Pura Vida Chiropractic
2138 NW Military Hwy Suite 103
San Antonio, TX 78231
210.685.1994
www.puravidasanantonio.com
Dan Foss, DC

Please complete this detailed history form and return it to the front desk staff. Should you require any assistance, please let us know, as we would be happy to assist.

Infant / Child Wellness Profile **Date:** _____

Name: _____ D.O.B. _____ (MM/DD/YYYY) Gender: ☐ Male ☐ Female

Address: _____

Postal Code: _____ Phone number: _____

Date of last MD visit and reason: _____

Previous Chiropractor and date of last visit: _____

Reason(s) for contacting us: _____

Other health concerns: _____

List other care undergone (including medications): _____

History of Birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ Medical ☐ Midwife

Assisted birth? ☐ Yes ☐ No If yes: ☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Induced Labour

Medications given to mother during labour? ☐ Yes ☐ No If yes, what: _____

Complications at birth? ☐ Yes ☐ No If yes, explain: _____

Was delivery normal? ☐ Yes ☐ No Duration of birth: _____

APGAR at birth: _____ After 5 minutes: _____

Growth and Development

Was the infant alert and responsive within twelve hours of delivery ☐ Yes ☐ No

If no, explain: _____

Do sleeping patterns seem normal to you: ☐ Yes ☐ No

If no, explain: _____

Since the health of the neurospinal system that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us:

Name: _____ **Date:** _____

Chemical Stressors

Was this baby breast-fed? ☐ Yes ☐ No If yes, for how long: _____

Formula introduced at age: _____ Type of formula used: _____

Was there introduction of cow's milk? ☐ Yes ☐ No If yes, at what age? _____

Food / Juice intolerance: ☐ Yes ☐ No If yes, type: _____

During pregnancy did mother smoke? ☐ Yes ☐ No During pregnancy did mother drink alcohol? ☐ Yes ☐ No

Any illness of the mother during pregnancy?: _____

Any drugs taken during pregnancy?: _____

Any exposures to ultrasound: ☐ Yes ☐ No If so, how many and what was the medical reason?: _____

Any invasive procedures (amniocentesis, CVS): _____

Any pets at home: ☐ Yes ☐ No

Any smokers in the home: ☐ Yes ☐ No How much: _____

Any vaccinations: ☐ Yes ☐ No Which ones? Any reactions? _____

Total # of courses of antibiotics to date? _____

Psychosocial Stressors

Any difficulties with lactation? ☐ Yes ☐ No Any problems with bonding? ☐ Yes ☐ No

Any behavioural problems: ☐ Yes ☐ No Onset: _____

Any night terrors, sleep walking, difficulty sleeping? ☐ Yes ☐ No If yes, explain: _____

Average number of hours of television/week? _____

Traumatic Stressors

Any traumas during pregnancy? (falls, accidents): _____

Any evidence of birth trauma: bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other?: _____

Any falls from couches, beds, change tables?: _____

Any traumas with bruising, cuts, stitches, fractures?: _____

Any hospitalizations: ☐ Yes ☐ No Explain: _____

Any surgeries or organs removed?: _____

Sports played and age began: _____

Weight of school backpack: _____ Approximate hours spent at play per week: _____

AUTHORIZATION FOR ASSESSMENT OF A MINOR

Parent(s) name(s): _____

Home telephone #" _____ Work telephone #: _____

I hereby authorize and consent to the chiropractic evaluation of my child

_____ _____

Parent Guardian Signature Witness Signature

Date: _____

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Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information(PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

☐ I, _____(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

☐ I, _____(print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used **within** the office for purposes of my care to those individuals designated by the doctor.

Patient or Parent Signature: _____Date: _____

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. In the event that your insurance does not pay on a timely manner, you may be asked to contact your insurance carrier.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

Assignment of Rights and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information and needed, and appear as needed to assist in the prosecution of such claims for benefits upon request.

To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility.

I instruct checks to be made payable to Pura Vida Chiropractic PLLC, and payment to be sent to 2318 NW Military Hwy Suite 103 San Antonio, TX 78231

This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award (s).

Patient or Parent Signature: _____ Date: _____

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

- I, the undersigned parent or legal guardian of _____ (minor child), hereby give my permission to the staff of Pura Vida Chiropractic to treat said child.

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time, I understand that failure to complete my recommended treatment plan may jeopardize my case.

Patient or Parent Signature: _____Date: _____