

A BETTER LIFE CHIROPRACTIC

Pediatric Entrance Form

Welcome to our practice! Please complete all questions for your child. Thank you.

Name: _____ Date: _____ SS#: _____

Local Address: _____ Home Phone: _____

City, State: _____ Zip: _____ E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex: Male Female

Referred by: _____

Parent/Guardian Name & Address (if different from above): _____

Parent/Guardian Work # _____ Parent's SS# _____

Who is financially responsible for this bill? _____

Method of Payment: (circle one) Cash Check Credit Card Insurance

Birth History: Vaginal C-Section Traumatic Non Traumatic
Forceps Vacuum Pre-Mature Full Term

Complications: _____

Birth Weight: _____

Has the patient ever had any:

Traumas? _____ Falls? _____

Automobile Accidents? _____ Broken Bones? _____

Circle applicable Health Conditions (Current or in the Past):

- | | | |
|------------------------|---------------------|------------------|
| Chronic Ear Infections | Colds/Flu | Bed Wetting |
| Asthma | Colic | Neck Pain |
| Allergies | ADD | Mid Back Pain |
| Headaches | ADHD | Low Back Pain |
| Diarrhea | Behavioral Problems | Sinus Problems |
| Poor Appetite | Scoliosis | Irritability |
| Digestive Problems | Seizures | Recurring Fevers |
| Temper Tantrums | Growing Pains | Constipation |

.....
Has your child been seen on an emergency basis? _____

List Surgeries: _____

List Medications: _____

Confidential: Has the patient ever been diagnosed with any of the following: HIV? Hepatitis? TB?

Childhood Diseases: (please circle all that may apply)

Chicken Pox Measles Mumps Whooping Cough Rubella

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Has the child been fully vaccinated? Yes No

If yes, when was the last shot given? _____ Type: _____

Adverse reactions ie: fever, chills, irritability, flu like symptoms, hearing loss, neurological problems, other?

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All first visit charges are payable when services are rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand A BETTER LIFE CHIROPRACTIC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to A BETTER LIFE CHIROPRACTIC will be certified upon receipt. HOWEVER, I clearly understand and agree that I am personally responsible for payment.

Interest in the amount of 18% per annual or 1.5% per month will be charged on your account if it becomes past due.

Signature

Date

In case of emergency, Please notify: _____
Name/Relation

Tel #



A BETTER LIFE CHIROPRACTIC

661 Goodlette Road North; Suite 108; Naples, FL 34109

Tel (239)263-3369 Fax (239) 263-8842

Dr. Deanna Barbaro

Chiropractor

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of all health care providers who specializes in that area.

Regardless of what the diseases is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic on this basis.

Signature

Date

**Patient Consent for Use and Disclosure
of Protected Health Information
A BETTER LIFE CHIROPRACTIC**

I hereby give my consent for Dr. Deanna Barbaro of A Better Life Chiropractic to use and disclose PROTECTED HEALTH INFORMATION (PHI) about me to carry out TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO).

A Better Life Chiropractic's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. A Better Life Chiropractic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Deanna Barbaro, A Better Life Chiropractic, 2228 N. Tamiami Trail, Naples, FL 34103.

With this consent, A Better Life Chiropractic may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, A Better Life Chiropractic may **mail** to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, A Better Life Chiropractic may **e-mail** to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that A Better Life Chiropractic restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to A Better Life Chiropractic's use and disclosure of my Protected Health Information (PHO) to carry out Treatment, Payment and Health care operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, A Better Life Chiropractic may decline to provide treatment to me.**

Signature of Patient or Legal Guardian

Date

Print Name of Patient

Print Name of Parent or Legal Guardian



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Dr. Deanna Barbaro

Chiropractor

Dear Patients:

Our massage therapist is a separate entity in our office; therefore, there is a required 24 hour cancellation policy. If notification is not received within this time period, you will be responsible for the massage session fees.

Full massage session fees will apply if you are late for your appointment.

No future massage appointments will be scheduled if you have an outstanding bill for massage fees.

Signature: _____

Print Name: _____

Date: _____