PEDIATRIC NEW PATIENT INFORMATION

Today's Date: _____

PATIENT INFORMATION

Child's First Name: _____ Last Name: _____

Reason for Visit: _____

Sex: M / F Date of Birth: _____ Age: _____ Child's SS#: _____

Home Phone #: _____

Home Address: _____

Who may we thank for referring you? _____

FAMILY INFORMATION

Mother's Name: _____ Father's Name: _____

Does one or both parents have custody? _____

Home Phone #: _____ Home Phone #: _____

Work Phone #: _____ Work Phone #: _____

Parent's Marital Status: Married _____ Single _____Divorced _____Widowed_____

List Ages of Other Children in Family: _____

PAYMENT INFORMATION

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N

If you have health insurance that may cover chiropractic care, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name: _____ DOB: _____ SS#: _____

Insurance Company Name: _____Phone #: _____

Insurance Company address to send claims: _____

Employer: _____ Group #_____ Insured's ID #: _____

CONSENT FOR CHIROPRACTIC CARE

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter (name)_____as the doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Guardian's Name (Printed) _____

Guardian Signature: _____

Date: _____Witnessed by: _____

PEDIATRIC HISTORY

ANSWER THE QUESTIONS THAT APPLY TO THE GROWTH AND DEVELOPMENT OF YOUR CHILD.

Yes No

__ __ Was this child born at home?

__ __ Were forceps or a vacuum extractor used? C-Section delivery?_____ Breech delivery?_____

__ __ Can your child sit unsupported?

__ __ Is your child crawling yet?

__ __ Is your child walking yet? At what age did your child start to walk? _____ Months

__ __ Have you noticed a foot turned in or out?_____

__ __ Do you have any other concerns about your child's growth & development? _____

HEALTH HISTORY

Yes No

__ __ Has your child any health problems? Infections?_____

__ __ Has your child had any other illnesses? _____

__ __ Is your child presently receiving any medications? _____

__ __ Has your child recently been vaccinated? _____ Any Reactions? _____

FAMILY HISTORY

Do you have a family history of:

Yes No

__ __ Heart trouble
__ __ Cancer
__ __ Nervous conditions
__ __ Depression
__ __ Inherited disease

Explain _____

_____

_____

_____

LIFE STYLE INFORMATION

DIET

Breast feeding this child? _____ Are you bottle feeding this child ? _____

What is his/her favorite food? _____What foods does she/he dislike?_____

_____

SLEEPING HABITS

Any problems with bed-time? _____

What position does he/ she sleep in? _____Hours total _____

Parent/ Guardian Signature _____ Date _____

CHIROPRACTIC EXAMINATION

EXAMINATION INFANT

Cry _____
Skin color, tone _____
Size (weight WNL or below?) _____
Body proportions _____
Nutritional status _____
Symmetry _____

NERVOUS SYSTEM

Joint ROM

Normal _____
Spasticity/ Flaccidity_____

Gentle stroking should produce movement or withdrawal of extremity or facial expression. Findings: _____

Rooting Reflex (Disappears at 3/4 months. Absence before is indicative of severe generalized or central nervous system disease). Findings:_____

Galant's Reflex (Disappears at 2 months. Transverse cord lesions may be detected using this reflex) Stroke along paravertebral line. Should produce curve of trunk towards stimulated side. Finding:_____

Moro sign (Startle reflex. Persistence beyond 4 months may indicate neurologic disease. Low spinal injury & dislocation of the hip may produce absence of response in one or both legs). Findings: _____

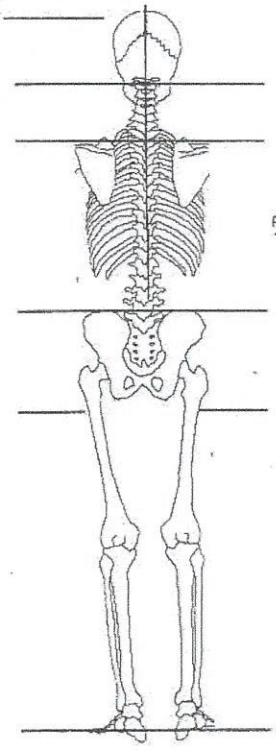
Babinski response (abnormal beyond age 2). Findings:_____

Ortolani's test (hip click). Findings: _____

Grasp reflex (persistence beyond 4 mo. suggests cerebral dysfunction). Findings:_____

