AXIOM
CHIROPRACTIC

How did you hear about us? Referral: _____ Google:○ Facebook:○ Instagram:○ Website:○ Event:○

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____/_____/_____ Age: _____ ○ Male ○ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address: _____ City: _____ State: ____ Zip: _____

Mother's Name: _____ Birthdate: _____-_____-_____

Mother's Phone: Home _____ Work _____ Mobile _____

Father's Name: _____ Birthdate: _____-_____-_____

Father's Phone: Home _____ Work _____ Mobile _____

Who is responsible for this bill? (This information is to ensure the safety and wellbeing of the minor listed above)

○ Father's Social Security #: _____-_____-_____ ○ Mother's Social Security #: _____-_____-_____

○ Father's Driver's License #: _____ ○ Mother's Driver's License #: _____

○ Other *(please explain)*: _____

Pediatrician/Family MD: _____ City/State: _____

Last Visit Date: _____-_____-_____ Reason for visit: _____

HAS YOUR CHILD EVER SUFFERED FROM - *Check all that apply*

○ Headaches	○ Fainting	○ Digestive Disorders	○ Behavioral Problems
○ Neck Problems	○ Dizziness	○ Poor Appetite	○ ADD/ADHD
○ Backaches	○ Bed Wetting	○ Stomach Aches	○ Asthma
○ Seizures/Convulsions	○ Poor Posture	○ Colds/Flue	○ Muscle Pain
○ Leg Problems	○ Growing Pains	○ Scoliosis	○ Broken Bones
○ Chronic Earaches	○ Colic	○ Diarrhea/Constipation	○ Fall from Bed/Couch
○ Sinus Trouble	○ Sleeping Problems	○ Sports Injury	○ Walking Trouble

○ Allergies to: _____ ○ Other:_____

BIRTH HISTORY

Full Term? ○ Yes ○ No If no, when? _____ Hours in Labor: _____ ○Induction ○C-section ○VBAC ○Natural

Name of OB:_____ Name of Midwife/Doula:_____

○Hospital Birth, where: _____ ○Bottle fed, how long?_____

○Birthing Suite, where: _____ ○Breast fed, how long?_____ Difficulty breast feeding? ○Yes ○No

○Home Birth ○Other:_____ ○Birth Trauma? _____

AXIOM CHIROPRACTIC 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 or your emergency contact.
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, texts, emails, and appointment reminders - **we may call your home, leave messages and texts** 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.
12. Photography- Photos and videos taken of you while in the office are able to be used by Axiom Chiropractic for marketing and educational purposes.

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 health records at no charge, and when timely notice is provided (72 hours). **X-rays** are original records. However, you may request a copy of your x-rays, but you will be responsible for this cost which is $10.

COMPLAINTS:

If you wish to make a formal complaint about how we handle or handled your health information, please call Dr. Landon Staley at (435)-233-6075. If he is unavailable, you may make an appointment with our receptionist to see him 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

AXIOM CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

☐ I understand my rights as well as the practice's duty to protect my child's health information and have conveyed my understanding of these rights and duties to the doctor. I have received a copy of Axiom Chiropractic Patient Privacy Notice. 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. At this time, I do not have any questions regarding my rights or any of the information I have received.

INFORMED CONSENT

REGARDING: Payments, Claims, Finances and Relationships:

☐ I hereby authorize payment to be made directly to Axiom Chiropractic, 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 Axiom Chiropractic for any and all services I receive at this office. I understand that I am directly and fully responsible to Axiom Chiropractic for all fees associated with chiropractic care my child receives.

☐ Under the terms and conditions of a 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.

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 very minimal, 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 Axiom Chiropractic 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 care.

_____ ____/____/_____

(PRINT) Child's/Patients Name **Date of Birth**

_____ ____/____/_____

(SIGN) Patient's or Authorized Person's Signature **Date**

_____ ____/____/_____

Witness Signature **Date**

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