderate** ○ **Strenuous**

What is your height and weight? **Height** _____ **Weight** _____

Feet inches

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, please check the Present.

Past	Present		Past	Present		Past	Present	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Stroke			
O	O	Lower Back Pain	O	O	Angina	O	O	Smoking/Use Tobacco
O	O	Shoulder Pain	O	O	Kidney Stones	O	O	Drug/Alcohol Dependence
O	O	Elbow/Upper Arm Pain	O	O	Kidney Disorders			
O	O	Wrist Pain	O	O	Bladder Infection	O	O	Allergies
O	O	Hand Pain	O	O	Painful Urination	O	O	Depression
			O	O	Loss of Bladder Control	O	O	Systemic Lupus
O	O	Hip/Upper Leg Pain	O	O	Prostate Problems	O	O	Epilepsy
O	O	Knee/Lower Leg Pain				O	O	Dermatitis/Eczema/Rash
O	O	Ankle/Foot Pain	O	O	Abnormal Weight Gain/Loss	O	O	HIV/AIDS
			O	O	Loss of Appetite			
O	O	Jaw Pain	O	O	Abdominal Pain		**Females Only:**	
			O	O	Ulcer	O	O	Birth Control Pills
O	O	Joint Swelling/Stiffness	O	O	Hepatitis	O	O	Hormonal Replacement
O	O	Arthritis	O	O	Liver/Gall Bladder Disorder	O	O	Pregnancy
O	O	Rheumatoid Arthritis						
O	O	General Fatigue	O	O	Cancer		**Other Health Problems/Issues:**	
O	O	Muscular Incoordination	O	O	Tumors	O	O	
O	O	Visual Disturbances	O	O	Asthma	O	O	
O	O	Dizziness	O	O	Chronic Sinusitis	O	O	

Indicate if an immediate family member has had any of the following:

O Rheumatoid Arthritis **O** Heart Problems **O** Diabetes **O** Cancer **O** Lupus **O** _____

List all prescription and over the counter medications, and nutritional/herbal supplements:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient's Signature: _____ **Date:** _____/_____/____

Doctors Additional Comments:

_____

_____

_____

Doctor's Signature_____**Date:** ____/____/____

Regarding your child today: (Please Circle)

Has your child ever been unconscious?	Yes	No
Has your child ever used cru crutches or corrective braces?	Yes	No
Is your child accident-prone?	Yes	No
Has your child fallen down any steps?	Yes	No
Has your child ever been involved in a car accident?	Yes	No
Has your child ever been hospitalized or had surgery?	Yes	No
Has your child ever had any broken bones or sprains injuries?	Yes	No
Is your child current with his/her vaccinations?	Yes	No
Is your child active in any particular sport?	Yes	No

If yes what type of sports?_____

Does your child have poor posture? Yes No

Is there anything else about your child that you wish to share with us, so that we can understand him/her better?_____
_____
_____
_____

I herby authorize Dr. Keith Pittman of Keith Clinic of Chiropractic and whomever he may designate, to administer care necessary to my child named above.

Parent/ Guardian's Name:_____ Date:_____

Witness:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- **Share information with your family, close friends, or others involved in your care**
- **Share information in a disaster relief situation**
- **Contact you for fundraising efforts**

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- **Marketing purposes**
- **Sale of your information**

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? **We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.**

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective September 23, 2013

Patients Name (printed) : _____ **Date:** _____

Patient Signature of Acceptance: _____ **Date:** _____

Witness: _____

INFORMED CONSENT

Disclosure & Consent
Chiropractic adjustments and Care

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risk and hazards involved. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I herby request and consent to performance of chiropractic adjustment and other chiropractic procedures, including carious modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other Licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below my diagnosis the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that in the practice of chiropractic there are some risk to exam and treatment including, but not limited to fractures, disc injuries, strikes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risk and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts the known, is in my best interest. I further acknowledge that no guarantees or assurance have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent from to cove treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
Print name

_____
Signature of Patient

_____
Date Signed

_____
Doctor Signature of Keith Clinic of Chiropractic P.A.

To be completed by the patient's representative:

_____
Print Name of Patient

_____
Print Name of Representative

_____
Signature of Representative

_____
Date Signed

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the use and disclose of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name:_____

Patient address:_____

SS#:_____ Date of Birth:_____

Person/Organization Providing Information:_____

Address:_____

Person/Organization Receiving Information:_____

Address:_____

For the purpose of _____

Specific description of information covering health care from_____ to _____

- Complete health records
- Lab and x-ray reports
- Other (Please specify)_____

Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If fail to specify an expiration date, event or condition, this authorization will expire in six months.
I may revoke this authorization at any time in writing to the concerned parties. The revocation will not be effective to the extent that others or we have acted in reliance upon this authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness