LIBERATION
CHIROPRACTIC & WELLNESS

7681 Old Shell Road, Ste B
Mobile, AL 36608
Phone 251.607.0040

New Patient Action Plan

1. Your child's first appointment today will consist of **posture images, examination, insight scan, and x-rays** if the doctor finds necessary. X-rays will then be marked and reviewed by the doctor to review results with you at your child's second appointment (typically 24 hours turnaround).

2. Your child's second appointment the doctor will review what was found on their x-rays, they will receive their **first adjustment, and if there are any additional tests or x-rays** needed to determine the best course of care, the doctor will order.

3. Your child's third appointment is the most important visit you will have; the doctor will go through all of their x-rays, findings, and offer **recommendations on course of care**. There is NO cost for this visit.

If you have insurance, we will verify your coverage for chiropractic care. If your insurance does not cover chiropractic care, we offer Patient Options DMCO; a medical discount program that can help you save on your chiropractic care.

New Patient Exam:

Date: _____ Time: _____ Cost: _____

Second Visit/First Adjustment:

Date: _____ Time: _____ Cost: _____

Third Visit: NO COST review of X-rays and Care Plan recommendations

Date: _____ Time: _____ Cost: No Charge

Total Cost: $ _____

Child's Name: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____Date: _____

LIBERATION CHIROPRACTIC & WELLNESS

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

PEDIATRIC APPLICATION FOR CARE AT LIBERATION CHIROPRACTIC & WELLNESS, PC

PATIENT DEMOGRAPHICS

Childs Name_____ Today's Date _____/_____/_____

Age: _____ Date of Birth _____/_____/_____ Birth Weight: _____ Current Weight: _____

Birth Height: _____ Current Height: _____ Address_____

City _____ State _____ Zip _____ Phone (Home) _____

Mothers Name: _____ Mother's Mobile _____ DOB_____/_____/_____

Fathers name: _____ Father's Mobile_____ DOB _____/_____/_____

Pediatrician/Family MD _____City & State_____

Last Visit: _____/_____/_____ Reason for visit:_____

Who is responsible for this bill?_____

☐ Father's Social Security # _____-_____-_____ ☐ Mother's Social Security # _____-_____-_____

Insured's Name:_____ Name of Insurance Company:_____

Insured's Date of Birth:_____/_____/_____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other

Please explain:_____

When did the problem first begin? Date _____/_____/_____ ☐ Unknown ☐ Gradual ☐ Sudden

Ever had this problem before? ☐ No ☐ Yes If yes when?_____

Any bowel or bladder problems since this problem began?: _____

Have you seen any other doctors for this problem? ☐ No ☐ Yes If yes who? _____

How long ago? _____ Days _____ Weeks _____ Months _____Years

What were the results of past treatment? _____

How is this problem NOW: ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same

☐ Rapidly Worsening ☐ Gradually Worsening ☐ On & Off

Please list any medication taken for this problem:_____

Please list any OTHER medications taken for any other problem:

_____

PAST HISTORY

Has your child ever sustained an injury playing organized sports? ☐ No ☐ Yes

If Yes; please explain:_____

Please check anything your child has ever suffered from:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Muscle Pain	☐ Leg Problems	☐ Reflux	☐ Seizures/Convulsions
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to_____
☐ 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 bed or couch	☐ Fall from crib	☐ Fall off swing
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	☐ Fall from changing table
☐ Fall down stairs	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐ Other: _____

Please list ALL history of surgeries (wisdom teeth, tonsils/adenoids, ear tubes, circumcision, etc):

_____

How was the child's birth (check all that apply)? ☐ Vaginal ☐ Cesarean ☐ Breach ☐ Traumatic ☐ Vacuum/Clamps Used ☐ Premature

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑Grandmother ❑Grandfather ❑Mother ❑Father ❑Sister ❑Brother ❑Son ❑Daughter

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

Any other hereditary conditions the doctor should be aware of? _____

INITIAL NERVE SYSTEM PROFILE

When was their most recent auto accident? _____ What speed was the collision?_____ mph

Type of impact: ❑ Front ❑ Side ❑ Rear Was treatment received? _____

Other spinal traumas in the past? _____

INITIAL NUTRITIONAL PROFILE

Are they diabetic, been diagnosed as pre-diabetic or with metabolic syndrome? ❑ Yes ❑ No

Do they eat breakfast daily from Monday to Friday? ❑ Yes ❑ No

How many days per week do they skip one meal? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4+

How many fast food, refined foods, or pre-pared meals do they eat per week? ❑ 0 ❑ 1-3 ❑ 4-6 ❑ 7+

How many servings of fruit do they have on a given day? ❑ 0-1 ❑ 2-3 ❑ 4+

How many servings of vegetables do they have on a given day? ❑ 0-1 ❑ 2-3 ❑ 4+

Do they regularly drink (1 or more per day) any of the following? (circle all that apply)

Tap Water Filtered Water Soda Diet Soda Sweet Drinks Coffee Juice Milk

Please list any supplements taken on a daily or irregular basis for any and all conditions:

_____

_____

_____

INITIAL FITNESS PROFILE

How many times per week do they exercise? _____Hours _____Days/Wk

What kind of exercise do they typically get: _____

What is their ideal weight? _____ lbs What is their current weight? _____ lbs

How willing are you/they to change any of these things to reach their health goals? (Scale of 1-10) _____

INITIAL TOXICITY PROFILE

Are they regularly exposed to cleaning products or industrial chemicals? ❑ Yes ❑ No

Have you ever noticed mold growing in your home or their school/day care? ❑ Yes ❑ No

Does your home, their school, or car have damp or mildew smell? ❑ Yes ❑ No

What is their history with vaccinations? ❑ Never ❑ Partial ❑ Delayed ❑ Full "on schedule"

Do they ever received a flu shot? ❑ No ❑ Yes If yes, how many? _____

Did your child get any COVID vaccines? ❑ No ❑ Yes If yes, how many and what brand? _____

Have they suffered any reaction to any shots, even minor? ❑ No ❑ Yes (describe) _____

Do you plan for your child to have any additional vaccines of any kind? ❑ No ❑ Yes

Have any members of your family been diagnosed with Fibromyalgia, Chronic Fatigue, or multiple chemical sensitivities?

