Whom may we thank for referring you to this office _____?

APPLICATION FOR CARE AT THRIVE WELLNESS CENTER

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ **Birth Date:** ____-____-____ **Age:** ____ ☐ Male ☐ Female

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone (Home): _____ **Birth Height:** _____ **Birth Weight:** _____

Current Height: _____ **Current Weight:** _____ **Pediatrician / Family MD:** _____

Last Visit: _____ **Reason for visit:** _____

Mother's Name: _____ **Mother's Cell:** _____ **DOB:** _____

Father's Name: _____ **Father's Cell:** _____ **DOB:** _____

HISTORY OF COMPLAINT

Purpose of this visit: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other: (please explain)

_____

Is your child experiencing: Pain / Discomfort (please identify where and for how long): _____

_____

1. **When did the problem first begin? Date:** _____ **Onset:** ☐ Unknown ☐ Gradual ☐ Sudden
2. **Has your child ever had this problem before?** ☐ Yes ☐ No **If Yes, explain when:**

   _____
3. **Any bowel or bladder problems since this problem began?** ☐ Yes ☐ No **If Yes, explain when:**

   _____
4. **Have you seen any other doctors/physicians for this problem?** ☐ Yes ☐ No

   If Yes, who? _____ **How long ago?** _____
5. **What were the results of past treatment(s)?** _____
6. **How is the problem now:** ☐ Rapidly Improving ☐ Slowly Improving ☐ About the same ☐ Worsening
7. **Please list any medications being taken:** _____
8. **Has your child ever sustained an injury?** ☐ Yes ☐ No

   If Yes, explain: _____
9. **Has your child ever been in an automobile accident?** ☐ Yes ☐ No

   If Yes, explain: _____
10. **Has your child ever sustained an injury due to an automobile accident?** ☐ Yes ☐ No

    If Yes, explain: _____

Please identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem(s):

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

Please **checkmark** (✓) for **YES** or leave **blank** for **NO**

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD / ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures / Hernias
☐ Muscle Pain	☐ Leg Problems	☐ Reflux	☐ Seizures / Convulsions
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Asthma
☐ Scoliosis	☐ Anemia	☐ Colds / Flu	☐ Walking Trouble
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Sleeping Problems
☐ Fall in baby walker	☐ Fall from crib	☐ Fall from bed or couch	☐ Fall from Changing Table
☐ Fall of bicycle	☐ Fall off slide	☐ Fall from high chair	☐ Fall off Skateboard / Skates
☐ Fall of swing	☐ Fall down stairs	☐ Fall off monkey bars	☐ Other: _____

I understand that I am directly and full responsible to Pratt Family Chiropractic, LLC (DBA: Thrive Wellness Center) for all fees associated with chiropractic care my child receives.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify Thrive Wellness Center.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Received**

Patient's Name: _____ **HR#:** _____ _____/_____/_____ **JDD, DC 2/2012**

NOTICE OF PRIVACY PRACTICE

This office is required to notify you, in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or **as dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to your. In addition, you will find we have placed several copied in report folders labeled '**HIPPA**' on tables in the reception. Once you have read this notice, please initial, sign and date, and return all documents to our front desk receptionist. A copy of this can be attained for your personal records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussions. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public Health and Safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government Agencies or Law Enforcement - to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails & appointment reminders - **we may call your home and leave messages** regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your **PHI**

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailing to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records (including x-rays) at no charge via usb storage device, when timely notice (72 hours) is provided. If you would like to have a disc of your images or files made, we will be happy to accommodate you. However, you will be responsible for the associated fees.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Thrive Wellness Center at (507) 258-4100. If we are unavailable, you may make an appointment with our office manager to discuss the concerns within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington, DC 20201

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

Please complete the following where indicated and return to our front desk staff.

Patient initial: _____ - **retaining page 1 of 2**

I hereby acknowledge I have read and received a copy of [insert Covered Entity Name] Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name **Date**

_____ _____

Patient's Signature **Telephone**

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Patient's Name: _____

FOR OFFICE USE ONLY:

Signed form received by: _____

Reason acknowledgment not obtained: _____

Efforts to obtain: _____

Patient's Name: _____ HR#: _____ Date: _____

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities and Therapeutic Procedures.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Pratt Family Chiropractic, LLC (DBA: Thrive Wellness Center), have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by means, method and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ _____

Patient or Authorized Person's Signature **Date** **Witness' Initials**

X-RAYS/IMAGING STUDIES

MALES ONLY: By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful considerations, I therefore, do herby consent to have diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____ _____

Patient or Authorized Person's Signature **Date** **Witness' Initials**

FEMALES ONLY: By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful considerations, I therefore, do herby consent to have diagnostic x-ray examination the doctor has deemed necessary in my case.

Check the boxes, included the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanations.

☐ My child has not had her first menstrual cycle yet.

☐ The first day of my last menstrual cycle was on _____ / _____ / _____ date.

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

☐ I am considered to be, and/or are post-menopausal by my primary medical doctors, and to the best of my knowledge, I am not pregnant.

_____ _____ _____

Patient or Authorized Person's Signature **Date** **Witness' Initials**