



Childhood Information

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- ◆ Today's Date: ___ \ ___ \ ___ .
◆ Child's Name: _____ .
◆ Mother's Name: _____ .
◆ Father's Name: _____ .
◆ Address: _____ .
◆ City: _____ ◆ Zip Code: _____ .
◆ Home Phone (parent): _____ email _____
◆ Birth Date: ___ \ ___ \ ___ ◆ Age: _____ ◆ Birth Weight: _____ .
◆ Current Weight: _____ ◆ Sex: M F

Birth History:

- ◆ Delivery: Normal Forceps Breech C-Section Home Hospital
◆ Infant Feeding: Breast Bottle Formula
◆ At Birth was there a presence of: Jaundice Cyanosis (baby turning blue)
◆ Congenital Defects/ Anomalies: _____ .
◆ Name of Obstetrician/ Midwife: _____ .
◆ Pediatrician/ Family M.D.: _____ .
◆ Date of last visit to M.D.: ___ \ ___ \ ___ ◆ Purpose: _____ .

History:

- ◆ How many prescriptions of antibiotics has your child taken in the last 6 months? _____ .
◆ For what illness(es)? _____ .
◆ How many in his/her lifetime? (estimate) _____ .
◆ How many other prescription medications has your child taken in the last 6 months, please list all that you can: _____ .
◆ According to the National Safety Council, approximately 50% of infants fall, head first from a high place (bed, changing area, etc.) during the first year of life. Has this happened to your child? Yes No
◆ Did your child have any other falls/jumped from a height over 3 feet? _____ .
◆ Please check off any of the following conditions your child has suffered from during the past six months:
 Ear Infections Asthma Allergies Temper Tantrums Chronic colds/cough
 Headaches ADHD Bed wetting Sleeping Problems Reoccurring Fevers
 Constipation Diarrhea Rashes Car Accidents Stomach/Digestive
 Seizures Colic Scoliosis Learning Disabilities
 Other, please describe: _____ .

- ◆ Purpose of this appointment: _____ .
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Creating Wellness for the Entire Family

CONSENT TO TREAT A MINOR

I (We) being the parent or guardian of _____, a minor, the age of _____ years old, do hereby consent, authorize and request Ranae Beard, D.C. to administer such treatment deemed advisable, necessary or requested on the above minor.

I (We) agree to hold her and Access To Health free and harmless from any claims, suits for damages or complications, which may result from such treatment.

Signed Parent/Guardian #1 _____

#2 _____

Date: _____

Witness: _____



ENTRANCE RECORD

The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and it's nerve roots. Misalignments of the spinal bones which interfere with the nervous system are called SUBLUXATIONS. Subluxations come from many causes and prevent various organs, glands, tissues and muscles from functioning properly.

The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the body to function properly and to heal itself.

Chiropractic does not treat disease or symptoms. The doctor of chiropractic's only goal is to allow the body to function properly and her only means is the vertebral subluxation.

Please understand that chiropractic is NOT a substitute for medical treatments of any kind. Also NO statement of the chiropractor is intended as medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

When you take a drug or medication there is a risk of dangerous side effect. When any medical test or procedure is performed certain risk is involved. When you walk down stairs, drive in a car, or play sports, there is always risk. On that note, chiropractic adjustments, which are always extremely safe and effective (a typical chiropractors malpractice costs less than their car insurance), pose a very tiny degree of risk in certain situations. The most common side effects seen in a small percentage of people are post adjustment muscle soreness. This is comparative to post exercise soreness. This typically subsides quickly. If you do experience any post adjustment sensations please tell the doctor on your next visit. If you have any questions concerning the safety of chiropractic in certain situations, please explain this to Dr. Ranae Beard, DC. She will do her utmost to care for you in the safest and most effective manner, just as she would her own family.

Please PRINT OR WRITE CLEARLY:

I, _____ have read the above, understand it fully and undertake Chiropractic care on this basis.

PARENT SIGNATURE

DATE

MINOR(S) NAME(S)



FINANCIAL POLICIES

1. We do offer a 30% time of service discount when services are paid in full at the time of the visit.
2. Payment is expected at the time of the visit unless other arrangements have already been made. We accept the following forms of payment: Cash, personal checks, and Visa, MasterCard and Discover cards.
3. We will bill your primary insurance company for your chiropractic care as a courtesy to you. (Note: Access to Health is in network for Blue Cross Blue Shield.) If for some reason your insurance company denies payment, we will sit down with you to discuss other arrangements.
4. The patient is always responsible for the payment of their care. An insurance contract is between the patient and the insurance company.
5. Ranae Beard, DC may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 1.5% per month.
6. Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient, not Access To Health, PC.
7. **Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.**

OFFICE POLICIES

1. Please be on time for your appointment. Being late will cause scheduling disruptions, which can interfere with the quality of care you and other patients receive.
2. Cancellations and missed appointments will result in a set back in your care. If you are not able to come in for your appointment, please reschedule as soon as possible. Missed appointments will be charged for a standard office visit (\$40).
3. Children are always welcome here with you during your visit or as patients. We appreciate your attention to their actions while in the office.

I, _____ have read the above,
acknowledge and understand the policies of this office as contained herein.

_____ Date: _____
Guardian signature

Minor(s) name(s) _____ Date _____

Witness signature

Access To Health, PC

Ranae Beard, D.C.
(970) 530-0981

3113 S. Taft Hill Rd.
Fort Collins, CO 80526

NOTICE OF PRIVACY PRATICES

This notice describes how Chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient of Access to Health, we MAY use or disclose personal and health related information about you in the following ways:

1. Your personal health information, including your clinical records, maybe disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
2. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if your employer is responsible for the payment of your services.)

Under federal law, we are also permitted to disclose your health information WITHOUT your consent or authorization in the following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency.
3. If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
4. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
5. If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, please advise us in writing as to your preferences.

You have the right to inspect or copy your health information for seven years from the date that record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible.

