PEDIATRIC REGISTRATION & HISTORY

Child's Name:____

Address:______________________ City:________________ State:______ Zip:______

Home Phone:______________________________ Cell Phone:______________

1st Parent's Name:______________________ Work Phone:______________

2nd Parent's Name:______________________ Work Phone:______________

Would you like our free monthly Wellness Newsletter by email? Y / N Email:______________

Birth date:____________ Age:______ Sex: M / F Number of siblings:______________

Birth Weight:____________ Current Weight:________

Birth Length:____________ Current Length:________

Type of birth (check all that apply) [ ] Normal Vaginal [ ] Forceps [ ] Vacuum

[ ] Breech [ ] C-section [ ] Home

[ ] Birth Center (name) ______________________

[ ] Hospital (name)______________________

Problems during pregnancy:______________________________________

Problems during labor delivery:______________________________________

APGAR Scores:__________ At birth, was there a presence of: Jaundice (yellow)

Cyanosis (blue)

Congenital anomalies/defects:______________________________________

Infant Feeding - Please list at what age the child received each method.

Breast ________ Bottle________ Formula ________

Number hours sleep per night:______ Quality of sleep: Good / Fair / Poor Explain:______________

Obstetrician/Midwife:______________________________________

Pediatrician:______________________________________

Date of last visit to MD:__________ Purpose:______________________________

Immunization History:______________________________________

Has your child ever been treated on an emergency basis? Y / N Explain:______________

Purpose of today's appointment:______________________________________

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

PEDIATRIC REGISTRATION & HISTORY

PERSONAL HEALTH HISTORY Has this child ever suffered from:

[ ] Dizziness
[ ] Backaches
[ ] Heart trouble
[ ] Diabetes
[ ] Tuberculosis
[ ] Colds/Flu
[ ] High blood pressure
[ ] Arthritis
[ ] Headaches
[ ] Asthma
[ ] Neuritis
[ ] Colic
[ ] Digestive trouble
[ ] Sinus trouble
[ ] Constipation
[ ] Bed-wetting
[ ] Anemia
[ ] Rheumatic Fever
[ ] Orthopedic
[ ] Diarrhea
[ ] Poor appetite
[ ] Hyperactivity
[ ] Sugar concentration
[ ] Behavioral problem
[ ] Convulsions
[ ] Paralysis
[ ] Muscle jerking
[ ] Fainting
[ ] Walking problems
[ ] Broken Bones
[ ] Ruptures/Hernia
[ ] Neck problems
[ ] Arm problems
[ ] Leg Problems
[ ] "Growing Pains"
[ ] Chronic Ear Infections
[ ] Blood disorders
[ ] Stomach Aches
[ ] Joint problems

Surgeries: ______________________________

Medications (name & purpose): ______________________________

Allergies: ______________________________

FAMILY HEALTH HISTORY
Please place a check mark if someone in the child's <u>immediate family</u> has had the following.
Please write <u>how they are related</u> to the child.

[ ] Back Problems ____________
[ ] Headaches ____________
[ ] High pressure ____________
[ ] Ulcer/Digestive Problem ____________
[ ] Thyroid Disorder ____________
[ ] Heart Disease ____________
[ ] Stroke ____________
[ ] Arthritis ____________
[ ] Diabetes ____________
[ ] Cancer ____________
[ ] Osteoporosis ____________
[ ] Mental Illness ____________

WELLNESS PROFILE
Chiropractic care affects more than just our muscles and bones. <u>Please share with us what health goals you hope to find for this child</u>. Check as many boxes as you wish

[ ] More energy
[ ] Better sleep
[ ] Freedom from pain
[ ] Better concentration
[ ] Easier breathing
[ ] More balanced posture
[ ] Try quality vitamins
[ ] Improve nutrition
[ ] Improved coordination
[ ] Reduce medications
[ ] Improve overall health
[ ] Better sports performance
[ ] Enhanced emotional well-being
[ ] Greater resistance to disease
[ ] Other

CONSENT TO TREAT A MINOR

NAME: ____

ADDR: ____

CITY: ____________________________________ ST _______ ZIP _______________

PHONE:___________________________________ SS# __________________________

I HEREBY AUTHORIZE:

Dr. Alyssa Guglielmo or any doctors associated with the above named practice,

to administer the required care as deemed necessary to

my (indicate relationship of child) ____

(Name of Child) ____

SIGNED: ____

WITNESSED: ____

Chiropractic Treatment Consent Form

Alyssa M. Guglielmo, DC, CACCP
Living Well Holistic Health, LLC
565 NJ-35, Suite #1
Red Bank, NJ 07701

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including the examination, and ancillary treatment for me (or for the person named below, for whom I am legally responsible) by the Doctor named herein, or other licensed Doctor who now, or in the future, will render care at this clinic.

I will have the opportunity to discuss with said Doctor the nature and purpose of chiropractic adjustments and other procedures, I understand, of course, that results cannot be guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks involved, though rare. They may include but are not limited to: fracture, disc injury, cervical dissection, stroke, dislocation, sprain/strain, or possible aggravation of the pre-existing condition which are designed to identify if the patient may be susceptible to that kind of injury.

If the Graston Technique is performed, I understand that a common side effect is bruising. Though controlled, this may last for several days and I understand that topical pain relief cream and ice may help to ease any soreness.

I have read, or have had read to me, the above consent form. If interested, I will have the opportunity to ask questions about its content, and by signing below, I agree to the above named procedures and to not hold the treating doctor liable if any side effects do occur. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

______________________	______________________
Date	Patient Signature
______________________	______________________
Witness Signature	Signature of Parent/Guardian

MISSED APPOINTMENT POLICY

I ______________________________, understand and agree that I am personally responsible for payment for appointments missed without 24 hours notice, and that it is not the responsibility of the insurance carrier or any third party payer to make payments on my missed appointments.

Given that we see one patient at a time, **missed appointments are billed *in full.***

A photocopy of this form shall be valid as the original.

PATIENT SIGNATURE: ______________________________
(Parent/Guardian if patient is a minor)

DATE SIGNED: ______________________________

Privacy Officer: ALYSSA M. GUGLIELMO, D.C. Effective Date: APRIL 14, 2003

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: in treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entitites' and providers' payment activities
- Other covered entitites' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer of this practice.

Changes to this Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: ____

Date of Birth: ______________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on requesrt.

Signature:

____

Date:

____

Relationship to patient (if signed by a personal representative of patient):

____