❑ No ❑ Yes (describe) _____

Do they have any known symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)?

❑ No ❑ Yes (describe) _____

INITIAL STRESS PROFILE

How many hours on average of sleep per night? _____ Hours

Are they ever given pills or OTC meds to go to sleep or relax? ❑ Yes ❑ No

Do they have problems focusing or procrastinate on projects? ❑ Yes ❑ No

Do they exhibit feelings of anxiety about completing tasks? ❑ Yes ❑ No

Do they get adequate time with both mother and father on a regular basis? ❑ Yes ❑ No

Parent/Guardian Signature: _____ Date: _____

Doctor Signature: _____Date: _____

INFORMED CONSENT AND AUTHORIZATION TO TREAT

I understand that my child's care plan has been designed to stabilize and correct their spine in order to reduce pressure on the nervous system. This is done per the exam and x-ray findings and our clinical experience with the goal of improving overall structure and function. In addition, I understand that my child's schedule for care may be increased or decreased by the doctor at any time in order to accomplish this goal. It is further understood that if there are any additional costs associated with a change in their care plan, they will be discussed with me prior to them receiving any additional services.

It has been explained to me and I acknowledge that the care plan I wish to participate in imposes two 'situational restrictions' which could cause their care to be suspended or terminated should either one occur. Both have been explained to me and I understand and agree to immediately notify this practice should the following circumstances arise:

In the event my child sustains a new injury or have an accident, I realize that they may experience new symptoms and/or a new problem may arise which could impede recovery from their current condition. In such an instance, I recognize that it is important to evaluate any new symptoms to determine how they may affect my child's current and future health status and assess whether there is a need to modify their current care plan. Once my child's new symptoms and condition are diagnosed and/or resolved, their care plan will resume.

In the event I decide to interrupt any payment due this office, either because I wish to discontinue my child's care or for any other reason, they may not resume care without an additional evaluation from their doctor. If I am making monthly payments at that time, it is possible that I will owe money since there may be more services being rendered in the beginning of my child's care than my monthly payments cover.

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 risk are most often very 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.

If applicable, 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 this office.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Liberation Chiropractic & Wellness P.C. 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 any means, method, and or techniques the doctor deems necessary to treat my child's condition at any time throughout the entire clinical course of their care.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____Date: _____

INFORMED CONSENT REGARDING X-RAYS AND IMAGING STUDIES

FEMALES please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see one of our staff members for further explanation.

If applicable, the first day of my minor child's last menstrual cycle was on _____-_____-20_____

❑ To the best of my knowledge, my minor child is currently not pregnant.

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 ionizing radiation (X-rays) to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I do hereby request and authorize imaging studies if required for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: ____ Date: ____________________

PAYMENT POLICY AND FINANCIAL AGREEMENT OF UNDERSTANDING

I understand that I am directly and fully responsible to Liberation Chiropractic & Wellness, P.C. for all fees associated with chiropractic care and other services my child receives.

I hereby authorize payment to be made directly to Liberation Chiropractic & Wellness, P.C., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Liberation Chiropractic & Wellness, P.C. for any and all services my child receives at this office.

☐ INSURANCE PATIENTS: I have been made aware that most insurance plans impose either a visit or dollar limit and/or restrict chiropractic management approaches by covering only a limited number of treatment types and/or techniques, some of which may be used to treat my child's condition(s) throughout the clinical course of their care. Further, it has been made clear to me that these limitations are not a consideration in formulating care plans, and that the doctor's recommendations are based solely on achieving my child's health goals. With this understood and the realization that full insurance reimbursement is unlikely, I agree to follow the doctor's recommendations for care irrespective of our health plan coverage.

In as much as the doctor has discussed the terms of this 'Agreement of Understanding' and I have conveyed my complete understanding of all payment options available to me, I prefer the office to bill my insurance company and await direct provider reimbursement for all covered services. For this consideration, I will provide any and all assistance, including assigning my benefits, in order to ensure proper reimbursement is made directly to Liberation Chiropractic & Wellness PC and its doctors as expeditiously as possible. I further understand that charges for all services have been reviewed with me in advance and those that my insurance does not cover are my responsibility. I further waive any requirement moving forward to sign a "Non-Covered Services Statement" every visit if required by my insurance.

☐ CASH PATIENTS: I would like to participate in the payment simplification program offered at this office to facilitate effortless payment for a certain portion of the cost of services and procedures I have consented for my child to receive over the course their treatment, and to make monthly payments towards my child's care plan for the course of their treatment. If for any reason I decide to discontinue my child's care plan, any unused amount I have overpaid will be refunded to me within 30 days of the practice receiving a written statement from me explaining the reasons for my decision.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____Date: _____

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 you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. 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 and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize 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 mailings 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 at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:
If you wish to make a formal complaint about how we handle your health information, please call our office at (251) 607-0040. If we are unavailable, you may make an appointment with our receptionist to talk with us 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

I have received a copy of Liberation Chiropractic & Wellness, P.C.'s Patient Privacy Notice. I understand my rights as well as the practices 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 Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me at the request of our staff. At this time, I do not have any questions regarding my rights or any of the information I have received, I do not have any concerns regarding these 'Policies ', and all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient Signature: _____ Date: _____

Staff Signature: _____Date: _____