preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

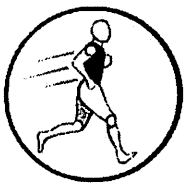
I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE

TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:
I give permission for the below named minor patient to be managed by the doctor when I am or when I am not present to observe such care.

Patient Name: _____
Patient age: _____ **DOB:** _____
Printed name of person legally authorized to sign for Patient:
_____
Signature: _____
Relationship to Patient: _____



Get *Moving*
Chiropractic

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the

Get Moving Chiropractic Dr. Katy R. Mooberry DC, CACCP

30772 Southview Dr. #140 Evergreen, CO 80439 Phone: 303-670-7777 Fax: 303-482-1946

Financial and HIPPA Policies

***Please read the following carefully and initial each statement on the line provided.**

_____**Financial Policy and Agreement:**

Payment is required for all office services on the day of service and may be paid by cash, check or credit card. There is a $30 fee for all returned checks. Payment on the day of service is eligible for a cash discount if you join the ChiroHealth USA (CHUSA) program (ask for more details). If you have insurance that pays for chiropractic care, we will be glad to verify benefits and bill them for you. You must pay deductibles and co-payments, if applicable, at the time of service. If you need financial assistance or need to make special arrangements please talk with us.

_____ **I understand that I am financially responsible for all charges whether or not paid by insurance and if I terminate or suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable.** I will be responsible for any costs of collections, attorney's fees or court costs required to collect my bill. If my bill is turned over to collection, I will pay for the charge added to my account. Insurance is billed by code; payment varies by plan.

_____ **Notice of Privacy Practices Acknowledgement:**

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practice. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at ant time to obtain a current copy of the Notice of Privacy Practices.

_____ I UNDERSTAND THERE IS 24 HOUR CANCELLATION NOTICE, OR I WILL BE CHARGED THE COST OF THE VISIT.

I have read all of the above agreements and I accept these terms and conditions.

_____ _____

Patient signature or Guardian if patient is under 18 years of age Date

PEDIATRIC PATIENT HISTORY

Neurological/Other
Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- ❑ Hearing loss or impairment
- ❑ Neurological disorders
- ❑ Obsessive Compulsive Disorder (OCD)
- ❑ ADD/ADHD
- ❑ Dyslexia
- ❑ Visual impairment
- ❑ Anxiety/Depression
- ❑ Autism/Autism Spectrum Disorder
- ❑ Tourette's Syndrome
- ❑ Other_____

Current/Past Medications and Treatment

List any medications that your child is taking:
List names, dosage, frequency

_____
_____

List any special dietary needs that your child has:

_____
_____
_____

List any supplements that your child takes:

_____
_____
_____

List any treatment that your child is currently undergoing with any health professional:

_____
_____

List any special services that your child is currently receiving at school or privately:

_____
_____
_____

List any previous chiropractic treatment, medications, or other medical treatment that your child has undergone:

_____
_____

Comments:_____
_____
_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. _____, D.C. to evaluate and treat my son/daughter as they deem necessary.

I also acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided. I also understand that any x-rays taken at this office are the property of this clinic.

_____ _____
Signature and relation of person completing this form **Date**

_____ _____
Signature of witness **Date**

PEDIATRIC PATIENT HISTORY

Newborn History
Did the child experience any of the following as a newborn:

- ❑ Required resuscitation/oxygen
- ❑ Prolonged jaundice
- ❑ Poor sleeper
- ❑ Immunizations in hospital
  If yes, specify vaccine:

- ❑ Distorted skull
- ❑ Difficulty latching/sucking
- ❑ Formula fed
- ❑ Breast fed
- ❑ Bottle fed
- ❑ Colic

Weight at birth:_____ Length at birth:_____

Health History
Has your child ever experienced the following or been diagnosed as having any of the following:

- ❑ Illnesses accompanied by a high fever
- ❑ Frequent headaches
- ❑ Seizures/Convulsions
- ❑ Chronic ear infections/earaches
- ❑ Head injury
- ❑ Serious fall(s) or repetitive falls
- ❑ Serious illness
- ❑ Epilepsy
- ❑ Meningitis
- ❑ Allergies to foods
- ❑ Environmental allergies
- ❑ Chemical insensitivities
- ❑ Undergone any surgeries
- ❑ Neck or back problems
- ❑ Adverse reaction to any vaccinations (even if mild)
  If yes, please explain:

- ❑ Dizziness
- ❑ Diabetes
- ❑ Hypoglycemia (low blood sugar)
- ❑ Trouble with bladder control (enuresis)
- ❑ Fainting
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Asthma
- ❑ Sinus problems
- ❑ Constipation
- ❑ Diarrhea
- ❑ Digestive disorders
- ❑ Rheumatic Fever
- ❑ Joint or muscle problems

Developmental History
Does or did your child have any of the following:

- ❑ Difficulty with crawling (on all fours)
- ❑ Difficulty learning to ride a bike
- ❑ Difficulty learning to read
- ❑ Difficulty using utensils
- ❑ Difficulty tying shoes
- ❑ Poor hand-eye coordination

- ❑ Did not crawl on all fours
- ❑ Appears clumsy
- ❑ Difficulty with writing
- ❑ Difficulty buttoning clothing
- ❑ Difficulty or awkward with walking/running
- ❑ Difficulty sitting still or paying attention

At what age did your child start to walk unassisted: _____

Comments:_____

_____

_____

PEDIATRIC PATIENT HISTORY

Child's Name:_____ **SS#:**_____
Last First MI

DOB: _____ **Grade In School:** ____ **Sex:**____ **Home Phone: (___)**_____

Address:_____ **City/Town:**_____ **State:**____ **Zip:** _____

Mother's Name:_____ **Cell/Work Phone:** _____/_____
Last First

Father's Name:_____ **Cell/Work Phone:** _____/_____
Last First

Referred By:_____ **Purpose of this appointment:** _____

Pregnancy History (Mother)

(If the child is adopted, answer to the best of your ability)
Did you experience any of the following during your pregnancy:

- ❑ Severe viral infection during the first trimester
- ❑ Breech position during pregnancy
- ❑ Accident or Infections
- ❑ Smoking
- ❑ Severe stress
- ❑ Pre-eclampsia
- ❑ Alcohol consumption and/or drug use
- ❑ Radiation exposure
- ❑ Hypertension (high blood pressure)
- ❑ Toxoplasmosis
- ❑ Uncontrolled Diabetes
- ❑ Toxemia

Labor and Delivery History

Did you and/or the child experience any of the following during the labor/delivery:

- ❑ Hospital birth
- ❑ Birthing home
- ❑ Long and/or difficult labor
- ❑ Placenta previa
- ❑ Forceps or suction cup used
- ❑ Fetal distress
- ❑ Elective c-section
- ❑ The child was a "blue baby"
- ❑ Home birth
- ❑ The labor was induced
- ❑ The delivery was rapid
- ❑ Breech birth
- ❑ Cord around the neck
- ❑ Emergency c-section
- ❑ The child was premature (2+ weeks)

Comments:_____