Upper Valley Chiropractic
"A Family Health and Wellness Center"

PEDIATRIC HISTORY FORM

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Date:_____

Patient Name: _____ S.S. #:_____-_____-_____

Address:_____ City:_____

State:_____ Zip:_____

Age:_____ Birth Date: _____/_____ /_____ Sex:_____ Weight:_____ Height: _____

Names of Parents / Guardians: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Referred By:_____

Purpose For Contacting Us? _____

_____

Referring Physician's Name and Address:_____

_____

What are the goals that you hope your child will gain?_____

_____

MEDICAL HISTORY:
Check the following conditions that your child has suffered from: (Please elaborate on all marked boxes as appropriate in the space provided)

☐ ADD/ADHD	☐ Constipation	☐ Fatigue	☐ Orthopedic Conditions
☐ Allergies	☐ Diabetes	☐ Headaches	☐ Scoliosis
☐ Asthma	☐ Digestive Problems	☐ Hearing Difficulties	☐ Seizures
☐ Blood Disorder	☐ Depression/ Anxiety	☐ Heart Problems	☐ Sleep Disturbances
☐ Chronic Colds	☐ Dyslexia	☐ Kidney Disorders	☐ Torticollis
☐ Colic	☐ Ear Infections	☐ Lymph Disorders	☐ Vision Difficulties
☐ Autism	☐ Sensory Processing Challenges		

☐ Other_____
_____
_____
_____
_____
_____

Current Medications:_____
Has your child ever had surgery? ☐ No ☐Yes_____
Did you CHOOSE to have your child vaccinated? ☐ No ☐ Yes_____
Has your child had a lot of dental work? ☐ No ☐ Yes If so, what and when?_____
Does your child wear any orthodontic devices? ☐ No ☐ Yes _____

PRENATAL HISTORY:
Were there any complications or unusual stressors during the pregnancy? ☐ Yes ☐ No _____
_____
Medications during pregnancy? ☐ Yes ☐ NO _____
Cigarette/ Alcohol use during pregnancy? ☐ Yes ☐ No _____

BIRTH HISTORY:

Was the delivery premature or full-term? Gestational Age: _____

Was the delivery via C-Section or vaginal delivery?_____

Was the delivery an emergency?_____

Was medication given to induce labor? ☐ Yes ☐ No _____

Were any medications given during labor? ☐ Yes ☐ No _____

Were forceps used in the delivery? ☐ Yes ☐ No Vacuum Extraction? ☐ Yes ☐ No

Any complications during the delivery? ☐ Yes ☐ No _____

Birth Weight:_____Length:_____

APGAR scores: at one minute_____, at five minutes_____

Was the use of oxygen required? ☐ Yes ☐ No

Did your child require additional hospitalization? ☐ Yes ☐ No _____

Was your child bottle, breast-fed or both?_____

Did your child have difficulty latching on or any sucking difficulties? ☐ Yes ☐ No _____

DEVELOPMENTAL HISTORY: (Physical, Speech, Emotional, Social, Academic)

Please tell us about your child's development. Did he/she show signs of delay or advancement? _____

_____

_____

_____

_____

_____

Age when he/she rolled over:_____

sat up unsupported:_____

crawled:_____

walked:_____

spoke his/her first word:_____

spoke in sentences:_____

became toilet trained:_____

Does he/she show any signs of food allergies/intolerances? ☐ Yes ☐ No _____

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball,

Cheerleading, Martial Arts, Wrestling, etc.) ? ☐ Yes ☐ No List: _____

_____

Has Your Child Ever Been Involved in a Car Accident ? ☐ Yes ☐ No _____

Has Your Child Been Seen on an Emergency Basis? ☐ Yes ☐ No, List: _____

Other Traumas Not Described Above ? ☐ Yes ☐ No, List: _____

Does your child tend to fall frequently? ☐ Yes ☐ No

Does your child show any signs of muscle weakness? ☐Yes ☐ No

Thank you for taking the time to complete this form. This information is valuable in obtaining an overall view of your child, as certain conditions or procedures may impact the spine and nervous system. Any additional information you'd like to share in order to help us learn more about your child is absolutely welcomed! _____

_____

_____

_____

WE ARE HERE TO SERVE YOU AND YOUR CHILD, AND ENCOURAGE YOU TO ASK QUESTIONS.

YOUR INPUT AND PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care to my Son / Daughter as deemed necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Witnessed: _____Date: _____

Name of Insurance Company: _____ Policy #: _____

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107 S. Main St.
West Lebanon, NH 03784

Form: Consent for Purpose of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Amber McLelland, DC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Amber McLelland, DC.

I understand that diagnosis or treatment of me by Upper Valley Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Upper Valley Chiropractic is not required to agree to the restrictions that I may request. However, if Amber McLelland, DC agrees to a restriction that I may request. the restriction is binding on Amber McLelland, DC and Upper Valley Chiropractic.

I have the right to revoke this consent in writing, at any time, except to the extent that Upper Valley Chiropractic or Amber McLelland, DC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Amber McLelland, DC's Notice of Privacy Practices prior to signing this document.

Amber McLelland, DC's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Upper Valley Chiropractic.

The Notice of Privacy Practices also describes my rights and the duties of Upper Valley Chiropractic with respect to my protected health information.

The Notice of Privacy Practices for Upper Valley Chiropractic is also provided at 107 S. Main St. #10, West Lebanon, NH 03784 and on the Upper Valley Chiropractic web-site.

The Notice of Privacy Practices also describes my rights and the duties of Upper Valley Chiropractic with respect to my protected health information.

Amber McLelland, DC reserves the right to change the privacy practices that are described in the Notices of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____/_____/_____
Date

_____
Description of Personal Representative's Authority

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Form Notice of Privacy Practice Summary

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Upper Valley Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes and to evaluate the quality of care that you receive.

Upper Valley Chiropractic will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires us to do so.

Upper Valley Chiropractic may use your information to provide appointment reminders and information about alternatives or other health-related issues.

Upper Valley Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research health and safety, governmental function in order to comply with workers compensation laws and regulations a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Amber McLelland, D.C. and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Upper Valley Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints please contact Amber McLelland, D.C. At 603-298-7400

_____ _____/_____/_____

Signature Date

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Patient Authorization Re: chiropractic care in an "open adjusting" environment.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. This "open adjusting" involves several patients being seen in the same adjusting area at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Upper Valley Chiropractic.

Your signature indicates your authorization of this activity.

_____ ____/____/_____
Signature Date

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

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Dear Patient:

Upon verifying your insurance coverage for Chiropractic Insurance, companies occasionally give this office incorrect information. Therefore, we strongly urge you to contact your insurance company to verify your own insurance.

Please verify the following information and **return this form** to Upper Valley Chiropractic.

Following this procedure may prevent problems with billing and payments, therefore preventing you from receiving an unexpected bill.

INSURANCE COMPANY_____
ID#_____

Customer Service Rep:_____

Effective Date of Insurance:_____

Copay/Explanation of Benefits:_____

Is a deductible required?_____

Are X-rays covered if necessary?_____

Is there a referral needed before service? _____

Number of Visits Allowed: _____ per Contract or Calendar year?

Additional Information: _____

Information Taken By: _____ Date: _____

Upper Valley Chiropractic, Dr. Amber L. McLelland, is **in Network** for: Blue Cross Blue Shield (Anthem), Cigna and Harvard Pilgrim, United Health Care, Aetna, Health Care Value Management, Great West

We are **Out of Network** for: Medicaid