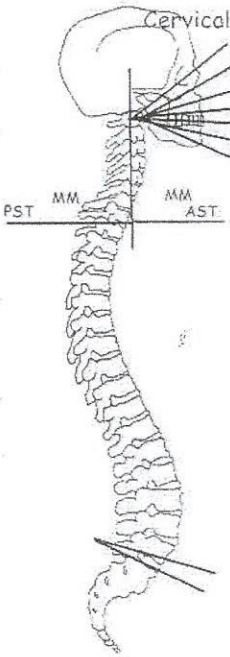
Palpation/Posture Analysis

DATE _____



DATE _____

Radiographic/Posture Study



Skull Position
Anterior Translation (AST)_____MM
Posterior Translation (PST) _____MM

Cervical Curve
Normal _____
Hypolordosis _____
Hyperlordosis _____

Thoracic Spine
A-P _____
Lateral _____

Lumbar Spine
A-P _____
Lateral _____

Pelvis
A-P _____
Greater Trochanters
(RT) _____
(LT) _____

Comments _____

ABUNDANT LIFE CHIROPRACTIC

Dr. Eric Harter
1611 Santa Barbara Blvd, Ste. 170
Cape Coral, FL 33991
Tel: 239-772-2266 Fax: 239-772-1017

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of posture correction and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor or chiropractic named above and/or with the other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her is in my best interest.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

ABUNDANT LIFE CHIROPRACTIC

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Cape Coral, FL 33991
Tel: 239-772-2266 Fax: 239-772-1017

ASSUMPTION OF RISK, RESPONSIBILITY AND LIABILITY WAIVER

I agree as follows:

Assumption of Risks:
I understand that during chiropractic visit (s) at Abundant Life Chiropractic and Dr. Eric L. Harter, Inc., I will be in unfamiliar surroundings and will be exposed to risks to my person and possessions. I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. Accordingly, I understand that despite its efforts, Abundant Life Chiropractic and Dr. Eric L. Harter, Inc. may not be able to ensure my complete safety at all times from such risks.

Assumption of Responsibility:
I understand that it is my responsibility for payment at the end of service and no insurance will be billed.

Liability Waiver:
I release and hold harmless Abundant Life Chiropractic and Dr. Eric L. Harter, Inc., their employees from any and all liability for any loss, damage, injury or expense that I may suffer as a result of my chiropractic visit (s) including, but not limited to, accidents, scheduling, sickness, government restrictions or regulations, any and all expenses which I may occur while participating in the chiropractic visit (s).
In the event one or more of the provisions of this waiver is deemed to be invalid, illegal or unenforceable in any respect under applicable law; the validity, legality and enforceability of the remaining provisions hereof shall not in any way be impaired thereby.
This waiver is effective while I am a patient and participating in the chiropractic visit (s). I understand that this agreement cannot be modified or interpreted except in writing by Abundant Life Chiropractic and Dr. Eric L. Harter, Inc. and no oral modification or interpretation shall be valid.

I have read this document carefully and acknowledge my responsibility and the effect of this liability waiver.

Patient Signature: _____ **Date:** _____

THIS NOTICE DESCRIBES HOW OUR OFFICE MAY USE AND DISCLOSE YOUR PERSONAL INFORMATION AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

In the course of your care as a patient at our office, we may' use or disclose personal and health related information about you in the following ways:

"Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment."

"Your health care records, as well as your billing records', may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are or may be responsible for the payment or services provided to you. "

"You have a right to request restriction on our use of your protected health information for treatment, payment, and operations purposes. Such requests are not automatic and require the agreement of this office. "

"Your name, address, telephone number, e-mail address, and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. "

"If you are not home to receive and appointment reminder or other related information, a message may be left on you answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations."

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

"'If we provide health care services to you in an emergency. "

"If we are required by law to provide care to you, and we are unable to obtain your consent after attempting to do so. "

"If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care. "

*If we are ordered by the courts or another appropriate agency. "

"You have a right to receive an accounting of any such disclosures made by this office. "

Any us or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information, you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail and e-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 or if you would like the information in a specific form, please advise us in writing as to your preferences.

You have the right to inspect and! or copy your; health information 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 the 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 the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to Dr. Eric Harter.

If you would like further information about our: privacy policies and practices, please contact Dr. Eric Harter. You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary, you care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever. Effective as of 04/15/03.

This notice and any alterations of amendments made hereto will expire seven years after the date upon which the record was created.

Name (printed) Signature; Date

If you are a minor, or if you are being represented by another party:

Personal Representative Name {print} Signature Date